Department of Justice

STATEMENT OF

MARY LOU LEARY
DEPUTY ASSISTANT ATTORNEY GENERAL
OFFICE OF JUSTICE PROGRAMS

BEFORE

SUBCOMMITTEE ON HUMAN RIGHTS AND THE LAW
COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

AT A HEARING ENTITLED

"HUMAN RIGHTS AT HOME: MENTAL ILLNESS IN U.S. PRISONS AND JAILS"

PRESENTED

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Hearing before
the Subcommittee on Human Rights and the Law
Committee on the Judiciary
United States Senate

Entitled
"Human Rights at Home: Mental Illness in U.S. Prisons and Jails"

September 15, 2009

Statement of
Mary Lou Leary
Deputy Assistant Attorney General
Office of Justice Programs

Mr. Chairman, Ranking Member Coburn and Members of the Subcommittee: I am pleased to have the opportunity to discuss the Department of Justice's (DOJ) efforts to improve the state and local criminal justice system's response to people with mental illnesses. We appreciate this Subcommittee's interest in this issue.

My name is Mary Lou Leary, and I am the Deputy Assistant Attorney General for the Office of Justice Programs (OJP) within the Department of Justice. OJP's mission is to provide leadership and services in grant administration and criminal justice policy development to support local, state and tribal justice strategies to achieve safer communities.

As the Subcommittee is well aware, many people entering this nation's criminal justice system are suffering from mental illnesses. According to a report from the Council of State Governments, funded, in part, by OJP's National Institute of Justice, 16.9 percent of the adults in a sample of local jails had a serious mental illness. That's

three to six times the rate of the general population. Also troubling is that while the serious mental illness rate was 14 percent for men, it was 31 percent for women. If these rates were applied to 13 million jail admissions reported in 2007, the study findings suggest that more than two million bookings of a person with a serious mental illness occur annually.

Many of the offenders with mental illnesses don't receive treatment. This is not only a disservice to the offenders and their families; it is a threat to public safety. Without treatment, these offender's conditions can worsen and they may pose a greater threat to themselves and others when they leave jail or prison.

To address this problem, OJP's Bureau of Justice Assistance (BJA) administers the Justice and Mental Health Collaboration Program (JMHCP) to help states, tribes and units of local government design and implement collaborative efforts between criminal justice and mental health systems. The program's goal is to improve access to effective treatment for people with mental illnesses involved with the justice system.

JMHCP grants can be used for a broad range of activities, including specialized law enforcement-based programs, mental health courts, mental health and substance abuse treatment for incarcerated offenders with mental illnesses, community reentry services, and cross-training of criminal justice and mental health personnel. The grants also allow for increased training of local law enforcement on how to identify and address encounters with people with mental illnesses. Each grantee is given the opportunity to

tailor their responses to best fit their particular location and the needs of their target population.

Eligible JMHCP applicants include states, units of local government, federally recognized Indian tribes and tribal organizations. All JMHCP grants require a joint application from a mental health agency and unit of government responsible for criminal and/or juvenile justice activities. This underscores the collaborative nature of this grant, which is intended to bring the criminal justice and mental health systems together to improve outcomes for people with mental illnesses in the justice system. Grants can be used for planning, implementing or for expanding existing programs.

From Fiscal Year 2006 through Fiscal Year 2008, BJA has awarded 76 JMHCP grants totaling nearly $12 million to 32 states, the District of Columbia and Guam. Most of these grants supported programs for adults, with some funding efforts for juveniles and a few for efforts targeting both populations. Projects have also been funded to provide training and technical assistance to grantees and to provide services to those applicant communities that applied, but did not receive funding.

In just a short period of time we have already seen significant progress from the JMHCP grantees. A New York City JMHCP program offers an alternative to traditional incarceration that combines mental health treatment with community service. In the first six months of 2009, the program admitted 47 percent more people than in the previous

six months. The program has also significantly increased the number of participants that were linked to long-term treatment services.

Another example is Cass County, North Dakota. In 2005, before the JMHCP grant, only 191 detainees were even referred for a psychological assessment and only 92 actually received one due to limited resources. In the first five months of 2009, with the JMHCP program in place, 550 detainees received an assessment. Of those people, 373 were referred for treatment and services, and 10 were transported for inpatient hospitalization or evaluation. Meanwhile, the state of Maine has used its JMHCP funds to move toward statewide inmate screening and assessment so that the most intensive interventions will be used for those who have the most impairments related to their mental illnesses and pose the highest risk to public safety.

We know that many people with mental illness cycle through the justice system, often for low-level crimes, without getting connected to needed mental health and other services. Encounters with law enforcement often play a critical role in whether or not people with mental illness continue to cycle in and out of jails and prisons. Law enforcement officers across the country are all too familiar with repeated calls for service involving situations where there are individuals that are exhibiting behaviors that indicate the presence of undiagnosed and diagnosed mental illness.

Many law enforcement officials across the country are partnering with local mental health advocates and mental health service providers to develop strategies to make

it easier for law enforcement to connect people with mental illnesses to much needed services and to minimize the likelihood that they will cycle through the system. These programs, often referred to as Crisis Intervention Teams or Co-Responder Models, are eligible to receive funding under the JMHCP. Seven jurisdictions have used BJA funds to start or enhance law enforcement response programs for people with mental illness. In addition, BJA has partnered with the Council of State Governments on a number of publications that address law enforcement response to individuals with mental illnesses. These include *Essential Elements of Specialized Law Enforcement-Based Programs* and *Strategies for Effective Law Enforcement Training.*

OJP and other DOJ components have launched collaborative projects with the Department of Health and Human Services to find other ways to help state and local governments improve the response to people with mental illness involved in the criminal justice system. BJA joined with the National Institute of Corrections (NIC) and the Substance Abuse and Mental Health Services Administration to provide technical assistance to states to build on existing efforts and replicate them statewide. These partners worked with the GAINS Center and the Council of State Governments Justice Center to sponsor a national conference in 2009, "Smart Responses in Tough Times: Achieving Better Outcomes for People with Mental Illness Involved in the Justice System." Over 450 people attended the conference, including many representatives from our JMHCP grantees and applicants.

BJA also partnered with the Council of State Governments Justice Center on a number of publications that address the criminal justice response to individuals with mental illnesses through mental health courts. These include *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court* and *Mental Health Courts: A Primer for Policymakers and Practitioners*. In addition, BJA has worked with the National Association of Counties on other related publications, *Reentry for Safer Communities, Effective County Practices in Jail to Community Transition Planning for Offenders with Mental Health and Substance Abuse Disorders* and *State and County Collaboration: Mental Health and the Criminal Justice System*. I am including these publications with my testimony.

Please be assured that our work and our commitment will continue. For Fiscal Year 2009, we will be awarding 43 JMHCP grants totaling nearly $8 million, with additional funding supporting training and technical assistance efforts. Also, many of the grants we will be awarding under the Second Chance Prisoner Reentry Initiative will support mental health treatment as part of comprehensive reentry efforts. In addition, we will continue to work with our partners within the Department of Justice and other federal agencies to explore new ways to help states and local communities improve mental health services for people in the criminal justice system.

Thank you for the opportunity to testify today. I welcome the chance to answer any questions you or other Members of the Subcommittee may have.

Issue Brief

State and County Collaboration:
Mental Health and the Criminal Justice System

NACo National Association of Counties
The Voice of America's Counties

December 2008

Issue Brief

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Mental Health and the Criminal Justice System

Produced by the Community Services Division of the County Services Department

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About NACo – The Voice of America's Counties

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo provides essential services to the nation's 3,066 counties. NACo advances issues with a unified voice before the federal government, improves the public's understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money. For more information about NACo, visit www.naco.org.

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Introduction

There is a disproportionate number of individuals with mental illness in the criminal justice system today, representing a mental health and criminal justice crisis that must be approached collaboratively. According to a 2006 Bureau of Justice Statistics report, more than half of all prison and jail inmates have a mental health problem.[1] Sixty- four percent of jail inmates are estimated to have a mental health problem compared to 56 percent of state prisoners (Figure 1). According to this same report, a quarter of both state and jail inmates who have a mental health problem have been incarcerated three or more times previously. This indicates that many of the individuals who are mentally ill in corrections today recidivate, which illustrates the difficulty and necessity of treating this population.

The criminal justice system has become increasingly overwhelmed with offenders who are mentally ill in the past decade due to deinstitutionalization which resulted in the release of thousands from psychiatric facilities. On account of this influx back into the community, many come into contact with the criminal justice system due to actions which are a result of their mental illness. Many end up being criminalized instead of receiving the treatment they need. Although this population can be best served with community-based treatment and services, the criminal justice system has been forced to care for individuals with mental illness despite often being ill-equipped to do so properly.[2]

Those who have mental health problems are often unable to access adequate services in the community. This may be due to lack of knowledge regarding available services, lack of funds, or a lack of capacity to access services. While the purpose of the criminal justice system is not to house individuals who are mentally ill, the high population of offenders with mental health needs represents an opportunity to provide access to treatment and other needed services. This requires a collaborative effort not only between the mental health and criminal justice systems, but ideally between levels of government. This special population of offenders with mental health needs requires a continuum of care in order to break the cycle of the revolving door of the criminal justice system.[3] In order to accomplish the goals of treatment and public safety through reduced recidivism, coordination between organizations and levels of government are required.

Since jails are locally operated facilities and prisons are maintained by the state, collaboration and coordination of services are necessary and have many benefits.[4] Continuing to jail and imprison individuals who are mentally ill is expensive. In 2005, local governments spent over $100 billion in corrections expenditures, while states spent about $60 billion (Figure 2). Coordination of resources represents opportunities for states and county governments to save money by reducing the amount of overlapping services. Collaboration also represents an opportunity among various organizations to combine services to allow for a continuum of care at all levels.[5]

Many state and county governments have begun to recognize the advantages of collaboration. The three states and local communities featured in this Issue Brief represent a range of collaborative efforts, including legislative efforts, a state-funded grant program with county-matched dollars, committee membership, and joint programming. All have made state and county collaborative efforts to reduce costs and improve public safety, programming, and the lives of offenders with mental health needs.

Those who have mental health problems are often unable to access adequate services in the community. This may be due to lack of knowledge regarding available services, lack of funds, or a lack of capacity to access services.

