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"It's the Hardest Decision I Have": Clients and Defenders on the Role of Mental Health in Case Strategy

Chelsea Davis*
Ayesha Delany-Brumsey**
Jim Parsons***

Abstract

In this paper, we present results from our recent study on public defense services for people with mental health conditions. Specifically, we explore how defenders and clients make decisions about case strategy, raising mental health in court, and treatment-based alternatives to incarceration. We also discuss client and defender perceptions about how client mental health affects case outcome. We gathered data for this study through interviews of matched client and defender pairs in Monroe County, N.Y. and Bronx County, N.Y. This includes a total of 200 clients and 104 defenders. Overall, our results speak to the challenge that defenders and clients face when trying to balance clients' legal and mental health needs, particularly when it comes to seeking treatment-based alternatives.

* Research Associate, Vera Institute of Justice. Ms. Davis earned her MPH in History and Ethics of Public Health from Columbia University in 2012.

** Director, Substance Use and Mental Health Program, Vera Institute of Justice. Dr. Delany-Brumsey earned her Ph.D. in Clinical Psychology from the University of California, Los Angeles in 2012.

*** Vice President and Research Director, Vera Institute of Justice. Mr. Parsons earned his M.Sc. in Social Research Methods from the University of Surrey in 1995.

I. INTRODUCTION

The overrepresentation of people with mental health disorders in our justice system[1] means that public defenders are frequently called upon to represent clients who have mental health conditions.[2] In this paper, we investigate how client mental health shapes defense strategy using data from our recent study. Specifically, we focus on two strategic decisions—raising mental health in court and advocating for a treatment-based alternative to incarceration (ATI), describing the factors that defenders and their clients weigh when making these decisions. In addition, we investigate defenders' and clients' perceptions of the impact of mental health on case outcome (*i.e.*, the length and type of sentence the client receives).

Increasingly, behavioral health treatment is mandated through the justice system and tied to criminal justice outcomes, requiring defenders to incorporate consideration of their clients' mental health and treatment needs into their defense practice. Clients, on the other hand, are in the position of having to make decisions about engaging in mental health care through the justice system—a decision that is driven not only by their clinical needs, but also by their legal needs. They must also consider whether engaging in services through the justice system will leave them with less autonomy over their care than if they were to engage in services through the community.[3] Yet, there is little research exploring how defenders and their clients make decisions about mandated treatment or their views about whether and how mental health should play a role in the client's case strategy.[4]

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[1] DAVID CLOUD, VERA INST. OF JUSTICE, ON LIFE SUPPORT: PUBLIC HEALTH IN THE AGE OF MASS INCARCERATION 5, 7 (2014), http://www.vera.org/sites/default/files/resources/downloads/on-life-support-public-health-mass-incarceration-report.pdf [https://perma.cc/83P4-FVHA]; Henry J. Steadman et al., *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 PSYCHIATRIC SERVS. 761 (2009); Arthur J. Lurigio, *People with Serious Mental Illness in the Criminal Justice System: Causes, Consequences, and Correctives*, 91 PRISON J. 67S (Supp. 2011).

[2] Although this study specifically focuses on the representation of clients with mental health conditions, we acknowledge that both the term and concept of "mental health" is broad and can encompass a range of conditions including substance use disorders. However, in this study we make a distinction between mental health and substance use, and many of the questions we asked study participants either referred to mental health and substance use separately, or we only asked about mental health. In their responses, some participants described mental health and substance use as one entity, others described these as separate entities, and some described them as distinct but related entities. The results that we present reflect this diversity in interpretation of the relationship between mental health and substance use.

[3] Cecelia Klingele, *The Promises and Perils of Evidence-Based Corrections*, 91 NOTRE DAME L. REV. 537, 571–75 (2015); John Petrila, *Mental Health Courts May Work, But Does It Matter If They Do?*, *in* PROBLEM SOLVING COURTS: SOCIAL SCIENCE AND LEGAL PERSPECTIVES 137–38 (Richard L. Wiener & Eve M. Brank eds., 2013).

[4] Tamar M. Meekins, *"Specialized Justice": The Over-Emergence of Specialty Courts and the Threat of a New Criminal Defense Paradigm*, 40 SUFFOLK U. L. REV. 1, 7–8 (2006).

According to the American Bar Association's (ABA's) Model Rules of Professional Conduct[5] and federal case law,[6] defenders must adhere to their client's wishes about the objective of the representation, specifically around discrete key decision points—whether to accept or refuse a plea, waive a jury trial, testify at trial, or appeal a conviction or sentence. For all other strategic decisions, the defender is encouraged to consult with the client, but ultimately, they must take the action they believe is in service of zealously representing their client's best interests.[7]

Providing zealous representation is not a trivial task in any situation, but doing so for a client with a mental health condition presents additional challenges. Broadly, the goal of criminal defense is clear**:** to the greatest extents possible, preserve the client's innocence and personal liberty. However, achieving this goal is not necessarily straightforward, particularly if lawyers are engaged in both "trial advocacy," as well as "treatment advocacy," where they work to meet the legal needs of their client as well as the client's complex psychosocial needs.[8]

Take, for example, the case of a client whose mental health condition has contributed to a long history of justice involvement. The client and his defender must face the complicated question of what outcome is in the client's best interest. In many ways, receiving a diversion program would be a good outcome—in the short-term the client avoids jail or prison, while in the long-term the client may receive care that addresses the roots of his justice involvement and helps him to live a fulfilling and productive life in the community. However, enrolling in such a program also has potential downsides**:** The program may not be appropriate for addressing the client's needs; he may be placed in a restrictive residential treatment program; or he may risk a punitive criminal justice sanction should he drop out of or fail the treatment program. There are similar concerns if that defender raises the client's mental health as a mitigating factor in court. In the best case, this strategy could lead to a reduced sentence. On the other hand, it could also raise concerns for the judge or prosecutor that the client is a danger to the community or too unreliable to return to court, and ultimately lead to a more restrictive outcome.

In our current court system, defenders are often expected to be able to make informed decisions about their clients' mental health needs, a skill that is traditionally the purview of medical and mental health providers. Defenders must inhabit this expanded defense function with minimal guidance on how to do so effectively while keeping their client's wishes paramount. Indeed, many public defense offices lack in-house social workers who could assess clients' mental

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[5] *E.g.*, MODEL RULES OF PROF'L CONDUCT r. 1.2(a) (AM. BAR ASS'N 2016).

[6] Jones v. Barnes, 463 U.S. 745, 751 (1983).

[7] *See* MODEL RULES OF PROF'L CONDUCT r. 1.2(a) (AM. BAR ASS'N 2016).

[8] Nicole Martorano Van Cleve, *Reinterpreting the Zealous Advocate: Multiple Intermediary Roles of the Criminal Defense Attorney*, *in* LAWYERS IN PRACTICE: ETHICAL DECISION MAKING IN CONTEXT 293 (Leslie C. Levin & Lynn Mather eds., 2012).

health.[9] Further, current performance standards such as the ABA's Criminal Justice Standards for the Defense Function provide little guidance, outside of the issue of competency, for representing clients with mental health conditions.[10]

To address this troubling lack of practical guidance around representing clients with mental health conditions, it is first necessary to understand how defenders grapple with meeting both their client's legal as well as extra-legal needs. Much of the current body of literature on defending clients with mental health disorders has examined issues of competency. However, the vast majority of clients with mental health disorders are able to assist in their own defense and, therefore issues of competency are not relevant.[11] Rather, defenders more frequently confront challenges around other key strategic decisions such as when to raise a client's mental health in court and whether to advocate for treatment-based ATIs.

There is also very little research devoted to understanding the preferences of clients around how their mental health should influence defense strategy, whether they have agency in these matters, and how they discuss these issues with their attorneys. For example, although ATIs are meant to be a way to connect clients with necessary treatment while reducing their justice involvement, little attention has been paid to understanding whether clients want to access treatment through the justice system or their perceptions of the advantages and drawbacks of participating in ATI programs. Therefore, it is particularly important that we understand clients' preferences and perspectives on how their attorneys are making decisions on their behalf.

The impact of mental health on case outcome is another area that is rich for investigation. Prevailing biases or "sanist myths" held about people with mental health disorders, such as that they are less human or more dangerous than people without mental health disorders, may mean that people with mental health disorders are more likely to face harsh or punitive treatment in the justice system.[12] Within the limited body of research on the relationship between mental health status and length of incarceration, the findings are mixed; while some data suggest that people with mental health disorders are incarcerated for longer periods than

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[9] DONALD J. FAROLE & LYNN LANGTON, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 231175, COUNTY-BASED AND LOCAL PUBLIC DEFENDER OFFICES, 2007 (2010).

[10] CRIMINAL JUSTICE STANDARDS FOR THE DEFENSE FUNCTION § 4-5.2 (AM. BAR ASS'N 2015).

[11] Gianni Pirelli et al., *A Meta-Analytic Review of Competency to Stand Trial Research*, 17 PSYCHOL. PUB. POL'Y & L. 1, 2–3 (2011); Ronald Roesch et al., *Defining and Assessing Competency to Stand Trial*, *in* THE HANDBOOK OF FORENSIC PSYCHOLOGY 327 (Randy K. Otto & Irving B. Weiner eds., 2d ed. 1999).

[12] MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL 21–58 (2000); CRAIG HANEY, MENTAL HEALTH ISSUES IN LONG-TERM SOLITARY AND "SUPERMAX" CONFINEMENT, 49 CRIME & DELINQ. 124 (2003); John F. Edens et al., *The Impact of Mental Health Evidence on Support for Capital Punishment: Are Defendants Labeled Psychopathic Considered More Deserving of Death?*, 23 BEHAV. SCI. & L. 603 (2005).

people who do not have those disorders, other data suggest that there is no difference.[13] Further, from a procedural justice standpoint, it is important to understand whether clients perceive their mental health as having impacted their case outcome because those perceptions may affect their sense of fairness and legitimacy in the court process. Defenders can also provide important insight into how mental health is associated with outcome, such as whether clients with mental health disorders are more likely to be held pre-trial, found guilty, or sentenced to more time. Additionally, it is important to understand whether the strategies developed for clients with mental health disorders actually make a difference when it comes to case outcome.

In order to explore these crucial issues, researchers from the Vera Institute of Justice and Policy Research Associates conducted a study of public defense services for people with mental health needs. We interviewed clients and their defenders at the beginning and end of their court cases. We gathered information on both defenders' typical strategic approach when representing clients with mental health disorders, as well as the specific strategies they took in representing the clients included in our study. We also asked clients about their experience with the justice system, how they wanted their lawyer to represent them, and their perceptions of the tactics their attorney used during their case.

II. METHODS

A. *Study Sites*

We conducted the study in Monroe County, N.Y. and Bronx County, N.Y. We chose these two sites because of their diverse demographics and because both counties are served by a range of public defense providers. See Tables 1 and 2 for a listing of county demographics and public defense providers.

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[13] *Compare* Jeffrey Draine et al., *The Impact of Mental Illness Status on the Length of Jail Detention and the Legal Mechanism of Jail Release*, 61 PSYCHIATRIC SERVICES 458 (2010), *with* Doris J. James & Lauren E. Glaze, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, NCJ 213600, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES (2006), http://www.bjs.gov/content/pub/pdf/mhppji.pdf [https://perma.cc/3GRB-56NP], *and* VERA INST. OF JUSTICE, LOS ANGELES COUNTY JAIL OVERCROWDING REDUCTION PROJECT xix (2011) http://www.vera.org/sites/default/files/resources/downloads/LA_County_Jail_Overcrowding_Reduction_Report.pdf [https://perma.cc/FKT9-CV9A].

Table 1. Study Site Demographics

	Bronx	Monroe
Total population	1,413,566	748,076
Age median	33 years	39 years
Gender		
Male	47%	48%
Female	53%	52%
Race/ethnicity[a]		
Black	30%	15%
Latino	54%	8%
White	11%	72%
Asian	4%	3%
Other/Two or more races	2%	2%
Household income median	$33,687	$51,371
Percent living in poverty	32%	14%

Notes: Data from this table is derived from the American Community Survey (2014). Percentages may not add to 100 because of rounding or missing data.

[a] In this race/ethnicity data, Latinos can be of any race while the other racial categories include people who indicated they were only of that race.

Table 2. Public Defense Providers of Study Sites

Bronx County	Legal Aid	Oldest nationwide public defense provider
	Bronx Defenders	Nonprofit public defense provider using a holistic defense model
	18 B (assigned counsel)	Court-appointed private attorneys that are appointment primarily when both Legal Aid and Bronx Defenders are conflicted out of a case
Monroe County	Monroe County Public Defender	Local public defender's office
	Monroe County Conflict Defender[a]	Represents clients when there is a conflict with the public defender
	Assigned Counsel Plan	Court-appointed attorneys who represent clients when there is a conflict with the other two offices

[a] The conflict defender operates only within Rochester City Court, Family Court, and in all appellate courts.

B. *Parallel Interview Procedure*

We conducted separate interviews with clients and their defenders to gather information on their perceptions of the case and their interactions with one another. In order to see how this may have changed over time, we conducted a baseline interview at the beginning of the court case, as close to the arraignment as possible, and a follow-up interview at the conclusion of the client's case, or at the end of our

one-year data collection period, whichever came first. All interviews were conducted by project staff and trained research interns. Notes were handwritten as many interviews were conducted in a jail setting and, therefore, researchers were not allowed to use laptops. Interviewers later entered the handwritten notes into the electronic study database for analysis.

C. *Participant Selection and Recruitment*

We recruited clients who had a criminal case in the Bronx or Monroe counties, were represented by a public defender, and had a mental health disorder. In both sites, jail staff informed us about individuals who were recently booked in the jail and who were identified by mental health staff as having a mental health disorder. We used a brief structured assessment to determine whether potential interviewees were competent to provide informed consent to participate in the study. Because we recruited study participants in the jail, all of the baseline interviews were with people who were held in pre-trial detention for the period between their initial court appearance and their arraignment. However, we conducted follow-up interviews in the jail, prison, or the community—wherever the client was. At baseline, all participants provided permission for us to contact their defender who we then recruited to the study.

D. *Interview Guide*

We created semi-structured interview guides, which included a mix of open-ended and fixed-response questions. Fixed-response questions were those where the interviewee had to answer with yes/no, or categorical questions such as gender or race. Other fixed-response questions included those answered using Likert Scales, a type of rating scale that includes responses such as 'always,' 'most of the time,' 'sometimes,' 'rarely,' and 'never.' For example, we asked attorneys about the extent of their agreement with the statement, "Securing access to treatment is the best outcome for clients with mental health disorders, even if it means more court supervision." Attorneys responded to this item using a five point scale: (0) Never, (1) Rarely, (2) Sometimes, (3) Usually, (4) Always.