1 Bureau of Justice Statistics. 2006. Special Report on Mental Health Problems of Prison and Jail Inmates.

2 Bell, Maureen. "Facilitating Collaboration Between Correctional and Mental Health Systems." Corrections Today (2003). *http://findarticles.com/p/articles/mi_hb6399/is_/ai_n29062379.*

3 National Institute of Justice. 1999. Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program, NCJ 175046.

4 Bureau of Justice Statistics. 2006. Special Report on Mental Health Problems of Prison and Jail Inmates.

5 National Institute of Justice. 1999. Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program, NCJ 175046.

Florida and the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program

Collaboration Through Legislation and a Grant Program

Florida has developed state and county collaboration through state legislation to create a grant program for local communities. Florida House Bill 1477 was approved by the Governor on June 19, 2007 and became effective July 1, 2007.[1] This bill created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Act and Grant Program within the Department of Children and Family Services (Figure 3). The purpose of the Reinvestment Grant Program is to provide funding to counties for programs that increase public safety by reducing recidivism, avoiding overspending on corrections by reducing the need for these services, and improving the success of treatment services. These programs focus on both juvenile and adult populations who have a mental illness, substance abuse disorder, or co-occurring mental health and substance abuse disorder. Individuals engaged in these initiatives are currently involved in the criminal justice system or are at risk of being so.[2]

Counties achieve these goals by receiving funding for a 1-year planning or 3-year implementation or expansion grant. The maximum grant award for a planning grant is $100,000, while the maximum grant award for the implementation or expansion grant is $1,000,000. This program is unique; the Act stipulates that in order for counties to receive state funding through this grant, they must commit to matching the funds dollar for dollar. The only exception lies with counties that are deemed "fiscally constrained;" those counties are obligated to a 50 percent match of state funds.[3] This program is significant because it begins a county and state collaboration through legislation and blended funding. The program encourages partnerships among the state and counties to address both juvenile and adult substance abuse and mental health needs.

As a result of HB 1477, 23 Florida counties have received grants from the state totaling roughly $9.6 million. Counties have matched these funds with a total of about $12.6 million for a grand total of around $22.2 million. All of the funds are focused on diverting those with substance abuse issues, mental health needs, or both (Figure 4). The state and county collaboration is not complete upon disbursement of funds to the counties. Per the passing of HB 1477, a Criminal Justice, Mental Health and Substance Abuse Policy Council has been created within the Florida Substance Abuse and Mental Health Corporation. This council works with counties that have received grant awards and identifies those which have planned, implemented, or expanded effective strategies for system change and reduced both recidivism and corrections costs. The council is tasked with disseminating this information throughout the state in order to increase awareness of effective strategies, thereby continuing the state and local collaboration.[4] For more information, please visit *www.samhcorp.org/home.htm*.

Utah and the Salt Lake County Criminal Justice Advisory Council (CJAC)

Collaboration Through Committees

Located in Utah, the Salt Lake County Criminal Justice Advisory Council (CJAC) was created as part of Salt Lake County's Criminal Justice Services Division. Although the group has become more formalized in the last seven years, CJAC was created over 15 years ago. The purpose of CJAC is to provide a venue for stakeholders at all levels to come together regarding criminal justice services and system change. CJAC is a leader in state and county collaboration through the mixed membership of the Council, as well as the mixed membership of their subcommittee, Span. Monthly meetings provide an opportunity to assess the criminal justice programs the group oversees and in turn recommend any changes. The 25 members of CJAC represent agencies and organizations at all levels, including city, county, and state.[5] Membership includes individuals from the following diverse agencies:[6]

- Law Enforcement Administrators and Directors
- Midvale City
- Salt Lake City Justice Court
- Salt Lake City Police Department
- Salt Lake City Prosecutor's Office
- Salt Lake County Criminal Justice Services
- Salt Lake County District Attorney's Office
- Salt Lake County Human Services
- Salt Lake County Justice Court
- Salt Lake County Mental Health
- Salt Lake County Sheriff's Office
- Salt Lake County Substance Abuse Services
- Salt Lake County Third District Court
- Salt Lake County Third District Juvenile Court
- Salt Lake Legal Defenders Association

1 Florida House of Representatives. 2007. CS/CS/HB 1477- Forensic Mental Health. *www.myfloridahouse.gov/SECTIONS/Bills/billsdetail.aspx?BillId=36628.*

2 Florida Substance Abuse and Mental Health Corporation. Press Release. *www.samhcorp.org/pdf/News_Release_08-07-07.pdf*

3 Florida Substance Abuse and Mental Health Corporation. Fact Sheet. *www.samhcorp.org/pdf/Program_Fact_Sheet.pdf*

4 Piekalkiewicz, Ellen. "Presentation on the CJMHSA Grant." Florida Substance Abuse and Mental Health Corporation. *www.samhcorp.org/RFA*

5 Salt Lake County Criminal Justice Advisory Council Membership. 2008. *www.cjac.slco.org/doctopdf/CJAC_Membership.pdf*

6 Salt Lake County Criminal Justice Advisory Council Agencies and Members. 2008. *www.cjac.slco.org/html/agencies.html*

- Statewide Association of Prosecutors
- Taylorsville City Police Department
- Utah State House of Representatives
- Utah State Senate
- West Valley Justice Court

CJAC also has a subcommittee called the Span committee. The Span committee oversees additional programs including several that receive both county and state funding. The programs the Span committee oversees with blended funding are the expansion of the Third District Mental Health Court, the RIO Housing program, and specialized probation and parole for mental health cases. Span committee membership continues the collaboration exemplified by CJAC. Span committee members include individuals from ten county agencies, one federal agency, two city agencies, and three state agencies including the Utah Division of Substance Abuse and Mental Health. The collaborative nature of this subcommittee allows for information sharing among all stakeholders working with individuals who are mentally ill in the criminal justice system. This information sharing allows stakeholders to streamline resources, share ideas, and avoid overlapping resources. For more information, please visit *www.cjac.slco.org*.

Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) and Harris County

Collaboration Through Joint Programming

In 1987, Texas established the Texas Council on Offenders with Mental Impairments (TCOMI). Through legislation, Texas has been able to create a system that addresses all aspects of the juvenile and adult criminal justice systems for those with special needs. The Texas Legislature has recently exhibited its commitment to improving the criminal justice system by reauthorizing a $35 million dollar package for criminal justice and mental health collaboration and programs. The legislature furthermore changed the name of TCOMI to the Texas Correctional Office on Offenders with Medical or Mental Impairments, otherwise known as TCOOMMI.[7]

TCOOMMI is involved in important work in the criminal justice and mental health realm. TCOOMMI has studied the current mental health screening practices in Texas jails, it has established a statewide data network to identify current and former offenders with mental health needs, established a 60 day bed residential program for probationers with mental health needs, and expanded their jail diversion program to three additional counties.[8] TCOOMMI has also been working closely with Harris County to establish a community-based competency restoration pilot. It is this program that truly demonstrates TCOOMMI's commitment to state and county collaboration for offenders with mental health needs.

In 2003, the Rusk Diversion Project was created by TCOOMMI in partnership with Harris County Mental Health and Mental Retardation Authority (MHMRA), the Harris County Sheriff, and the Courts. The Harris County Rusk Diversion Project (Figure 5) is a community-based competency restoration project that was created to address the financial burden of committing incompetent defendants to the state hospital for restoration of competency. In the past, defendants who signified a mental health issue during their first court appearance were automatically sent for a competency evaluation at the state hospital. The cost of transporting individuals to the state hospital is high and oftentimes unnecessary. Several studies indicate that the majority of offenders who are mentally ill transferred to the state hospital were actually not in need of restoration.[9]

Instead of automatically being sent for a lengthy hospital stay, defendants are currently referred for psychiatric stabilization through this diversion project. A psychiatric review is completed at the first appearance in court if there is any question regarding mental stability. Each individual that is referred for a psychiatric evaluation is screened and sent to a psychiatrist, who then follows up with a re-evaluation 14 days after the initial treatment.

The goal of the project is to reduce the cost of lengthy hospital stays by aiming to identify defendants who can be restored to competency while remaining at the jail. Reducing transportation costs is not the only goal of the Rusk Diversion Project; another goal is to provide local treatment, thereby making family visitation more likely. Educating officers for the purpose of early identification and managing of offenders with mental health needs are additional goals of the program, as well as providing information to the courts regarding mental health conditions of inmates for the purpose of assisting with release and detention decisions. This information, combined with the continuous collaboration of the criminal justice and mental health systems, allows for the option of interventions to break the cycle of incarceration for this population.

There have been several program outcomes:[10]

- 74 percent (419) of defendants were served by the competency restoration project and diverted from state hospital commitments.
- The disposition of cases occurred faster due to the shorter amount of time defendants spent in the Rusk Diversion

7 Texas Department of Criminal Justice. 2005. The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments.

8 Texas Department of Criminal Justice. 2005. The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments.

9 Texas Department of Criminal Justice. 2005. The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments.

10 Texas Department of Criminal Justice. 2005. The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments.

Project compared to the length of a state hospital commitment.

- Costs to the Sheriff's Department were reduced due to the decrease in state hospital admissions.

These program outcomes suggest that many offenders with mental health needs are being diverted from unnecessary lengthy hospital stays. This not only reduces costs, but cases are processed in a more timely manner as the defendants are able to stand trial earlier than if they had been admitted to the state hospital. The diversion program also allows for local treatment so family members can continue to be supportive and physically present in the offenders' lives. The money saved with this program can also be reinvested back into the criminal justice system by being applied to other mental health diversion programs or treatment services offered in the jail. Look for the 2009 Biennial Report for additional information on the state and county collaboration of Harris County's and TCOOMMI's Rusk Diversion Project. For more information, please visit *www.tdcj.state.tx.us*.

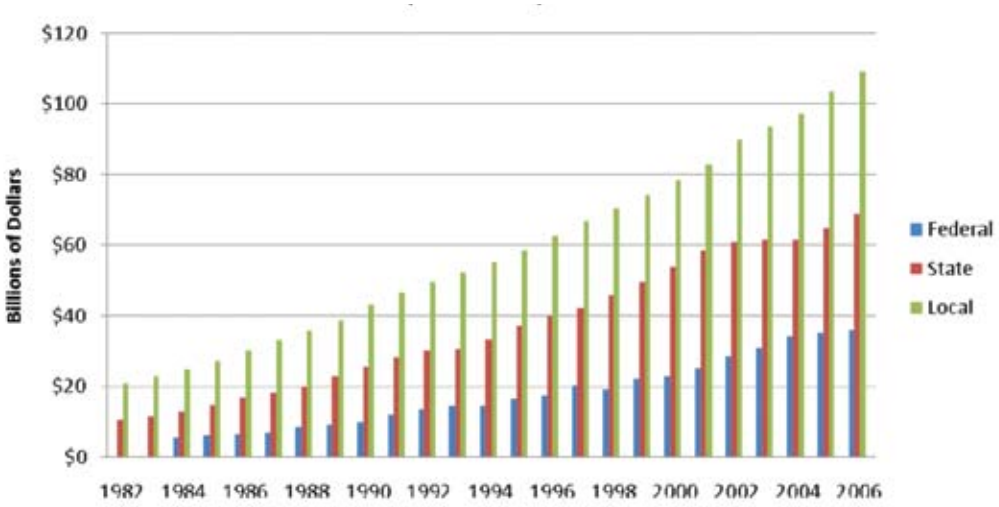
Figures

Figure 1: Percent of Inmates In Prisons or Jails Who Have a Mental Health Problem

Mental Health Problem	State Prison	Federal Prison	Local Jail
Any mental health problem	56	45	64
Recent history	24	14	21
Symptoms	49	40	60

Source: Bureau of Justice Statistics. 2006. Special Report on Mental Health Problems of Prison and Jail Inmates.