E. *Participants*

We interviewed 200 clients and 104 defenders. Many of the defenders had multiple clients in the study and, therefore, participated in multiple interviews—one for each client. In total, we conducted 639 interviews, 200 baseline and 133 follow-up interviews with clients and 156 baseline and 150 follow-ups with defenders. See Table 3 for a listing of defendant demographics and other participant characteristics, and Table 4 for a listing of attorney demographics.

Table 3. Defendant Demographics

	Bronx	Monroe
Total interviews	(N = 100)	(N = 100)
Age mean (standard deviation)	37 years (11)	34 years (11.3)
Age at first arrest	20 years (7.7)	18 years (6.9)
Age at first incarceration	23 years (8.4)	20 years (7)
Race/ethnicity		
Black	42%	60%
Latino	38%	14%
White	5%	17%
Asian	--	--
Other	15%	9%
Gender		
Male	61%	79%
Female	37%	21%
Transgender	2%	--
Had job immediately before arrest		
Yes	30%	38%
Non-English language spoken at home		
Yes	51%	21%
Charge		
Misdemeanor	52%	38%
Felony	48%	62%
Note: Percentages may not add to 100 because of rounding or missing data.		

Table 4. Lawyer Demographics

	Bronx	Monroe
Total interviewees	(71)	(33)
Age average (standard deviation)	38.6 years (10)	40.8 (10.6)
Race/ethnicity		
Black	16%	--
Latino	10%	3%
White	63%	91%
Asian	7%	--
Other	1%	3%
Gender		
Male	46%	48%
Female	52%	48%
Transgender	--	--
Defender agency		
Monroe County Public Defender	--	94%
Legal Aid (Bronx)	47%	--
Bronx Defenders	47%	--
18 B (Bronx)	7%	3%
Years practicing mean (sd)	11 years (11)	13 years (10)
Note: Percentages may not add to 100 because of rounding or missing data.		

F. *Data Analysis*

Prior to conducting analyses, we cleaned the interview data. This included having a member of the study team compare the handwritten interview notes to what was entered into the electronic database to ensure accuracy. We analyzed fixed-response questions by calculating descriptive statistics such as the frequency or means of responses. We analyzed open-ended responses using inductive content analysis: two independent reviewers read all of the responses to each question, identified common themes, and then coded each response to the most relevant theme(s). When we report the percent of responses that refer to each theme, the total can sum to greater than 100 because interviewees could give responses that refer to multiple themes.

III. RESULTS[14]

We draw upon the in-depth interviews we conducted with attorneys and clients to first describe how attorneys develop their case strategy when representing clients with mental health disorders. We then focus more specifically on how defenders make decisions around raising mental health in court as well as describe, from the client's perspective, whether they viewed raising their mental health in court as ultimately helpful or harmful to their case. We then explore defendants' and clients' views of whether and when to seek a treatment-based diversion program. Finally, we discuss how clients and attorneys believe the client's mental health disorder impacted case outcome.

A. *Mental Health and Attorneys' Case Strategy*

We asked defenders to reflect generally, not in relation to any particular case, on whether their strategy is different when representing clients with mental health disorders and what factors they take into account when developing a defense strategy for those clients. Overwhelmingly, 86% of attorneys reported that their case strategy does differ when they have a client with a mental illness. Defenders described nuanced strategic considerations including acknowledging that they develop strategies to respond to the unique considerations of each case. In particular, some of the ways in which defenders described the impact of mental health on strategy include that mental health needs can be used as a mitigating circumstance, can determine whether a client can testify, or impact the way defenders think they can communicate with their client. Speaking to some of these considerations, and to the complexity of the decision making process, one attorney said:

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[14] Though many results are included in tables throughout this paper, detailed data from this study is on file with the authors.

> *[The client's mental health] is something I take into consideration with regards to length and how many times a client has to return to court; how that may disrupt the client or increase their anxiety. It impacts my decision about whether to go to trial. At times, I will use it to get a better disposition. Other times, I don't raise it because it would prolong court supervision of treatment, which I think can be harsh. The court is less equipped to understand the nuances of such treatment.*

When reflecting on the specific factors that influence how they develop their case strategy when their client has a mental illness, most defenders cited multiple factors; the most commonly cited factor was perceived type and/or severity of the client's disorder, noted in 79% of responses. For instance, attorneys indicated that when clients had what they perceived as a more severe disorder, they would be more concerned about that client testifying or the client's ability to assist in his/her own defense. The perceived severity or kind of disorder also impacted whether attorneys felt they could effectively communicate with clients and whether they trusted their client's version of events. As one attorney said:

> *Depending on what the illness is, I would treat someone who is getting medications for depression differently than someone who has been in and out of the psych ward, used ACT [assertive community treatment] teams, etc.*

The next most commonly cited factor, indicated in 57% of responses, was the relevance of the client's mental health to the crime. Here, attorneys discussed how they were more likely to integrate their client's mental health into their defense if there was evidence it was directly linked, or could be an explanatory factor for, the crime—particularly if they could argue that mental health treatment could prevent future crime. Attorneys also discussed mental health in terms of mens rea, or criminal culpability.

The attorney's perception about whether discussing their client's mental health in court would lead to leniency or increased punitiveness was also an important factor in shaping case strategy (34% of responses). Noted in far fewer responses were factors such as the clients' need for treatment, treatment history, or the perceived availability of treatment resources in the community.

Finally, some attorneys felt that the impact of the client's mental health on case strategy was not as significant as the impact that communication could have on the attorney-client relationship. As one defender stressed:

> *The challenge with clients with mental illness is not the legal defense; it's how you work on the case with the client. I often don't raise the issue in court, but it may impact my relationship with the client and how I communicate about the defense strategy with them.*

Or as another attorney said:

> *I start all attorney-client relationships with the basics. In trying to explain the legal process or expectations of the courtroom, if I find that I have challenges with communication or that I have to modify expectations, I think about bringing in a social worker or mental health professional.*

See Table 5 for a listing of the factors that attorneys indicated influence their defense strategy in cases with clients with mental health disorders.

Table 5. Factors that Shape Defense Strategy

Factor	% Responses	Impact	Example
Severity and kind of disorder	79%	Attorneys indicated that their perception of the severity of the client’s mental health disorder influenced their belief about whether the client could testify or assist in their own defense. The severity or kind of disorder also impacted whether attorneys trusted their client’s version of events or felt they could effectively communicate with them.	*“It depends what the illness is and how it affects daily abilities. All clients who have been released have to come back to court, and, if they’re not able to come back to court, they might have to end their case sooner (take a plea).”* *“There are a lot: client’s ability to interpret what happened to them or what they did or did not do, client’s ability to recall events accurately. . .”*
Relevance of mental illness to crime	57%	Attorneys were more likely to integrate their client’s mental health disorder into their defense if there was evidence it was directly linked to or an explanatory factor for the incident in such a way that mental health treatment would prevent further crime. Attorneys also discussed relevance in terms of mens rea, or criminal culpability.	*“Every case is unique. In some cases when the intent or mental status of the defendant is an element of the crime, it is important to ascertain as much as possible the defendants’ mental health history and current treatment status to determine whether their mental health status could have played a role in the crime and therefore be a possible element in the case.”*
Nature and facts of the case	33%	The type or severity of the charge as well as the strength of the case impact whether attorneys take into account the mental health of their clients.	*“It depends on the type of case. With a jumping the turnstyle case, mental health won’t factor in as much as in a more substantive case like an assault/violent case. In cases involving violence, and drug cases where a client self medicates, a client’s mental health might play more of a role in treatment and defense strategy.”*

Table 5. Factors that Shape Defense Strategy (cont'd)

Factor	% Responses	Impact	Example
Potential disposition or sentence	24%	Attorneys indicated they might be more likely to seek a plea if incarceration is likely, particularly if their client has a mental health disorder.	*"I would be more concerned about a mental health client going to prison than a client without mental health, a greater fear of incarceration of those clients with mental health. Mental health clients want faster conclusion of cases, because they are very stressed out by the case looming over them . . . if they goes to trial, taking stand may undermine the defense."*
Potential for information to help or harm negotiations during the case	34%	Defenders considered whether the court's knowledge of their client's mental health disorder would help their case, meaning more leniency, or hurt them, resulting in a more punitive outcome.	*"The bottom line is you have to try to win the case so if the MH information will help, then I will use it, but if it doesn't, then I won't use it. For instance, if I am defending a client based on what happened, I will use mental health services. If the case is involving identifying if the defendant was there, then I won't use it."*
Treatment and criminal history	19%	Client's criminal and treatment history impacted defender strategy. A long criminal record meant that attorneys had fewer options to negotiate. Past treatment validated mental health issues and showed community ties, and proof that somebody was untreated at the time could allow defenders to argue that future crime is preventable if clients do maintain treatment.	*"The main thing is to show that the criminal event was an aberration and a recurrence could be prevented by the correct mental health treatment."*
Availability of community resources	16%	Attorneys were more likely to factor a client's mental health needs into their strategy if they thought there were adequate community services for potential diversion.	*"Whether my client wants to address whatever conditions they may have, whether disclosing any information about that condition would be beneficial to the client's criminal case and what resources are available to us and to the client."*
Client's wishes	16%	Defenders considered their client's willingness to plead guilty, go to trial, or have their mental health be a part of their defense.	*"Whether or not the client wants to go to trial or wants a plea. What the client wants."*
Client need for treatment	12%	Some attorneys considered the client's need for mental health treatment when creating a defense strategy that may or may not involve seeking an ATI.	*"Addressing clients' primary need is the foundation of my practice. If a client's primary need is fighting law enforcement injustice, that's where the case will go. If someone has mental health issues, their mental health needs to be enhanced by my representation. If they're getting care, I have to make sure they maintain that care."*

In addition to asking, in general, about how mental health impacts case strategy, we also asked defenders during the follow-up interview to what extent the mental health of the client included in this study influenced the defenders' strategy on that case. Most, 67% of defenders, interviewed at follow-up said their client's mental health had no impact on the case strategy. An additional 18% said the client's mental health had 'minimally' or 'somewhat' impacted strategy. While 10% said mental health had 'a fair amount' or 'drastically' impacted case strategy. The remaining lawyers did not provide an answer to this question.

On the subject of client mental health and defense strategy, defenders indicated that each case presents a unique set of considerations which must be taken into account when developing a case strategy. When the client has a mental health condition, these set of considerations includes whether the client's condition is so severe as to impair attorney-client communication or the client's ability to participate in his defense. An additional consideration is whether discussing the client's mental health in court will lead to a more lenient or more punitive outcome. However, by the follow-up interview, most defenders indicated that their client's mental health had little influence on their defense strategy. One possible explanation for this is that other non-mental health related case factors, such as the charges the client was facing, were more relevant for determining case strategy.

B. *Raising Mental Health in Court*

We also explored the specific considerations, strategic and otherwise, that factored into defenders' decision making about whether and when to raise mental health in court, as well as whether clients perceived this course of action to be helpful. We asked defenders how often they typically, that is without reference to the client included in the study, raise mental health for clients facing felony charges if they believe it will result in a shorter or less restrictive sentence. Responding on a five-point scale from 'never' to 'always,' 76% of defenders indicated that, under these circumstances, they would 'usually' or 'always' raise mental health. Attorneys noted the potential for the client's mental health to serve as a mitigating factor; however, they also indicated that this is primarily true only when a client is facing felony charges. Many attorneys also discussed how raising a client's mental health in court is a challenging strategic decision that could either result in leniency or a more punitive response from the court. As one attorney said:

> *Usually mental health isn't a mitigating factor in misdemeanor cases because the client is usually not facing jail time or probation. In felony cases, it's more important, because you are trying to keep clients away from longer sentences. For misdemeanor clients, it's the inverse—you don't want to bring up their mental health because it can be a disservice to them.*

At the follow-up interview, attorneys reported that their client's mental health had only been raised in 25% of cases. In the majority of these instances, 68%, it was raised by the defender, as opposed to the prosecutor, judge, or another court actor. In total, defenders raised mental health in 17% of the cases included in this study. Attorneys cited multiple reasons for why they did not raise mental health in court: In 32% of cases, the defender didn't think mental health was relevant to the case. In 31% of cases, attorneys thought raising mental health wasn't worth the risk of a more punitive outcome. For instance, one attorney said:

> *At the time of arraignment, it seemed counterproductive. My goal was to get her out; and talking about her mental health disorder didn't seem like it was going to motivate the judge to release her.*

In less than 10% of cases, attorneys indicated that they did not raise mental health in court because they believed the client was competent to assist in his or her own defense:

> *I felt that she was competent to assist in her defense. She did not present as clearly in need of mental health assistance, and given the severity of the potential punishment she faced, I thought it less likely that raising her mental health status would lead to an advantageous disposition.*

In 8% of cases, attorneys noted that the client's substance use or physical health were more relevant to the client's case than the client's mental health. In another 8% of cases, the attorney reported that the client's case resolved quickly and so they did not raise mental health. Less commonly, attorneys reported that they did not raise their client's mental health status because the client did not present them with symptoms of a disorder, so the attorney either considered the diagnosis made by the jail to be irrelevant, deferred to their client's assertion that he or she did not have a mental health disorder, or said their client had a substance use disorder and not a mental health condition.

Finally, although all the defenders were aware that this is a study about representing clients with mental health disorders, 16% reported that they did not raise their client's mental health because they were unaware of their client's mental health status. This occurred primarily in cases that resolved so quickly that we conducted the baseline and follow-up interviews with defenders at the same time, after the case disposition.[15]

Amongst the relatively small percent of defenders who did raise their client's mental health, 61% of the time, they reported that they did so in order to help their client access treatment. As one lawyer said:

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[15] As described in the methods section above, we received information about the client's mental health status directly from the jail, prior to the client's arraignment.

> *Her mental health needs were pretty obvious and we have a mitigation specialist who is very dogged to match the person to the right type of treatment. So there was the potential for her to get really good service.*

Another 17% raised mental health in order to explain their client's behavior. For example, one attorney said it was raised

> *because [the client's mental health] was critical to his actions and behavior. Everything, from his behavior and his inability to refrain from contacting the complainant, stemmed from his illness and stability.*

Thirteen percent of the time, attorneys used the client's current involvement with a treatment program as a way to demonstrate stability and ties to the community. Another 13% of the time, attorneys indicated that they had concerns about the client's competence, which they raised in court. Finally, attorneys gave a range of less common responses such as wanting to explain a missed court date.

For those defenders who did choose to bring up mental health in court, we asked whether this decision worked in their client's favor or not. Most of the time (65%), attorneys indicated that it did work in their client's favor because the client got treatment or additional services or it led to a reduced sentence. On the other hand, 7% of the time, attorneys felt that raising mental health ended up being to their client's detriment. According to one attorney in the Bronx:

> *[I]f anything it might have been detrimental if the judge thought it made him not care about the community service that he missed a couple days of. He had four open cases and [the judge] wanted to resolve them all, so she may have used his mental illness in a snap judgment thinking it was protective to set bail and keep him there to resolve all those issues at once.*

Another attorney, whose client did not want treatment, said:

> *In this case, it backfired because the judge wanted to get her treatment. She would have had to stay in jail longer. Everybody wanting to get her treatment ended up hurting her.*

The rest of the time (28%), attorneys felt that raising mental health had no impact on the case.