Figure 2: Criminal Justice Expenditures by Level of Government



Source: Bureau of Justice Statistics. 2008. *Justice Expenditure and Employment Extracts.*

Figure 3: Results of the Creation of the Reinvestment Grant Program

- Requires Florida Substance Abuse and Mental Health Corporation to establish a statewide grant review committee;
- Authorizes counties to apply for a planning grant or an implementation or expansion grant;
- Creates the Criminal Justice, Mental Health and Substance Abuse Technical Assistance Center at the Florida Mental Health Institute, University of South Florida and;
- Creates the Criminal Justice, Mental Health and substance Abuse Policy Council within the Florida Substance Abuse and Mental Health Corporation

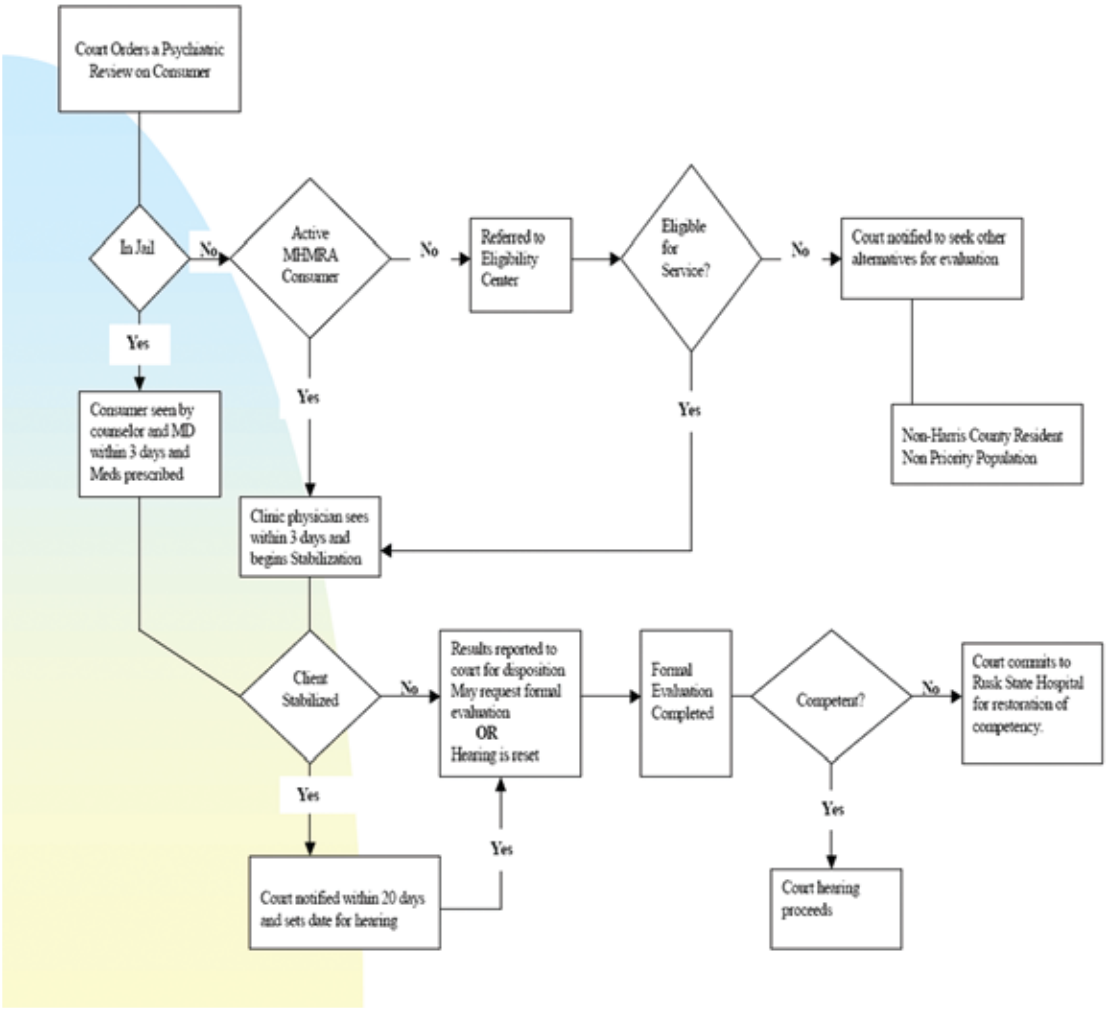
Source: Florida Substance Abuse and Mental Health Corporation. Fact Sheet. *www.samhcorp.org/pdf/Program_Fact_Sheet.pdf*

Figure 4: Grant Allocations and Matching Funds in Florida as of August 26, 2008

County	Amount Awarded by the State	Matched Dollars from the County
Alachua	$999,000	$999,000
Broward	$991,368	$991,368
Charlotte	$60,190	$60,190
Citrus	$50,166	$50,166
Duval	$91,200	$93,319
Flagler	$40,447	$23,061
Hillsborough	$999,999	$1,000,000
Lake	$60,000	$60,000
Lee	$997,698	$2,030,473
Leon	$792,624	$890,469
Marion	$59,000	$68,587
Martin	$100,000	$100,000
Miami- Dade	$999,000	$999,000
Monroe	$92,568	$92,568
Nassau	$225,000	$225,000
Orange	$954,663	$2,476,788
Osceola	$87,500	$87,500
Palm Beach	$100,000	$100,000
Pinellas	$117,419	$117,419
Polk	$980,706	$1,021,530
St. Lucie	$688,576	$1,087,929
Sumter	$50,000	$25,000
Volusia	$65,300	$65,408
Totals	$9,602,424	$12,664,775

Source: Florida Substance Abuse and Mental Health Corporation. 2008. Cost Comparison by County. *www.samhcorp.org/RFA*

Figure 5: Diagram of the Rusk Diversion Project



Source: Texas Department of Criminal Justice. 2005. *The Biennial Report of the Texas Correctional Office on Offenders with Medical and Mental Impairments*.

Improving Responses to People with Mental Illnesses

The Essential Elements of a Specialized Law Enforcement–Based Program

BJA Bureau of Justice Assistance

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

Improving Responses to People with Mental Illnesses

The Essential Elements of a Specialized Law Enforcement–Based Program

A report prepared by the
Council of State Governments Justice Center
in partnership with the Police Executive Research Forum

for the

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Office of Justice Programs
U.S. Department of Justice

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JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS

POLICE EXECUTIVE RESEARCH FORUM

BJA Bureau of Justice Assistance

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This report follows and builds on the format and scope of *The Essential Elements of a Mental Health Court*, published in 2008 with the support of BJA (available at www.consensusproject.org/mhcp/essential.elements.pdf). A similar document describing the elements of programs that bring together the corrections and mental health systems is in production at this writing and will be made available at www.consensusproject.org.

Council of State Governments Justice Center, New York 10005

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- Mr. Stephen Baron, Director, *District of Columbia Department of Mental Health**
- Ms. Lesley Buchan, Program Director, *Community Services Division, National Association of Counties*
- Major Sam Cochran, Crisis Intervention Team Coordinator, *Memphis (Tenn.) Police Department*
- Dr. Steven M. Edwards, Senior Policy Advisor for Law Enforcement, *Bureau of Justice Assistance, U.S. Department of Justice*
- Mr. Leon Evans, Executive Director, *Bexar County (Tex.) Jail Diversion Program*
- Deputy Chief Del Fisher, *Arlington (Tex.) Police Department*
- Ms. Elaine Goodman, Former Coordinator, *NAMI New Jersey Law Enforcement Education Program*
- Mr. Robert Hendricks, Policy Advisor, *Bureau of Justice Assistance, U.S. Department of Justice**
- Mr. Ron Honberg, Director of Legal Affairs, *NAMI**
- Ms. Linda Keys, Director of Clinical Services, *Mental Health Center of Dane County (Wis.), Inc.*
- Mr. Adam Kirkman, Project Associate, *GAINS TAPA Center for Jail Diversion**
- Commander Barbara Lewis, *Orange County (Fla.) Sheriff's Office*
- Chief Stefan LoBuglio, *Montgomery County (Md.) Pre-Release and Re-Entry Services Division*
- Officer Joan M. Logan, Crisis Intervention Team Coordinator, *Montgomery County (Md.) Police Department**
- Mr. Loel Meckel, Assistant Director, *Division of Forensic Services, Connecticut Department of Mental Health and Addiction Services*
- Ms. LaVerne Miller, Director, *Howie the Harp Peer Advocacy Center*
- Chief Richard Myers, *Appleton (Wis.) Police Department*
- Ms. Michele Saunders, Executive Director, *Florida Partners in Crisis**
- Sergeant Rick Schnell, *San Diego (Calif.) Police Department*
- Ms. Bonnie Sultan, CIT Technical Assistance Center Coordinator, *NAMI**
- Dr. Bruce Taylor, Director of Research, *Police Executive Research Forum*
- Representative John Tholl, Vice-Chair, *Criminal Justice and Public Safety Committee, New Hampshire House of Representatives*

1. Advisory Board members' titles and agency affiliations reflect the positions they held at the time of their involvement with the project.

- Lieutenant Richard Wall, *Los Angeles (Calif.) Police Department*
- Lieutenant Michael Woody (ret.), Law Enforcement Liaison, *Ohio Criminal Justice Coordinating Center of Excellence**

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Finally, the authors wish to express their gratitude to the nearly two hundred contributors who provided feedback in an August 2006 online Web forum. Far too many to name individually, these practitioners, policymakers, and advocates offered insights and suggestions that informed the authors and can be seen throughout these pages.

Introduction

Law enforcement officers throughout the country regularly respond to calls for service that involve people with mental illnesses—often without needed supports, resources, or specialized training.[2] These encounters can have significant consequences for the officers, people with mental illnesses and their loved ones, the community, and the criminal justice system.[3] Although these encounters may constitute a relatively small number of an agency's total calls for service, they are among the most complex and time-consuming calls officers must address.[4] At these scenes, front-line officers must stabilize a potentially volatile situation, determine whether the person poses a danger to him- or herself or others, and effect an appropriate disposition that may require a wide range of community supports.

In the interests of safety and justice, officers typically take approximately 30 percent of people with mental illnesses they encounter into custody—for transport to either an emergency room, a mental health facility, or jail.[5] Officers resolve the remaining incidents informally, often only able to provide a short-term solution to a person's long-term needs. As a consequence, many law enforcement personnel respond to the same group of people with mental illnesses and the same locations repeatedly, straining limited resources and fostering a collective sense of frustration at the inability to prevent future encounters.[6]

In response, jurisdictions across the country are exploring strategies to improve the outcomes of these encounters and to provide a compassionate response that prioritizes treatment over incarceration when appropriate. These efforts took root in the late 1980s, when the crisis intervention team (CIT) and law enforcement–mental health co-response models, described in more detail below, first emerged. Since that time, hundreds of communities have implemented these programs; some have replicated the models, and others have adapted features to meet their jurisdiction's unique needs. Although this number represents only a small fraction of all U.S. communities, there are many indications that the level of interest in criminal justice–mental health collaborative initiatives is surging.[7]

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2. For the purposes of this document, "officer" refers to any law enforcement personnel with direct contact with the community; this includes sheriffs' deputies, state troopers, and other individuals with arrest powers.