In addition to understanding defenders' choices around raising mental health in court, we also elicited clients' preferences and perceptions about this practice. At follow-up, 73% of clients reported that their defender had not raised their mental health in court, 17% reported that their defender had, and the remaining 11% did not provide a response to this question.

For the clients who reported that their defender raised their mental health, almost all (91%) felt that it was helpful. Clients indicated that this strategy was helpful either because they received a more lenient sentence, they received treatment as part of their sentence, or because the judge or prosecutor was more empathetic. As one client said, raising mental health was

> *. . . very helpful to my case because it gives them an understanding of the type of person that I am and what I am really capable of doing; only when I don't take my medication I'm really bad.*

Another client said it was helpful:

> *[T]hey offered me a program, but ultimately dropped the charges down to disorderly conduct. I think the judge showed leniency because of my mental health and medical issues.*

A small number of clients (5) were unsure whether raising mental health was helpful or harmful. As one client reflected:

> *Well, it got me mental health court, but I don't know if that was good.*

Only two clients felt that raising mental health was harmful; one because her mental health was raised without seeking her permission and the other did not provide an explanation. Fortunately, the client who reported that her defender did not consult with her prior to raising mental health in court appears to be in the minority. Indeed, the majority of both defenders and their clients reported that the defender consulted with the client prior to raising mental health. Of those clients who reported that their lawyer raised their mental health in court, 73% reported that their attorney asked their permission prior to doing so, 18% indicated that their attorney did not seek their permission, and the remaining 10% did not provide a response to this question. Similarly, of the attorneys who raised their client's mental health, in most instances (85%), they reported that they consulted with their client before hand. For those that did not consult with their client, they gave a variety of reasons such as having spoken with the client's family instead, not having the opportunity to discuss it with their client, having raised the client's health off the record, or because the client trusted their decision-making.

Here, we found that defenders generally acknowledged that they would raise a client's mental health in court if they thought doing so would lead to a reduced sentence. However, for the clients included in this study, very few defenders actually raised mental health. The primary reasons for declining to raise this issue was that defenders felt mental health was either not relevant to the client's case or they worried that making the court aware of their client's mental health might lead to a more punitive outcome. That said, both defenders and clients agreed that, for the minority of cases in which the defender did raise mental health, it was helpful

to the client—either because they received a more lenient sentence or because they received treatment. Finally, clients and defenders reported that most clients gave permission for their defender to raise their mental health in court, which indicates some level of client autonomy over this decision. This result, however, is based on the small sub-sample of clients whose mental health was raised.

C. *Seeking and Accepting Treatment-Based Alternatives to Incarceration*

Deciding whether or not to raise a client's mental health in court is a prerequisite to another key decision that defenders and clients often face: whether to seek a treatment-based ATI. To assess attorneys' typical beliefs and practices about seeking an ATI, we asked a series of closed-ended questions on a five-point scale from 'never' to 'always.' We asked attorneys to respond to these questions based on their general strategy, not in reference to the client included in this study. We also asked attorneys to focus exclusively on their beliefs about seeking an ATI when the client is facing felony charges because the severity of the potential sentence makes seeking an ATI more likely. Their responses to these series of questions reflected competing priorities of seeking to help their client access needed services while also ensuring their liberty.

On the one hand, attorneys stressed the need to minimize their client's contact with the justice system: 71% percent of attorneys reported that they 'usually' or 'always' prefer that their client is released to the community pre-sentence irrespective of mental health needs. Similarly, 74% of attorneys reported that it is 'usually' or 'always' their priority to obtain the shortest sentence for their client irrespective of mental health needs.

On the other hand, in response to the statement, "Getting access to treatment for a client with serious mental illness takes precedence over all other considerations," 26% of attorneys indicated that it 'always' or 'usually' takes precedence, and an additional 41% said that it sometimes takes precedence. Similarly, 18% of defenders said it is 'usually' or 'always,' and 50% said it is 'sometimes' true that securing access to treatment is the best outcome for clients with mental health disorders, even if it means more court supervision.

We then asked attorneys to describe in detail how they strike a balance between their interest in achieving a low charge or short/non-restrictive placement for their client with their interest in helping their client treat their mental health condition. Almost half (45%) of attorneys said achieving the least restrictive placement is always their first priority. For instance, one lawyer said:

> *Generally, my first priority is to get them out of the criminal justice system. Even if I think they might need treatment, I don't think it's the role of the courts necessarily to mandate treatment because the client ends up in jail if they can't complete the treatment.*

Another attorney described how accessing treatment is only a priority in so far as it can be used to secure a less restrictive outcome:

> *My role isn't to treat their mental health disorder. Treating that is only relevant to the extent that it is in service to getting the best possible outcome to resolve the case.*

A sizeable number of attorneys, 34%, said that following their client's wishes is their first priority. As one defender told us:

> *The client's desire is the most important thing, some clients want to kick a habit, obviously most want to get out of jail as soon as possible, and my advice tends to err on the side of less long-term exposure to incarceration, but they are still the boss.*

Another defender said:

> *Honestly, I try to err on the side of advocating for what the client wants, not necessarily their best interests.*

The remaining 20% of attorneys said that their clients' need for treatment and non-restrictive placements are not in conflict:

> *They are not mutually exclusive, and are almost completely separate. Treatment is only useful in so far as it helps the case. Leaving it out of the plea isn't precluding them from getting treatment, so you don't really have to balance them. It's not a valid dichotomy. If there's a very specific case where they are at odds, I just ask the client and support their choice.*

Some of the attorneys who did not feel that there was a conflict were attorneys who had access to in-house social workers who can help clients obtain services outside of the justice system:

> *I'm lucky that . . . my social workers can find a program without it being ordered. So I'm more likely to go for the lowest sentence or amount of supervision, knowing that, if my client wants a program, we can do it voluntarily.*

But even when attorneys were able to describe using one of these strategies for balancing their client's treatment needs with achieving a favorable legal outcome, they also described how challenging it is to maintain this balance. As one defender in the Bronx said:

> *I try to meet in the middle between the two. A lot of times, I leverage mental health treatment as a way to resolve the case. Issues come up when a one size fits all program, which the prosecutor or judge wants because they're used to it but which isn't really good for the client, gets enforced on a client.*

Another lawyer, described making these decisions

> *carefully; the best thing to do is refer to the factors mentioned previously. While you want the court to consider a person's mental health status, you want to avoid having the court have the power to impose an alternative sentence that involves jail or something draconian. There are so many collateral consequences. For instance, having substance use issues and getting arrested could lead to losing public housing.*

Simply put by one attorney:

> *I don't; I can't—it's the hardest decision I have.*

To understand how this complex decision-making about ATIs was applied in the case of the clients included in this study, we asked defenders to describe the most pertinent features of their client's case that would determine whether the attorney would seek an ATI. Perhaps unsurprisingly, most attorneys listed a combination of factors. The most commonly cited factor, given in 52% of responses, was client willingness to be diverted and admitted to a treatment program. In addition, 50% of attorneys mentioned the potential sentence and strength of the case as an important factor; this includes the consideration that advocating for a treatment-based ATI might not be worth the risk of a potentially more punitive, lengthy, or restrictive outcome. Less commonly mentioned, in descending order, were the existence of parole issues or other recent and pending cases (37%), the judge or prosecution's willingness to divert (28%), the client's need for treatment (22%), their client's chance of success in the ATI (22%), the client's eligibility for an ATI (20%), the presence of a co-occurring substance use disorder (17%), the availability of treatment in the community (9%), and the need to avoid jail (9%). These factors are described in Table 6.

Table 6. Factors that Shape the Decision to Seek Diversion

Factor	% Responses	Impact	Example
Client's willingness	52%	Defenders stated that their willingness to seek diversion was dependent upon their client's willingness to do so.	*"Ultimately I don't make those decisions, she does. If there is an option on the table, I will discuss it with her."*
Potential sentence or strength of case	50%	If the potential sentence is short or the defense's case is strong, defenders are reticent to recommend an ATI that could result in longer or more restrictive court supervision.	*"It's always dangerous to mandate treatment or programs that could go on longer than the case itself. In this case, it [the charge] really wasn't that serious so it didn't seem appropriate. Court mandated treatment drags on too long and can make the situation worse. It can also leave the client more susceptible to re-arrest if the case is still open."*
Parole, pending or past criminal cases	37%	When clients had long criminal histories or other pending cases, it made plea negotiations more difficult.	*"Treatment is not an issue in this case. The most pertinent thing is that she's on probation and a plea could result in a violation."*
Prosecutor or judge's willingness to divert	28%	Lawyers described how the DA or judge's willingness to divert is a determining factor in whether the defender moves forward with that strategy.	*"The prosecutor's willingness to go along with treatment. Whether or not a judge would be willing to release him from jail to an inpatient treatment program."*
Client's need for treatment	22%	A client's need for treatment was sometimes justification for an attorney to seek an ATI.	*"If he has a diagnosis and needs treatment—I would consider treatment."*
Chance of success in program	22%	Defenders were reticent to recommend an ATI for a client who had previously negative experiences with such programs, mostly because of the risk of punitive outcomes for failing treatment programs.	*"She has failed TASC twice. And she's on painkillers for her back issues and no program will take her on the painkillers and she says she can't get off the painkillers and her wife and best friend say she can't complete a program, so I'm worried she'd fail and be sent upstate."*
Eligibility	20%	Defenders were sometimes unsure about whether their client would be eligible for diversion.	*"Due to the charges, he is not really a candidate for diversion or ATI programs, but it might perhaps be a possibility as the case goes forward."*
Co-occurring substance use disorder	17%	Defenders often considered advocating for programs that address co-occurring substance abuse.	*"The most pertinent feature is probably that it's a drug case and she takes drugs because of her addiction. Her mental health has been affected by the drugs; it makes her more likely to be considered for treatment like TASC."*

Table 6. Factors that Shape the Decision to Seek Diversion (cont'd)

Factor	% Responses	Impact	Example
Availability of treatment	9%	Defenders factored in whether treatment would be available in the community. Defenders were also concerned that clients would not have access to services without the criminal justice system.	*"If treatment [is] available. If [the] client [is] interested . . ."*
Need to avoid jail or inability to pay bail	9%	Defenders felt that clients with mental health disorders needed to get out of jail and strategies to accomplish that as soon as possible were prioritized.	*"The only pertinent feature of this case is that my client is incarcerated and can't make bail. This deprives us of basically an option except for treatment."*

We also asked defenders about whether their client was ultimately diverted. At baseline, 46% of defenders reported that their clients were eligible for diversion, but thought that only a little over half of those eligible (52%) could expect to receive a treatment-based ATI as part of a guilty plea. By the follow-up, 40% of defenders reported that their clients were eligible for diversion. Of these eligible cases, defenders sought a treatment-based ATI 36% of the time, and ultimately, 20% of the eligible cases were diverted to an ATI—a total of 12 individuals. For the minority of defenders who sought an ATI, a little under half (46%) said they did so primarily because their clients needed treatment. The remainder reported that they sought an ATI either because their client requested an ATI (28%) or because treatment was better than incarceration (26%) even if the treatment was not necessary to help improve their client's mental health.

Most attorneys, however, did not seek an ATI, and of those, almost half (49%) said they did not because they were able to secure a favorable, or better than expected, outcome for their client without having to advocate for an ATI. Many defenders (23%) chose not to seek an ATI because they felt that justice-system based treatment was more punitive or risky than a definite period of short incarceration. This type of response was particularly common when the client faced a misdemeanor charge:

> *It's always dangerous to mandate treatment or programs that could go on longer than the case itself. In this case, it really wasn't that serious so it didn't seem appropriate. Court-mandated treatment drags on too long and can make the situation worse. It can also leave the client more susceptible to re-arrest if the case is still open.*

The next most common reason for not seeking an ATI was that it was not an option (17%), mainly because defenders didn't think their clients were eligible for diversion. Other reasons included that the client didn't want an ATI (6%), the

negative impacts of pleading guilty on parole or other ongoing cases (3%), or the defender thought the client would not succeed in the ATI (2%). As one defender said:

> *She has failed TASC [an ATI program] twice . . . and she's on painkillers for her back issues and no program will take her on the painkillers and she says she can't get off the painkillers and her wife and best friend say she can't complete a program, so I'm worried she'd fail and be sent upstate.*

For their part, during the baseline interview, clients generally expressed a favorable view of seeking a treatment-based ATI. At baseline, 74% indicated that they would be willing to accept a program, 19% would not be willing, and 7% indicated the decision would be dependent on the kind of treatment or terms of the plea. Over half (51%) of the clients who said they would accept an ATI said they would do so because they needed treatment services. One client described that he would accept treatment:

> *Of course. Don't have to ask me twice. I need it. If I wasn't using drugs (self-medicating) and was on psych meds, I wouldn't be here. After all, I'm the one who turned myself in. I want to be a good person.*

A woman in the Bronx said:

> *Because I need help. I'm willing to surrender to stop doing drugs. It's time for a change. I am 45 years old and have beautiful children and I am grateful to have them in my life and I need help. I am not a bad person, I just need stability.*

Another 40% said they would accept an ATI because treatment would be better than jail. In the words of one client:

> *It would benefit me more than jail could help me because I would not be sitting around doing nothing all day. The program would help me with school, getting me a job, and housing. It would also help me stop smoking weed.*

Other clients described how treatment programs are preferable to jail because they can stay in their community in a safe environment:

> *It will be more beneficial to me because I will still be able to do the things I normally do like take care of my son and better myself at the same time. The environment is not as dangerous as jail. My mental*

> *health issues make me clash with people in jail who don't understand my thoughts and way of life.*

Other clients reported that they wished to avoid the deleterious impact of jail on their mental health:

> *A treatment program would help me more than sending me back upstate [to prison] because the upstate trip messed me up mentally. The treatment program can help me get back to society.*

Another client described the same sentiment:

> *I'm more apt to bounce back if someone is trying to help me with my problem, instead of someone throwing me in a box and ignoring my problem.*

Of the 7% of clients who indicated they might accept an ATI, they all said that their decision would depend on the kind of plea offered or the kind of treatment. Some of these clients indicated, for example, that they were only willing to plead guilty to a violation or misdemeanor, but not to a felony. Others stated that they were only willing to accept outpatient treatment. Describing this decision making, one client said:

> *They always send me to inpatient. When you are in inpatient you have to do so much. They even tell you that you have to save money so you give them money and when it is time for you [to] get it back, they don't give it back to you. [Outpatient] for me . . . is more freedom, you get to be your own person. You get to talk to the counselor and go to the groups. In inpatient, they have no time for you; it is about money.*

Of the clients who said they would not accept an ATI, 26% were not interested because they did not believe that they needed treatment. An additional 23% said they were not guilty and would not take a guilty plea:

> *Because I am not guilty of what they are charging me. In my other cases, where they have evidence and I am guilty, then I would accept it, but not for this case.*

Another 23% expressed a concern that was also highlighted by a number of defenders, saying that treatment was more punitive or more risky than jail:

> *I don't like being on a leash, especially by the court system. That is all it is . . . they put you in a program, you fuck up, they put you back in jail. I'd rather just do time.*

Moreover, 15% of clients said they were in a program already, and 13% were convinced treatment doesn't work:

> *I have been to various drug treatment programs and they have not helped me and what I believe will help me is to get a job . . . I could run a program I have been to so many.*

Factors that influence whether clients would accept an ATI are detailed in Table 7.