3. The nation's prisons and jails hold unprecedented numbers of people with mental illnesses—many of whom came into contact with law enforcement as a result of behaviors related to their illness. For example, in 1999 the Los Angeles County Jail and New York's Rikers Island jail each held more people with mental illnesses than any psychiatric inpatient facility in the United States. The most recent data from the Bureau of Justice Statistics, U.S. Department of Justice, reveals that more than half of all prison and jail inmates reported that they had any one of a number of mental health symptoms. E. Fuller Torrey, "Reinventing Mental Health Care," *City Journal* 9 (1999):4; Doris J. James and Laura E. Glaze, *Mental Health Problems of Prison and Jail Inmates,* U.S. Department of Justice, Bureau of Justice Statistics, NCJ-213600 (Washington, D.C.: Bureau of Justice Statistics, 2006).

4. Recent data indicate that behaviors that appear to be the result of a mental illness are a factor in approximately 3–7 percent of all law enforcement calls for service. See Martha W. Deane, Henry J. Steadman, Randy Borum, Bonita M. Veysey, and Joseph P. Morrissey, "Emerging Partnerships between Mental Health and Law Enforcement," *Psychiatric Services* 50 (1) (1999): 99–101; Lodestar, *Los Angeles Police Department Consent Decree Mental Illness Project Final Report* (Los Angeles: Lodestar, 2002); Jennifer L.S. Teller, Mark R. Munetz, Karen M. Gil, and Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls," *Psychiatric Services* 57 (2006): 232–37; William Terrill and Stephen Mastrofski, "Situational and Officer-Based Determinants of Police Coercion," *Justice Quarterly* 19 (2002): 215–48.

5. Linda Teplin, "Managing Disorder: Police Handling of the Mentally Ill," In *Mental Health and the Criminal Justice System,* ed. Linda Teplin. (Beverly Hills, CA: Sage Publications, 1984); Thomas M. Green, "Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies," *International Journal of Law and Psychiatry* 20 (1997): 469–86; Jennifer L.S. Teller, Mark R. Munetz, Karen M. Gil, and Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls," *Psychiatric Services* 57 (2006): 232–37.

6. Thomas M. Green, "Police as Frontline Mental Health Workers: The Decision to Arrest or Refer to Mental Health Agencies," *International Journal of Law and Psychiatry* 20 (1997): 469–86; Gary Cordner, "People with Mental Illness," *Problem-Oriented Guides for Police Problem-Specific Guides Series,* 40, U.S. Department of Justice (Washington, D.C.: Office of Community Oriented Policing Services, 2006).

7. Federal interest in criminal justice–mental health initiatives is perhaps best illustrated by the broad bipartisan support for the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA) and its subsequent appropriations. MIOTCRA facilitates collaboration among the criminal justice, juvenile justice, mental health treatment, and substance abuse systems in diverting individuals to treatment when appropriate. Among its allowable uses, MIOTCRA funds can support law enforcement training. For more information on MIOTCRA, see www.consensusproject.org/resources/government-affairs/fed-leg-MIOTCRA.

Specialized Law Enforcement–Based Response Programs

This document focuses on specialized law enforcement–based response programs that meet three criteria: (1) they enhance traditional law enforcement roles to provide a new set of response options for frontline personnel that are tailored to the needs of people with mental illnesses; (2) when appropriate, they establish a link for these individuals to services in the community; and (3) they are based in law enforcement agencies with strong collaborative ties to mental health partners, other criminal justice agencies, and community members.[8]

Specialized law enforcement–based response programs include both the CIT and law enforcement–mental health co-responder models.

- The CIT model originated in the Memphis (Tenn.) Police Department and is therefore often called the Memphis Model. It was developed in response to a tragic incident in which a law enforcement officer used lethal force against a person with a mental illness. This model is designed to de-escalate tensions at the scene and to reduce the need for use of force during these types of encounters. To improve the likelihood of a safe and effective outcome, the CIT model includes training and deployment of self-selected officers to provide a first-response to the majority of incidents involving people with mental illnesses.
- The co-responder model was developed in Los Angeles County and implemented soon after in San Diego (Calif.). Leaders in those jurisdictions were concerned that they were unable to link people with mental illnesses to appropriate services or provide other effective and efficient responses. They identified limitations on officers' time and lack of awareness about both community mental health resources and the characteristics of individuals who need access to those services as major obstacles. They then developed an approach that pairs specially trained officers with mental health professionals to provide a joint secondary response to the scene.

About the Elements

As the growing number of interested communities grapple with implementing specialized law enforcement–based programs at the local level, there is a commensurate demand for more information on the key elements of promising programs. Several communities have tried to identify critical program elements, particularly for CIT initiatives, to promote consistency and quality.[9] Until this BJA-supported effort, however, there had been limited debate or agreement at the national level about which elements were essential to successfully implement any specialized law enforcement–based response program—regardless of the specific model.

This report articulates 10 essential elements for *any* specialized law enforcement–based response program. The elements are derived from recommendations made by a broad range of practitioners and other related experts to ensure they are practical and valuable (see the "Document Development" section, p. ix). They provide practitioners and policymakers with a common framework for program design and implementation that will promote positive outcomes while being sensitive to every jurisdiction's distinct needs and resources. Each element contains a short

8. Many communities also have developed teams of community mental health professionals, such as mobile crisis or assertive community treatment teams, to assist officers at the scene. While these models are undoubtedly a valuable resource for many communities and departments, they are not law enforcement–based and thus are not within the scope of this document. For further discussion of how law enforcement have collaborated with mental health mobile crisis teams, see www.uc.edu/criminaljustice/ProjectReports/MCT_Report.pdf. For more on how mental health agencies have tailored assertive community treatment teams to work with a justice-involved population, see www.gainscenter.samhsa.gov/text/ebp/Papers/ExtendingACTPaper.asp.

9. Most notably, promoters of the CIT model have recently formed a national group, the CIT National Organization (www.cit.memphis.edu/cno.html), to provide leadership and guidance to jurisdictions implementing CIT programs. Several members of the CIT National Organization also serve on the advisory board that has guided the development of this publication, to ensure complementary products. The National CIT Organization's guide describes critical elements of the CIT model using three categories: operational, ongoing, and sustaining elements. A draft of the guide is available at www.cit.memphis.edu/~cjus/dw.php?id=cjuscitdw01. In contrast, this document provides a framework for developing or enhancing elements of a specialized law enforcement–based response of *any* type.

statement (in italics) describing criteria that specialized law enforcement–based response programs should meet to be effective, followed by several paragraphs explaining the element's importance and how its principles can be achieved.

The document reflects two key assumptions: First, each element depends on meaningful collaboration among professionals in the criminal justice and mental health systems. Although achieving the requisite level of collaboration is often difficult—particularly when faced with long-standing system barriers—successful partnerships are needed to carry out any of the elements. Second, law enforcement represents only the first of several criminal justice agencies with which people with mental illnesses may come in contact. Addressing problems raised by the large numbers of people with mental illnesses in the criminal justice system requires a comprehensive community- and systemwide strategy in which the law enforcement–based program plays only one part. The impact of a specialized law enforcement–based response program on jails, courts, the community-based mental health system, and the larger community must therefore be considered when planning and implementing the program.

The elements are meant to help guide individuals in communities that are interested in developing a law enforcement–based program or improving the organization and functions of an existing program. This document can be used as a practical planning tool for a specialized response at each stage of the process (e.g., designing the program, developing or enhancing policies and procedures, monitoring practices, and conducting evaluations). This report is meant to be a "living, breathing document" and thus will be updated or supplemented as specialized law enforcment–based programs mature, and to address new research studies that can provide a stronger base of knowledge about how these programs can best operate, their impact on the community and various affected systems, and the relative importance of the elements that form them.[10]

Document Development and Related Materials

The essential elements are based on information from a variety of sources, including interviews with law enforcement executives and officers, mental health professionals, advocates, and mental health consumers who have been engaged in these programs for many years, as well as a review of the scholarly literature. A panel of national experts guided early drafts of this document. It was then posted on a Web-based discussion forum through which hundreds of stakeholders reviewed it and provided feedback.[11] An advisory group of leading executives, practitioners, researchers, and other experts subsequently reviewed and discussed the comments and suggested revisions.

The Bureau of Justice Assistance (BJA), U.S. Department of Justice, is developing a series of resources for law enforcement practitioners and their community partners as part of BJA's Law Enforcement/Mental Health Partnership Program. This report serves as the centerpiece of this series. The *Improving Responses to People with Mental Illnesses* series includes a collection of resources that will complement the essential elements: a practical handbook on implementing effective training strategies; a monograph on tailoring law enforcement responses to the unique needs of the jurisdiction, which will include specific examples from the field; and Web-based information on statewide efforts to coordinate these law enforcement responses. Also available is an online database, the Criminal Justice/Mental Health Information Network, which includes profiles of local law enforcement responses to people with mental illnesses. This project is coordinated by the Council of State Governments Justice Center in partnership with the Police Executive Research Forum.

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10. Updates to this document will be available at www.consensusproject.org/issue-areas/law-enforcement.

11. Throughout this document, the term "stakeholders" is used to describe the diverse group of individuals affected by law enforcement encounters with people with mental illnesses, such as criminal justice and mental health professionals; myriad other service providers, including substance abuse counselors and housing professionals; people with mental illnesses (sometimes referred to as "consumers") and their loved ones; crime victims; and other community representatives.

Ten Essential Elements

1 Collaborative Planning and Implementation

Organizations and individuals representing a wide range of disciplines and perspectives and with a strong interest in improving law enforcement encounters with people with mental illnesses work together in one or more groups to determine the response program's characteristics and guide implementation efforts.

Specialized responses to people with mental illnesses are an outgrowth of community policing and as such should reflect a partnership between a law enforcement agency and other stakeholder groups and individuals. Partners for the lead law enforcement agency should include mental health service providers, people with mental illnesses and their family members and loved ones, and mental health advocates. Based on the nature of the problem, additional partners could include other area law enforcement professionals; health and substance abuse treatment providers; housing officials and other service providers; hospital and emergency room administrators; crime victims; other criminal justice personnel such as prosecutors and jail administrators; elected officials; state, local, and private funders; and community representatives. Any stakeholder may initiate the planning for the specialized response, but to take root, the lead law enforcement agency must fully embrace the effort.

At the outset of the planning process, leaders from each of the stakeholder agencies who have operational decision-making authority and community representatives should come together as a multidisciplinary *planning committee*. This executive-level committee should examine the nature of the problem and help determine the program's objectives and design (see Element 2, Program Design), taking into consideration how the committee will relate to other criminal justice–mental health boards that may be in place or are in the process of being established. The planning committee also should provide a forum for developing grant applications and working with local and state officials. Although focused primarily on planning decisions, members should remain engaged during the implementation phase to provide ongoing leadership and support problem solving and design modifications throughout the life of the program.

Agency leaders on the planning committee also should designate appropriate staff to make up a *program coordination group* responsible for overseeing day-to-day activities. (In some jurisdictions, the two bodies may be the same—particularly those with small agencies, in rural areas, or with limited resources.) This coordination group should oversee officer training, measure the program's progress toward achieving stated goals, and resolve ongoing challenges to program effectiveness. The group also should serve to keep agency leaders and other policymakers informed of program costs, developments, and progress. Both groups' members should reflect the community's demographic composition.

To overcome challenges inherent in multidisciplinary collaboration, including staff turnover and changes in leadership, partnership and program policies should be institutionalized to the extent possible. Interagency memoranda of understanding (MOUs) can be developed to address key issues such as how each organization will commit resources and what information can be shared through identified mechanisms.

2 Program Design

The planning committee designs a specialized law enforcement–based program to address the root causes of the problems that are impeding improved responses to people with mental illnesses and makes the most of available resources.

As a critical first step in the design process, the planning committee should develop a detailed understanding of the problems in its jurisdiction and identify all contributing factors. In this analysis, it is important to understand the driving force(s) behind current efforts to improve the law enforcement response. In some jurisdictions, law enforcement executives may become aware of the problem because of a tragic incident. In others, executives may realize there are operational challenges presented by particularly complex field encounters, such as the inordinate amount of time officers spend waiting for medical clearance in emergency rooms or the frequency with which officers repeatedly come in contact with the same individuals without an effective resolution.

The committee must examine the reasons why these incidents occur and other aspects of the problem that may not have been raised by the single high-profile incident. It should look at law enforcement data on calls for service, beat boundaries, feedback from officers, community survey data, and other sources of information. To enhance their understanding of root causes and available resources, committee members also should examine factors such as the community's inpatient and outpatient treatment options, crisis response services, ancillary services such as housing and substance abuse treatment, population, and geography. They also may want to talk to people in other jurisdictions who have grappled with limited community resources to see what alternatives are available to increase the reach of existing services.

The analysis of the problems and assessment of available and potential resources to address them should drive the short- and long-term goals of the program. For example, if the analysis reveals that a significant barrier to improving the law enforcement response is that officers lack the training to safely de-escalate situations involving people with mental illnesses, one program goal would be to correct this deficiency. If officers cannot efficiently link people to mental health treatments, another goal may be to revise and streamline processes for connecting to these services.

Once the program's purpose is defined, the committee must address personnel assignments and related considerations. The planning committee must decide whether some or all officers should be trained to stabilize and de-escalate situations involving people with mental illnesses in immediate response to the call for service. Should all officers receive some baseline training and others receive more extensive training? Should a subset of officers be trained to respond with a mental health professional? When considering the answers to questions like these, the committee should explore the practical implications of different staffing options and present them to the chief law enforcement executive or his or her designee on the committee. The committee also must help interpret the criteria for emergency mental health evaluation and decide how officers will access that service. These decisions will help the committee determine which additional skills and information the identified group of responders should receive in training.

If committee members, including representatives from policing, conclude that a subset of officers will respond to incidents involving people with mental illnesses, they should help the law enforcement executive determine how many officers are needed to cover all shifts and geographic districts. The committee also should develop personnel selection criteria and a process for identifying officers best suited for the challenges of this new role. In particular, planners should consider officers' ability to reorient from the more traditional method of gaining control by using an authoritative approach during a field contact to a nonadversarial, crisis-intervention style. To the extent possible, the selection process should be voluntary, yet selective.

3 Specialized Training

All law enforcement personnel who respond to incidents in which an individual's mental illness appears to be a factor receive training to prepare for these encounters; those in specialized assignments receive more comprehensive training. Dispatchers, call takers, and other individuals in a support role receive training tailored to their needs.

Training must be provided to improve officers' responses to people with mental illnesses. Agencies may differ in the amount of training they offer: some will provide comprehensive training to all officers, some will provide this training only to a subset, and some will provide basic training to everyone in combination with more comprehensive training to a subset. At a minimum, a group of officers sufficient to cover all time shifts and geographic districts should receive extensive skills and knowledge training that builds on the more cursory information routinely given on this topic at recruit and in-service trainings.[12] The chief law enforcement executive should ensure that training is also provided to supervisory and support personnel, such as midlevel managers, field training officers, call takers, and dispatchers, who advance the specialized program's operations.

Planning and implementing a training initiative that supports the specialized program should be a collaborative effort between the law enforcement agency and stakeholders represented on the program coordination group. The coordination group should help guide training decisions, which include selecting content and techniques, ensuring the instruction is culturally competent, identifying and preparing trainers, and evaluating effectiveness. The group's multidisciplinary/multisystem composition helps make certain that the training initiative reflects an appropriate range of perspectives; members can identify mental health practitioners, consumers, and family members to provide some of the training instruction. Likewise, the group helps ensure quality by establishing a process for consistently reviewing and evaluating training and then modifying the curriculum based on the findings. The group can be particularly helpful in identifying resources to defray law enforcement agency costs.

Specialized training should, at a minimum, provide officers with an improved understanding of the following: mental illnesses and their impact on individuals, families, and communities; signs and symptoms of mental illnesses; stabilization and de-escalation techniques; disposition options; community resources; and legal issues. Trainers should provide sufficient opportunities for hands-on experiential learning, such as role play and group problem-solving exercises.

Training should address issues specific to the community in which it is being given. Mental health personnel and other stakeholders should be invited to participate in the specialized training to help improve cross-system understanding of agencies' roles and responsibilities, as well as to convey any requirements for accessing community-based services. Planners should brief any trainers outside law enforcement about effective techniques, language, and sensitivities to the law enforcement culture that will improve their connection with this audience. When possible, additional cross-training should be provided to improve the mental health professionals' understanding of law enforcement issues, such as ride-alongs and other opportunities to see policies translated into action.

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12. For more information on various types of training opportunities for law enforcement personnel, see Council of State Governments, *Criminal Justice/Mental Health Consensus Project Report* (New York, N.Y.: Council of State Governments, 2002), www.consensusproject.org.

4 Call-Taker and Dispatcher Protocols

Call takers and dispatchers identify critical information to direct calls to the appropriate responders, inform the law enforcement response, and record this information for analysis and as a reference for future calls for service.

When 911 or other call takers receive a request for service they suspect involves a person with a mental illness, they should gather descriptive information on the person's behavior; determine whether the individual appears to pose a danger to him- or herself or others; ascertain whether the person possesses or has access to weapons; and ask the caller about the person's history of mental health or substance abuse treatment, violence, or victimization. All call takers should receive training on how to collect the most useful information quickly. To supplement this training, members of the coordinating group with mental health backgrounds should develop a concise list of questions for call takers to have on hand when answering service requests that seem to involve someone with a mental illness.

Call takers and dispatchers must have an understanding of the purpose of the specialized program and how it works—particularly what types of calls for service should be directed to particular officers or teams. Dispatchers must be provided with up-to-date information on staffing patterns during all shifts and over all geographic areas that identify law enforcement or mental health responders designated to respond to calls that appear to involve a person with a mental illness.

The coordinating group should also provide these personnel with specific guidance on how to record information in the dispatch database about calls in which mental illness may be a factor. The information should be used for assessing procedures, informing future responses, and evaluating program outcomes (see Element 10 for more on how evaluations promote sustainability). Locations of repeat calls for service involving individuals with mental illnesses can be coded to help ensure that specially trained officers will be dispatched to respond to those locations in the future. Coding can help agencies ultimately reduce call and transport time, as well as potential injuries to all involved, by dispatching experienced officers. To protect community members' privacy, the notes made on these locations must never identify specific individuals and must be reviewed periodically to ensure accuracy (see Element 7 for more on confidentiality concerns). Responding officers should also validate and update this information when they clear a call to that location. All communications personnel and responding officers should be instructed to avoid using slang and pejorative language when describing individuals thought to have a mental illness.

5 Stabilization, Observation, and Disposition

Specialized law enforcement responders de-escalate and observe the nature of incidents in which mental illness may be a factor using tactics focused on safety. Drawing on their understanding and knowledge of relevant laws and available resources, officers then determine the appropriate disposition.

Specialized law enforcement–based response programs are designed to resolve officers' encounters with people with mental illnesses safely and, when appropriate, link these individuals to mental health supports and services that reduce the chances for future interactions with the criminal justice system. The success of these programs is contingent on officers' using tactics that safely de-escalate situations involving someone who is behaving erratically or is in crisis. The high prevalence of trauma histories in this population requires the use of trauma-informed responses. In addition to de-escalating the incident, responding officers should assess whether a crime has been committed and observe the person's behavior within the given circumstances to determine if mental illness may be a factor. Officers should draw upon expertise acquired in specialized training and from their experiences to identify signs and symptoms of mental illness. Officers must ascertain whether the person appears to present a danger to him- or herself or others. To assist in this determination, officers may gather information from knowledgeable individuals at the scene, including mental health co-responders.

Officers must make disposition decisions based on their observations, information they gather at the scene, and their knowledge of community services and legal mandates. To assist officers in their decision making, the planning committee should develop clear guidelines that are consistent with the program's goals and governing authorities. For example, such programs might promote alternatives to incarceration for eligible individuals. If a person has come to the attention of law enforcement because of behaviors that appear to result from a mental illness and no serious crime has been committed, guidelines and protocols consistent with existing law should enable officers to divert the individual to mental health supports and services. When a serious crime has been committed, the person should be arrested.

To make these decisions, officers must be familiar with available community resources—particularly any 24-hour center that can receive individuals in mental health crises. Officers also must understand their state's criteria for involuntary emergency evaluation to make appropriate decisions regarding whether to detain and transport the person to a facility where he or she can undergo an emergency mental health evaluation. Officers must take into consideration both the individual's treatment needs and civil liberties and should pursue voluntary compliance with treatment whenever possible.

In the rare case when an incident involves barricaded individuals or de-escalation fails, responding officers will require additional support. Some agencies may equip officers who most frequently encounter people with mental illnesses with less-lethal weapons, so as to minimize injuries that could occur if there is a threat to safety and some use of force becomes necessary. Agencies should provide officers with additional training on the safe and appropriate deployment of these weapons and should establish protocols to guide officers in their decisions to use them. The planning committee also should develop protocols to make certain there is effective coordination during such incidents among specialized law enforcement responders, SWAT teams, and mental health professionals. Although agencies often are under pressure to resolve these situations quickly, it may be best, when there is no imminent threat of danger, to allow time for mental health personnel with expertise in crisis negotiation and law enforcement operations to communicate with the individual.

6 Transportation and Custodial Transfer

Law enforcement responders transport and transfer custody of the person with a mental illness in a safe and sensitive manner that supports the individual's efficient access to mental health services and the officers' timely return to duty.

Law enforcement is authorized to provide transportation for people who are under arrest or who they believe meet the criteria for emergency evaluation (whether the evaluation is voluntary or involuntary). These individuals are in law enforcement custody, and rules and regulations regarding restraints in custodial situations apply.[13] Given the frequent history of traumatic experiences among people with mental illnesses, custodial restraints may create acute stress, which in turn may escalate their degree of agitation. Law enforcement executives, with input from other program planners, should review policies regarding restraints in custodial situations and balance considerations of officer and citizen safety with the impact of these controls on people with mental illnesses.