Table 7. Would Clients Accept a Treatment Program as Part of a Guilty Plea?

Response		% Responses	Impact	Example
Yes (74%)	Need treatment or other services	51%	Many clients would accept a program because they thought they needed treatment.	*"I need help. I need the treatment. My mother would be less depressed if I am in a treatment program, and since she has cancer, I don't want to stress her out."*
	Treatment is better than jail	40%	Clients would accept treatment because it was a better alternative to jail, mostly because it allowed them to remain integrated in society, around family, and because it's a way to avoid the negative impacts of jail on mental health.	*"It would benefit me more than jail could help me because I would not be sitting around doing nothing all day." "Because jail doesn't do a damn thing for you except drive you more crazy."*
	Other	10%		
No (19%)	Treatment is more punitive or risky than jail	23%	Clients were concerned ATIs were too risky, either because the program could take longer than a jail sentence or because punishment for failing the program could be more punitive than the original potential sentence.	*"I don't like being on a leash, especially by the court system. That is all it is . . . they put you in a program, you fuck up, they put you back in jail. I'd rather just do time."*
	Not guilty	23%	Some clients wouldn't plead guilty under any circumstances.	*"I would not accept it because I am not guilty in this case. If I was guilty, then I would accept a treatment program."*
	Treatment doesn't work	13%	Some clients believed that treatment wouldn't work for them.	*"Because I have been to various drug treatment programs and they have not helped me and what I believe will help me is to get a job. . . I could run a program I have been to so many."*
	Don't need treatment	26%	Clients didn't think they needed mental health treatment.	*"I am not pleading guilty and I don't have a drug problem so I wouldn't go to the program."*
	Already in a program	15%	Some clients were already enrolled in a behavioral health treatment program and wouldn't accept another.	*"Because I'm in mental health already. I just did 7 months in NarcoFreedom and completed it. It's 6 months but they gave me an extension to find my own place."*
	Other	1%		

Table 7. Would Clients Accept a Treatment Program as Part of a Guilty Plea? (cont'd)

Response		% Responses	Impact	Example
Maybe (7%)	Depends on kind of treatment or plea	100%	Some clients would only accept an ATI if it were an outpatient, rather than an inpatient program. Other clients would plea to a violation or misdemeanor, but not a felony.	*"They always send me to inpatient. When you are in inpatient you have to do so much. They even tell you that you have to save money so you give them money and when it is time for you get it back, they don't give it back to you. . . [Outpatient] for me it is more freedom, you get to be your own person. You get to talk to the counselor and go to the groups. In inpatient they have no time for you—it is about money."*

When strategizing about seeking an ATI, defenders discussed a range of considerations including striving for the least restrictive outcome, the clients' wishes/priorities around diversion, the strength of the case, and whether an ATI would place the client at risk of a punitive criminal justice sanction if the client fails the program. At baseline, most clients indicated a willingness to be diverted, primarily because they wanted treatment or because they wanted to avoid jail or prison. However, follow-up defenders indicated that most clients were not diverted and that they did not seek diversion in most of these cases because they were able to secure a favorable outcome without seeking diversion.

D. *The Relationship between Client Mental Health and Case Outcome*

In addition to exploring the strategies of raising mental health in court and advocating for a treatment-based ATI, we also explored the relevance of mental health for influencing case outcome. Although many clients (58%) articulated a connection between their mental health and their arrest or history of justice involvement, most clients (73%) did not believe mental health influenced the ultimate outcome of their case. For instance, one client told us:

> *No, it played a role in me catching a case, but I didn't get leniency or get anything extra because of it. It just got me the case . . . I could have dealt with it better if I could have controlled my anger and been more rational. If I could have controlled my anger, I wouldn't have ended up here.*

Or as another client said:

> *No [mental health] had nothing to do with [the case outcome]. The judge did not want to hear about mental health.*

Several clients thought their mental health should have made a difference in sentencing or disposition:

> *I don't think that it has, and I think that in a way it should . . . because if they understood the reasons why I fled [from the cops] and had some background about me and my mental health that would help . . . because of my experiences in the past it was just a natural reaction [to flee from the cops].*

Another client said:

> *I think my mental health should have played a part in my case. I think [the defender] was just trying to get me off the hook. I asked for mental health court and he said I couldn't get it, but he never really got into the reason why I couldn't get it.*

A little less than a quarter (24%) of clients thought mental health did in fact impact case outcome and sentencing. The remaining 3% were not sure what role their mental health had in the case outcome. For those individuals who felt that their mental health impacted their case outcome, about 20% did not indicate whether they thought the outcome was positive or negative. However, over 70% thought their mental health condition contributed to a better outcome. One client said:

> *Yes, [mental health contributed to a better outcome] because [of] my history and how much I have been through, and they looked at all [of] that; my history didn't show me being aggressive or malicious; it showed my depression and trauma and you could tell that I had poor judgment, but I didn't do anything maliciously.*

Fewer than 10% of clients who thought that their mental health was associated with their case outcome thought that it led to a worse outcome. In one instance, a client thought the court's knowledge of their mental health condition and co-morbid substance use negatively impacted their case:

> *My mental issue is what is making me relapse, so not taking care of it, it is back. The issue is that I have drug problems, they don't see me like a sick person; they see me as social garbage.*

In addition to examining the impact of mental health on case outcome from clients' perspectives, defenders were also asked to summarize what they thought

were the most important features of the case that led to the outcome. Attorneys noted multiple compounding factors, the most common of which, heard in 35% of responses, was that the client had other pending cases or an extensive criminal history. Attorneys indicated that these indicators of prior justice involvement made negotiating with the judge and prosecution much more difficult. The next most common factor, mentioned in 21% of responses, was simply the strength and facts of the case, with attorneys indicating that in some ways, the case outcome was a foregone conclusion. Similarly, whether the client was charged with a misdemeanor or felony was a factor mentioned in 15% of responses; attorneys frequently discussed how more serious charges made it more difficult to negotiate with the judge or prosecutor. Often, these two sets of factors converged in one response: "The seriousness of the allegations and the prior convictions for a violent felony makes negotiating with the judge more difficult."

Relatively few attorneys noted factors such as the client's mental health (5%), substance use (9%), treatment history (4%), or the defender's advocacy for an ATI (4%) as impacting case outcome. Indeed, attorneys emphasized the influence of factors outside of the client's mental health and substance use on case outcome. As one attorney said:

> *The overwhelming factor in this case was the multiple indictments which the client faced and the potential for an extended period of incarceration if convicted after trial or failing to complete treatment that motivated the eventual disposition.*

We also asked attorneys at the follow-up interview whether, on a five-point scale from 'not at all' to 'drastically,' certain factors would have improved the outcome of their case. Generally, defenders were not optimistic that any of the specified factors would have made an impact. Attorneys assumed that having a judge or prosecutor who had a better understanding of mental health issues would have had no, or only minimal impact on case outcome in 65% of cases. Also, most attorneys did not think that having access to more mental health treatment/assessment resources or more training/experience around representing clients with mental health disorders would have had a significant impact on case outcome. Indeed, 69% of attorneys said that access to additional resources would have had no or minimal impact on case outcome, and 73% said the same of additional training for attorneys.