The planning committee should identify facilities that are capable of assuming custodial responsibility, are available at all times, and have personnel qualified to conduct a mental health evaluation.[14] Speedy custodial transfer is critical to the overall success of law enforcement responses. To enable officers to return quickly to their duties, staff in the receiving facility should efficiently and accurately obtain relevant law enforcement information. Protocols should ensure that medical clearance is achieved in a timely manner and that people brought by law enforcement are never turned away. If law enforcement responders determine that the person with a mental illness should be arrested and officers take the person to jail or lockup, then qualified staff should be available to screen the arrestee at intake for mental health status, medication needs, and suicide risk.

In noncustodial situations in which the person does not meet the criteria for emergency evaluation and is not under arrest—but officers determine he or she would benefit from services and support—officers should try to connect the individual with a friend or family member, peer support group, or treatment crisis center. Similarly, officers should seek to engage the services of the individual's current mental health provider or a mobile crisis team. In some jurisdictions, law enforcement may also collaborate with mental health professionals to help transport individuals to evaluation or treatment facilities.

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13. Law enforcement agencies generally define custody using a case law standard that can be described as whether or not a "reasonable person" would feel free to leave.

14. H. Steadman and colleagues have used the term "specialized crisis response site" (SCRS) to refer to such a facility. SCRSs are defined as "sites where officers can drop off individuals in psychiatric crisis and return to their regular patrol duties. These [prebooking diversion] programs identify detainees with mental disorders and work with diversion staff, community-based providers, and the courts to produce a mental health disposition in lieu of jail." They also can link individuals to substance abuse and other treatment. See H. Steadman, K. Stainbrook, P. Griffin, J. Draine, R. Dupont, and C. Horey, "A Specialized Crisis Response Site as a Core Element of Police-Based Diversion Programs," *Psychiatric Services* 52 (2001): 219–222.

7 Information Exchange and Confidentiality

Law enforcement and mental health personnel have a well-designed procedure governing the release and exchange of information to facilitate necessary and appropriate communication while protecting the confidentiality of community members.

Law enforcement and mental health professionals should exchange information about people with mental illnesses who frequently come in contact with the justice system for many reasons: foremost among them, information sharing is essential to achieve desired outcomes by helping responders be more sensitive to individual needs, reduce injury, and enhance their ability to determine next steps. To facilitate an appropriate disposition decision, law enforcement officers should collaborate with mental health professionals to better understand the individual's mental health needs. Similarly, mental health providers working at receiving facilities can conduct a more effective mental health evaluation if law enforcement officers share their observations regarding the person's behavior at the scene. In addition to improving the outcomes of specific incidents, sharing information across systems will help program planners as they develop the program and its outcome measures.

The program's planning committee should carefully consider the type of information needed and existing barriers to its exchange and then develop procedures (and in some cases MOUs) to ensure that essential information is shared in an appropriate manner. These protocols should be reviewed during cross-training sessions, which will provide law enforcement and mental health professionals an opportunity to develop relationships with their counterparts and learn why they need certain information. Agency leaders also can explore the possibility of linking information systems to share certain information either on an ongoing or a one-time basis.[15]

Information should be shared in a way that protects individuals' confidentiality rights as mental health consumers and constitutional rights as potential defendants. The planning committee should determine which personnel have the authority to request and provide information about an individual's mental health and criminal history. In general, mental health records should be maintained by mental health professionals. Information exchanges should be limited strictly to what is needed to inform an appropriate incident response or disposition, and officers should focus on documenting observable behaviors only. All communications must, of course, comply with state and federal laws requiring the confidentiality of mental health records, such as the Health Insurance Portability and Accountability Act.[16] Cross-training should ensure that program staff understand relevant state and federal regulations about issues such as how medical information is released, secured, and retained.

Individuals with mental illnesses who have been in contact with a mental health agency should be offered an opportunity to provide consent in advance for mental health providers to share specified information with law enforcement authorities if an incident occurs (sometimes called an advance directive).[17] Individuals should be asked if an advance directive exists, and if so what the instructions are and who should be contacted to verify this information.

Officers can play an important role in exchanging information with family members and crime victims by providing explanations about criminal proceedings or diversion programs. They may inform the person with a mental illness and his or her family members about mental health treatment linkages and how to access other services or support groups, such as those related to substance use disorders. Law enforcement officers also can assist victims of crimes committed by people with mental illnesses by providing information about protective orders, victim support groups, and other services.

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15. The Bureau of Justice Assistance has supported groundbreaking advances that facilitate the electronic exchange of information between agencies. To learn more about efforts involving the development of national policies, practices, and technology capabilities that support effective and efficient information sharing, see www.it.ojp.gov.

16. For more information, see John Petrila, "Dispelling the Myths about Information Sharing between the Mental Health and Criminal Justice Systems," National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness (February 2007).

17. For more information on psychiatric advance directives, see the National Resource Center on Psychiatric Advance Directives (NRC-PAD), at www.nrc-pad.org. NRC-PAD provides an overview, forms to complete psychiatric advance directives, links to state statutes, educational Web casts and discussion forums, and other resources.

8 Treatment, Supports, and Services

Specialized law enforcement–based response programs connect individuals with mental illnesses to comprehensive and effective community-based treatment, supports, and services.

Law enforcement officers often are called to respond to incidents that are the manifestation of an untreated or inadequately treated mental illness. Specialized law enforcement–based responses provide an opportunity to link these individuals to community mental health supports and services that promote long-term wellness and reduce the chance of future negative encounters with officers.

When law enforcement responders bring individuals who are not under arrest to licensed mental health professionals at a receiving facility, staff there should be qualified to conduct a mental health evaluation; assess the contributions of mental illness, substance abuse, and other medical conditions to current behavior; and manage crisis situations. With their knowledge of available community-based treatment resources, mental health professionals can then link the individual to needed supports and services.

Individuals with mental illnesses often require an array of services and supports, which can include medications, counseling, substance abuse treatment, income supports and government entitlements, housing, crisis services, peer supports, case management, and inpatient treatment. Planners of the specialized response program should anticipate the treatment needs of the individuals with whom law enforcement will come in contact and work with service providers in the community to better ensure these needs can be met and coordinated.

Because many individuals with mental illnesses who come into contact with law enforcement have co-occurring substance use disorders, follow-up services will be most effective when delivered by providers with the capacity to integrate treatment approaches. Accordingly, the planning committee should consider how the program can help connect individuals with co-occurring disorders to integrated treatment and should advocate for greater access to this and other evidence-based practices.[18] Planners should pay special attention to the service needs of racial and ethnic minorities and women by making culturally competent and gender-sensitive services available to the extent possible.

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18. For our purposes here, evidence-based practices (EBPs) refer to mental health service interventions for which consistent scientific evidence demonstrates their ability to improve consumer outcomes. R. E. Drake, H. H. Goldman, H. S. Leff, A. F. Lehman, L. Dixon, K. T. Mueser, and W. C. Torrey, "Implementing Evidence-Based Practices in Routine Mental Health Service Settings," *Psychiatric Services* 52 (2001): 179–182. Other EBPs include assertive community treatment, psychotropic medications, supported employment, family psychoeducation, and illness self-management. For more information on the application of EBPs in forensic settings, see materials produced by the National GAINS Center at www.gainscenter.samhsa.gov/html/.

9 Organizational Support

The law enforcement agency's policies, practices, and culture support the specialized response program and the personnel who further its goals.

Law enforcement leaders who recognize the value of a specialized response program to reduce repeat calls for service and produce better outcomes for people with mental illnesses must create an organizational structure to support it. Leadership cannot be limited to endorsing the program and authorizing staff training. Establishing that the response program is a high priority for the agency is essential and is best demonstrated through visible and practical changes in how the agency partners with the community and realigns internal processes.

Specifically, leaders should embrace new partners and foster a supportive culture through frequent messages about the value of this type of "real" policing work. Communications with officers at every level of the agency should stress the benefits of the response program. Officers should be encouraged to volunteer for the program's assignments when possible, rather than receive mandatory reassignment. Enlisting the support of supervisors and field training officers is critical to transforming how the program will be viewed by others in the agency. A program "champion" in a position of authority within the agency and with a demonstrated commitment to the specialized program should be identified to serve as the agency's representative on the coordination group and the program's representative within the agency.

Leaders should modify officers' performance evaluations to take into account the initiative's unique objectives. As a program designed to improve the safety of all those involved in an incident and to reduce the number of people inappropriately taken into custody, success should not be measured by the number of arrests. As with other successful law enforcement problem-solving efforts, personnel performance should be evaluated and rewarded based on officers' success collaborating with and making referrals to community partners, addressing the underlying causes of calls for service, and taking measures that reduce the need for force.[19] The law enforcement agency and planning committee should acknowledge these professionals' hard work through commendation ceremonies and other forms of recognition.

Agency leaders may need to adjust officers' schedules, obtain grants, or devote funds to specialized program training, create new positions dedicated to coordinating program activities and recruiting and screening responding officers, and revise deployment strategies to maximize the availability of trained law enforcement responders across shifts and geographic areas. Agencies may find it beneficial to develop a standard operating procedure to enumerate specific processes and roles and responsibilities within the program. In some jurisdictions, these issues will require close cooperation with labor unions.

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19. For more information on innovative personnel performance measures for community policing initiatives, see Mary Ann Wycoff and Timothy N. Oettmeier, *Evaluating Patrol Officer Performance under Community Policing: The Houston Experience,* U.S. Department of Justice (Washington, D.C.: National Institute of Justice, 1993).

10 Program Evaluation and Sustainability

Data are collected and analyzed to help demonstrate the impact of and inform modifications to the program. Support for the program is continuously cultivated in the community and the law enforcement agency.

The planning committee should take steps early in the design process to ensure the program's long-term sustainability. Accordingly, the committee should identify performance measures based on program goals; these measures should consider quantitative data on key aspects of program operation, as well as qualitative data on officers' and community members' perceptions of the program. It may be helpful to aggregate baseline data before program implementation for later comparisons with new program information. To the extent possible, existing law enforcement and mental health agency data collection mechanisms should be adapted to accommodate the program's specific needs; planners may consider engaging a university partner to guide these data collection efforts. The planning committee should work with law enforcement and mental health agencies to ensure that the data are collected accurately and appropriately.

The data law enforcement personnel collect should focus on questions most critical to the program's success in achieving its goals, including the number of injuries and deaths to officers and civilians; officer response times; the number of incidents to which specially trained officers responded; the number of repeat calls for service; officers' disposition decisions, such as linking a person with services; and time required and method used for custodial transfer. Data should be used to refine program operations as needed, as well as review individual case outcomes and determine if follow-up by a mental health professional is warranted.

Program leaders should gauge the attitudes of community leaders, the media, key public officials, and other policymakers toward the program. It may be helpful to engage elected officials early in the process and keep them involved—from the initial kickoff through refunding and long-term implementation—to promote sustainability and desired legislation. The committee also should survey officers—both specialized responders and others—so that law enforcement leaders can better assess the program's usefulness to the entire department and address any concerns. Based on this information, the planning committee should determine the most effective way to promote the program's positive impact on the community, individuals, and agencies and respond to program shortcomings or high-profile tragic events.

While in-kind contributions from partners can go a long way toward offsetting certain program costs, planners should identify and cultivate long-term funding sources to cover costs that would otherwise fall to the law enforcement agency to absorb. Requests for funding should be based on clearly articulated program goals and, to the extent possible, should incorporate data demonstrating program outcomes.

Departments also should focus on sustaining internal support for the program, such as offering refresher training to help officers refine their skills and expand their knowledge base. To promote longer-term commitments from specialized officers, departments also should provide incentives and other organizational support for serving in the program.

Conclusion

Many law enforcement agencies around the nation struggle to respond effectively to people with mental illnesses. Officers encounter these individuals when citizens call them to "do something" about the man exhibiting unusual behavior in front of their business, the woman sleeping on a park bench, or someone who is clearly in need of mental health services—whether or not a crime has been committed. Law enforcement professionals in many jurisdictions have lacked community-based support, guidance, and a clear framework for crafting a program to improve their response to people with mental illnesses.

But innovative solutions are at hand. Increasingly, law enforcement agencies of all sizes are implementing creative approaches despite scarce resources. The range of approaches in communities across the country reflects the realization that strategies must be tailored to each jurisdiction's unique needs. These agencies are engaged in problem solving with a range of partners from diverse disciplines and have access to a growing pool of programs and knowledge about promising practices. This publication outlines the essential elements of successful specialized law enforcement–based efforts that reflect this expanded knowledge base and experience to better guide practitioners initiating or enhancing their own programs.

The tone of the elements may suggest that these changes are easy to make. They are not. There are many challenges to these efforts, including politics, turf battles, competition for limited funding, lack of legal foundations for officers' actions, and scarce law enforcement and community mental health resources. Leaders in jurisdictions that have implemented a specialized response acknowledge that it takes commitment to overcome these obstacles, but agree that the costs—in dollars and human lives—are too high to sanction continuing with only more traditional law enforcement responses to people with mental illnesses. Their efforts have resulted in increased public safety and improved public health.

The Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, provides leadership training, technical assistance, and information to local criminal justice agencies to make America's communities safer. Read more at www.ojp.usdoj.gov/BJA/.

The Council of State Governments (CSG) Justice Center is a national nonprofit organization serving policymakers at the local, state, and federal levels from all branches of government. The CSG Justice Center provides practical, nonpartisan advice and consensus-driven strategies, informed by available evidence, to increase public safety and strengthen communities. Read more at www.justicecenter.csg.org.

The CSG Justice Center also coordinates the Criminal Justice/Mental Health Consensus Project. This project is an unprecedented national effort to improve responses to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. Read more at www.consensusproject.org.

The Police Executive Research Forum (PERF) is a national membership organization of progressive police executives from the largest city, county, and state law enforcement agencies. PERF is dedicated to improving policing and advancing professionalism through research and involvement in public policy debate. Read more at www.policeforum.org.

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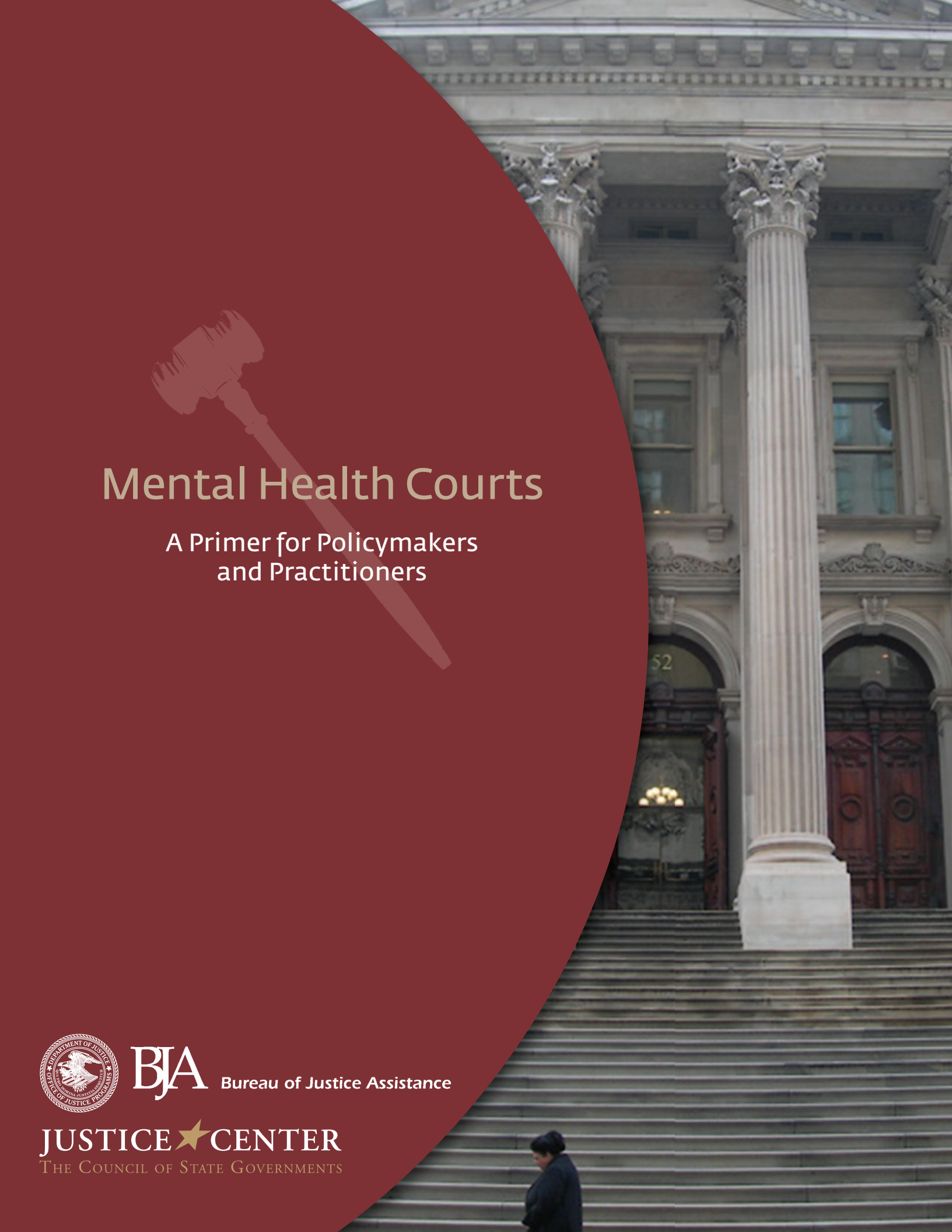

Mental Health Courts

A Primer for Policymakers and Practitioners

BJA Bureau of Justice Assistance

JUSTICE CENTER
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Mental Health Courts

A Primer for Policymakers and Practitioners

A report prepared by the
Council of State Governments Justice Center
Criminal Justice/Mental Health Consensus Project
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Introduction

Mental health courts have spread rapidly across the country in the few years since their emergence. In the late 1990s only a handful of such courts were in operation; as of 2007, there were more than 175 in both large and small jurisdictions.[1]

If this recent surge in popularity is any indicator, many more communities will consider developing a mental health court in the coming years. This guide is intended to provide an introductory overview of this approach for policymakers, practitioners, and advocates, and to link interested readers to additional resources.

The guide addresses a series of commonly asked questions about mental health courts:

- Why mental health courts?
- What is a mental health court?
- What types of individuals participate in mental health courts?
- What does a mental health court look like?
- What are the goals of mental health courts?
- How are mental health courts different from drug courts?
- Are there any mental health courts for juveniles?
- What does the research say about mental health courts?
- What issues should be considered when planning or designing a mental health court?
- What resources can help communities develop mental health courts?

Why Mental Health Courts?

Mental health courts are one of many initiatives launched in the past two decades to address the large numbers of people with mental illnesses involved in the criminal justice system. While the factors contributing to this problem are complicated and beyond the scope of this guide, the over-representation of people with mental illnesses in the criminal justice system has been well documented:[2]

- Prevalence estimates of serious mental illness in jails range from 7 to 16 percent, or rates four times higher for men and eight times higher for women than found in the general population.[3]
- A U.S. Department of Justice study from 1999 found that half of the inmates with mental illnesses reported three or more prior sentences.[4] Other research indicates that people with mental illnesses are more likely to be arrested than those without mental illnesses for similar crimes and stay in jail and prison longer than other inmates.[5]
- In 1999, the Los Angeles County Jail and New York's Rikers Island jail held more people with mental illnesses than the largest psychiatric inpatient facilities in the United States.[6]
- Nearly two-thirds of boys and three-quarters of girls detained in juvenile facilities were found to have at least one psychiatric disorder, with approximately 25 percent of these juveniles experiencing disorders so severe that their ability to function was significantly impaired.[7]

Without adequate treatment while incarcerated or linkage to community services upon release, many people with mental illnesses may cycle repeatedly through the justice system. This frequent involvement with the criminal justice system can be devastating for these individuals and their families and can also impact public safety and government spending. In response, jurisdictions have begun to explore a number of ways to address criminal justice/mental health issues, including mental health courts, law enforcement–based specialized response programs, postbooking jail diversion initiatives, specialized mental health probation and parole caseloads, and improved jail and prison transition planning protocols. All of these approaches rely on

extensive collaboration among criminal justice, mental health, substance abuse, and related agencies to ensure public safety and public health goals.

Mental health courts serve a significant role within this collection of responses to the disproportionate number of people with mental illnesses in the justice system. Like drug courts and other "problem-solving courts," after which they are modeled, mental health courts move beyond the criminal court's traditional focus on case processing to address the root causes of behaviors that bring people before the court.* They work to improve outcomes for all parties, including individuals charged with crimes, victims, and communities.

*Drug courts have been particularly instrumental in paving the way for mental health courts. Some of the earliest mental health courts arose from drug courts seeking a more targeted approach to defendants with co-occurring substance use and mental health disorders.

What Is a Mental Health Court?

Despite the recent expansion of mental health courts, there are not yet nationally accepted, specific criteria for what constitutes such a court. Although some initial research identified commonalities among early mental health courts, the degree of diversity among programs has made agreement on a core definition difficult.[8] Mental health courts vary widely in several aspects including target population, charge accepted (for example, misdemeanor versus felony), plea arrangement, intensity of supervision, program duration, and type of treatment available. Without a common definition, national surveys developed on mental health courts have relied primarily on self-reported information to identify existing programs.[9]

The working definition that follows distills the common characteristics shared by most mental health courts. The Justice Center worked with leaders in the field to also develop consensus on what these characteristics should look like and how they can be achieved, as documented in *The Essential Elements of a Mental Health Court*.*

A Working Definition of a Mental Health Court

A mental health court is a specialized court docket for certain defendants with mental illnesses that substitutes a problem-solving model for traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, nonadherence may be sanctioned, and success or graduation is defined according to predetermined criteria.[10]

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*As the commonalities among mental health courts continue to emerge, practitioners, policymakers, researchers, and others have become interested in developing consensus not only on what a mental health court is but on what a mental health court should be. *The Essential Elements of a Mental Health Court* describes 10 key characteristics that experts and practitioners agree mental health courts should incorporate. Michael Thompson, Fred Osher, and Denise Tomasini-Joshi, *Improving Responses to People with Mental Illnesses: The Essential Elements of a Mental Health Court* (New York, NY: Council of State Governments Justice Center, 2008), www.consensusproject.org/mhcp/essential.elements.pdf.