Both clients and defenders perceived little impact of mental health on case outcome. Indeed, defenders more commonly reported that non-mental health related factors such as the client's criminal justice history or the facts of the case were related to the outcome. That said, for the subset of clients who did believe that mental health impacted case outcome, most felt that the impact was positive.

IV. DISCUSSION

Representing clients with mental health conditions is a common occurrence for defenders. Indeed, the defenders we interviewed for this study estimated that, on average, nearly 40% of their clients have a mental health disorder. However, almost no research has been devoted to understanding how defenders incorporate their client's mental health status into their defense strategy or how clients want their mental health to play a role in their case. Therefore, in this study, we asked clients and defenders to provide their perspective on the relationship between client mental health and defense strategy, with a particular focus on two strategic decisions that only have to be considered when a client has a mental health condition: raising mental health in court and advocating for a treatment-based ATI. We also asked defenders and clients to comment on how mental health ultimately impacted case outcome.

When discussing defense strategy, clients and defenders described the tension between meeting a client's legal needs and securing access to treatment. This tension is perhaps most evident in their decision making around pursuing treatment-based ATIs. For instance, the majority of clients were willing to accept an ATI as part of a guilty plea. Of those who would accept an ATI, almost half would do so primarily because they needed treatment, a consideration driven by clinical needs. However, a little more than one-third described avoiding a custodial sentence as their primary motivation for accepting an ATI, a mainly legal consideration. Similarly, for those who would not accept an ATI, they provided a mix of therapeutic and legal considerations—that they did not need treatment, were unwilling to plead guilty, or were concerned about the potential for treatment to be more punitive or place them at risk for a lengthy custodial sentence if they do not comply with the conditions of treatment.

Defenders worked to strike a similar balance. For instance, almost two-thirds indicated that they preferred for their clients to receive a less restrictive sentence/outcome, irrespective of the client's clinical needs—a preference that prioritizes legal considerations over therapeutic ones. On the other hand, when asked in a different question about whether securing access to treatment was the best outcome for clients, even if it meant more court supervision, over two-thirds of defenders thought this was sometimes, usually, or always the best outcome. These contradictory results speak to the difficulty of balancing therapeutic and legal needs. While defenders may have felt that their clients could benefit from treatment, their ability to prioritize this may have been overwhelmed by their professional responsibility to pursue the least restrictive outcome for their client.

In resolving this tension, defenders tended to prioritize meeting their client's legal needs first and approached securing treatment as a mitigation strategy. For instance, when asked about how their clients' mental health usually shapes their legal strategy, defenders spoke most often of how mental health could be used to explain their client's behavior or make a case for reduced culpability—both strategies that could result in a less restrictive outcome. Defenders were much less

likely to mention the client's need for treatment or other clinical considerations as factors that shape their strategy. Decisions about whether to raise mental health in court were most commonly driven by how likely they thought that it could serve as a mitigating factor, a consideration more common in felony cases than misdemeanors.

Ultimately, even in a sample with over half of clients charged with felonies, very few defenders raised the mental health needs of their clients in court or advocated for a treatment-based ATI for eligible clients. This is not to say that attorneys are incorrectly prioritizing their clients' legal needs over their clinical needs. This is instead to highlight the fact that, as clients' representatives in the justice system, they advocate first and foremost for a favorable legal outcome.

Additionally, the majority of clients and defenders that we interviewed did not think that mental health had a significant impact on case outcome. Defenders reported that factors such as criminal history, pending cases, the strength of their client's case, and the seriousness of the charges influenced the outcome far more than mental health status. Almost three-quarters of clients also did not believe that mental health influenced the outcome of their case, although many thought their mental health should have led to a more lenient sentence.

There are some limitations to our study design, which are important to note. First, because jail staff provided us with the information about which clients had a mental health condition, we were only able to recruit clients who were held in pre-trial detention from the time between their arrest and arraignment date. The experience of these clients may be different from clients who are not held pre-trial. There is, however, some limited data to suggest that, compared to people without mental health disorders, people with mental health disorders are more likely to be held pre-trial.[16] Therefore, it may be particularly important to understand the unique perspective of this set of clients.

Another limitation is that all of the clients in the study had to be competent to provide informed consent to participate in the research; they had to understand the purpose of the study, what their participation entailed, and any potential risks or benefits of participating. This standard means we were less likely to be able to interview clients who had the most impairing disorders, particularly those clients who may not have been competent to participate in their own defense. However, as noted earlier, the majority of clients with mental health disorders are competent to participate in their defense.

Finally, as with all interviews, but perhaps more relevant in a study where participants are in the midst of a criminal justice case, there is a possibility that participants' responses may have been biased by their desire to provide socially

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[16] COUNCIL OF STATE GOV'TS JUSTICE CTR., IMPROVING OUTCOMES FOR PEOPLE WITH MENTAL ILLNESSES INVOLVE WITH NEW YORK CITY'S CRIMINAL COURT AND CORRECTION SYSTEMS 3 (2012), https://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf [https://perma.cc/WRV8-6DEE].

desirable answers to the interviewers. However, we took all possible steps to minimize this possibility including: informing participants that their answers are confidential, emphasizing to clients that their participation in the study was voluntary and would have no impact on their case outcome, and responding to participants during interviews with neutral and non-judgmental language.

Even with these limitations, this study remains one of the few to examine defense services for clients with mental health conditions and, to our knowledge, the only one that includes dual perspectives of public defenders and their clients. This research makes a significant contribution to our understanding of this important relationship by describing the challenges inherent in defenders' and clients' efforts to balance legal considerations and therapeutic needs.

Further, our results call into question the utility of treatment-based alternatives to incarceration as an effective means for meeting the clinical needs of justice-involved individuals. If decisions about whether to connect someone to care through the justice system are, by necessity, based on whether this will ultimately result in a better justice outcome, then considerations about how the care could improve an individual's functioning are necessarily secondary. Indeed, if, as defenders report, they are more likely to advocate for an ATI when a client is facing a felony charge, then clients with misdemeanor charges may be less likely to be connected with needed care. Further, justice-system based treatment options have the potential to be punitive: they may confine people to long periods of unnecessary residential care or sentence them to long incarceratory sentences if treatment fails. These are risks clients and defenders were often unwilling to take.

Treatment-based ATIs were developed in reaction to the increasing number of people with mental health conditions in the justice system. Such alternatives were meant to ensure that clients receive care that helps them stabilize, live functional lives, and reduce future justice involvement. However, even with the proliferation of these programs, the proportion of people with mental health disorders in the justice system remains relatively unchanged.[17] Indeed, findings from this study allude to some of the pitfalls of mandated treatment. If we are to end the over-incarceration of people with mental health conditions, we must look outside of the justice system and work to increase community capacity to provide effective, non-mandated care to those at greatest risk of arrest and incarceration.

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[17] Michael S. Martin et al., *Stopping the Revolving Door: A Meta-Analysis on the Effectiveness of Interventions for Criminally Involved Individuals With Major Mental Disorders*, 36 LAW & HUM. BEHAV. 1 (2012); Jennifer L. Skeem et al., *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 LAW & HUM. BEHAV. 110 (2011).