What Types of Individuals Participate in Mental Health Courts?

The majority of mental health court participants suffer from serious mental illnesses. Mental illness is a general term that includes a range of psychological disorders. A subset of serious mental illnesses is severe and persistent mental illness. This includes conditions that involve long-term and profound impairment of functioning—for example, schizophrenia, schizoaffective disorder, bipolar disorder (formerly called manic depression), severe depression, and anxiety disorders. In addition to describing level of functioning, most states also use criteria for "severe and persistent" to prioritize access to public mental health services.

Some mental health courts accept individuals with a broader array of disabling conditions than mental illness alone. While developmental disabilities, traumatic brain injuries, and dementias are not included in federal statutory and regulatory definitions of serious mental illness, they may be the cause of behavioral problems that result in criminal justice contact and may also co-occur with serious mental illnesses. Each mental health court determines how flexible to be on eligibility requirements and, when screening an individual who does not precisely fit standard criteria, whether to accept participants on a case-by-case basis. Working with individuals who have needs that fall outside the typical mental health service continuum requires additional partnerships with other community agencies, and so acceptance decisions are based, in part, on an individual's ability to benefit from a court intervention given these clinical and system capacity considerations. All individuals must be competent before agreeing to participate in the program.

Although addictive disorders are considered mental illnesses and are included in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* their diagnosis, treatment interventions, and providers differ from those for nonaddictive mental illnesses. Nevertheless, the majority of people with mental illnesses involved with the criminal justice system—approximately three out of four—also suffer from a co-occurring substance use disorder.[11] As a result, mental health courts must address this population and treat both mental health and substance use disorders in a comprehensive and integrated fashion. The vast majority of mental health courts accept individuals with co-occurring disorders, and some courts even seek out this population, but few mental health courts accept defendants whose only mental disorders are related to substance use.

The prevailing belief in the scientific community is that mental disorders, both addictive and nonaddictive, are neurobiological diseases of the brain, outside the willful control of individuals. People with mental illnesses cannot simply decide to change the functioning of their brain. As with physical illnesses, it is believed that mental disorders are caused by the interplay of biological, psychological, and social factors. This acknowledged lack of control contributes to the belief that mental health courts, which rely on treatment and flexible terms of participation rather than the traditional adversarial system, represent a more just way for courts to adjudicate cases involving people with mental illnesses. Nevertheless, entering a mental health court does not negate individuals' responsibility for their actions. Mental health courts promote accountability by helping participants understand their public duties and by connecting them to their communities.

What Does a Mental Health Court Look Like?

The enormous variability in mental health court design and operation has led some observers to note that "if you have seen one mental health court, you have seen one mental health court." Nevertheless, while great variety exists, mental health courts share several core characteristics. What follows is a description of one mental health court in action that reflects some of these central features, the "essential elements."

Every Wednesday afternoon, County Courthouse Room 13 assumes a mental health docket. The courtroom team (judge, defense attorney, prosecutor, probation officer, court coordinator, and case manager) has already met for several hours to discuss the people who will be appearing that day.

The first individuals before the bench are those entering the court for the first time. They have already undergone basic screening for program eligibility, had their mental health needs assessed, and been given a description of the mental health court program. The judge explains why they have been offered the opportunity to participate and describes the court's procedures. She asks if they want to enter the program and whether they fully understand the terms of participation. Those who agree to participate (the majority) are welcomed into the court.

After the new participants have been admitted, the court proceeds with status hearings for current program participants. The judge inquires about their treatment regimens, and publicly congratulates those who received positive reviews from their case managers and probation officers at the staff meeting. One participant receives a certificate for completing the second of four phases of the court program. The judge hands down sanctions of varying severity to individuals who have missed treatment appointments—tailored to the needs of each participant. The judge also informs several participants that certain privileges they had hoped to obtain will be withheld because of their misconduct over the past two weeks. Throughout the status hearings, conversation remains informal and individualized, often relaxed. Observers unfamiliar with mental health court procedures may be uncertain of what they are witnessing, but they will be sure of one thing: this is not a typical courtroom.

In the following days, the mental health court team will work to develop a service plan for each new participant to connect him or her quickly to community-based mental health treatment and other supports. Those individuals who have declined to participate will return to the original, traditional court docket.

What Are the Goals of Mental Health Courts?

At their heart, mental health courts represent a response to the influx of people with mental illnesses into the criminal justice system. They seek to use the authority of the court to encourage defendants with mental illnesses to engage in treatment and to adhere to medication regimens to avoid violating conditions of supervision or committing new crimes. Unlike some programs that divert individuals from the justice system and merely refer them to community service providers, mental health courts can mandate adherence to the treatment services prescribed, and the prospect of having charges reduced or dismissed provides participants with additional incentives.

Communities start mental health courts with the hope that effective treatment will prevent participants' future involvement in the criminal justice system and will better serve both the individual and the community than does traditional criminal case processing. Within this framework, mental health court planners and staff cite specific program goals, which usually fall into these categories:

- Increased public safety for communities—by reducing criminal activity and lowering the high recidivism rates for people with mental illnesses who become involved in the criminal justice system
- Increased treatment engagement by participants—by brokering comprehensive services and supports, rewarding adherence to treatment plans, and sanctioning nonadherence
- Improved quality of life for participants—by ensuring that program participants are connected to needed community-based treatments, housing, and other services that encourage recovery
- More effective use of resources for sponsoring jurisdictions—by reducing repeated contacts between people with mental illnesses and the criminal justice system and by providing treatment in the community when appropriate, where it is more effective and less costly than in correctional institutions

How Are Mental Health Courts Different from Drug Courts?

Drug courts are the best known and most widespread of the various problem-solving court models and have in many ways served as a prototype from which mental health courts have evolved. The high rate of co-occurring mental health and substance use disorders among individuals in the criminal justice system also suggests significant overlap in the target populations of these related court programs. In fact, in some jurisdictions, the inability of the local drug court to effectively manage individuals with serious mental illnesses precipitated the development of a mental health court.

Important differences remain in the principles and operation of drug courts and mental health courts; mental health courts are not merely drug courts for people with mental illnesses.[12] Although little research has been conducted comparing drug courts and mental health courts, it is already clear that jurisdictions interested in building on the experiences of their drug courts to develop a mental health court will need to adapt the model in significant ways to accommodate individuals with mental illnesses.

The majority of the differences listed below stem from the fact that mental illness, unlike drug use, is, in and of itself, not a crime; mental health courts admit participants with a wide range of charges, while drug courts focus on drug-related offenses. Also, whereas drug courts concentrate on addiction, mental health courts must accommodate a number of different mental illnesses, and so there is greater variability among treatment plans and monitoring requirements for participants than in drug courts.

Key Differences between Drug Courts and Mental Health Courts

PROGRAM COMPONENT	DRUG COURTS . . .	MENTAL HEALTH COURTS . . .
Charges accepted	Focus on offenders charged with drug-related crimes	Include a wide array of charges
Monitoring	Rely on urinalysis or other types of drug testing to monitor compliance	Do not have an equivalent test available to determine whether a person with a mental illness is adhering to treatment conditions
Treatment plan	Make treatment plans structured and routinized; apply sanctioning grid in response to noncompliance, culminating with brief jail sentence	Ensure that treatment plans are individualized and flexible; adjust treatment plans in response to nonadherence along with applying sanctions; rely more on incentives; use jail less frequently
Role of advocates	Feature only minimal involvement from advocacy community	Have been promoted heavily by some mental health advocates, who are often involved in the operation of specific programs; other mental health advocates have raised concerns about mental health courts, either in general or in terms of their design
Service delivery	Often establish independent treatment programs, within the courts' jurisdiction, for their participants	Usually contract with community agencies; require more resources to coordinate services for participants
Expectations of participants	Require sobriety, education, employment, self-sufficiency, payment of court fees; some charge participation fees	Recognize that even in recovery, participants are often unable to work or take classes and require ongoing case management and multiple supports; few charge a fee for participation

Are There Any Mental Health Courts for Juveniles?

The development of mental health courts for juveniles began several years after the emergence of adult programs. In 2001 Santa Clara, California, became the first jurisdiction to use this strategy to address the large numbers of youth with mental health needs involved with the juvenile justice system.[13] A number of other juvenile mental health courts have since been catalogued, and as of 2007 the National Center for Mental Health and Juvenile Justice (NCMHJJ) had identified 18 juvenile mental health courts in operation. An additional 20 jurisdictions indicated they were either considering or actively planning a juvenile mental health court.[14] The small number of juvenile mental health courts does not in any way reflect an infrequency of mental illnesses among youth in the juvenile justice system. In fact, the percentage of individuals with mental illnesses is just as significant in the juvenile justice system as in the adult system, if not more so.

Given that the juvenile mental health courts have developed more slowly than adult mental health courts, less is known about their operation and effectiveness. NCMHJJ's study of juvenile mental health courts has revealed that many different models exist; nevertheless, like adult courts, several themes characterize these courts:

- They work best when part of a larger comprehensive plan that incorporates other elements, such as diversion and treatment, to address the mental health needs of these youth.
- The majority use a postadjudication model, although several function at the preadjudication stage.
- Most juvenile mental health courts accept youth who have committed either felonies or misdemeanors; however, many have broad discretion in determining whether to include youth who have committed very serious felonies.
- They vary on which mental health diagnoses to focus on when identifying participants, with some accepting youth with any mental health disorder, others including only youth with certain serious disorders, and still others concentrating on youth with co-occurring mental health and substance use disorders.[15]

Juvenile mental health courts offer many of the same benefits as adult programs. They also confront many of the same operational problems, but because of their participants' status as minors, juvenile mental health courts also must address an additional layer of challenges and tasks. These include identifying developmental issues that affect cognition, behavior, and the potential effectiveness of mental health treatment; working with parents and guardians; and involving a larger number of other systems, including the education and foster care systems.

What Does the Research Say about Mental Health Courts?

Research on mental health courts can be divided into two main types: studies assessing court operations (process evaluations) and studies assessing court effectiveness (outcome evaluations). Given the short tenure of most mental health courts, the greatest volume of research examines court operations and the way in which participants flow through the various programs.

Process evaluations

Process evaluations completed as of 2007 confirm that all mental health courts have some commonalities, but there are also some important differences. One of the few comparative studies, which looked at seven mental health courts' operations, found there were differences between early mental health courts and more recently developed ones, deemed "second-generation courts."[16] According to this study, while procedures varied greatly from court to court, the newer courts were more likely to share these elements:

- They consider defendants charged with felonies, as opposed to only misdemeanors, for acceptance into the program.
- They allow only postplea program enrollment, which means that the time from jail admission to program enrollment is usually longer.
- They rely more heavily on criminal justice staff, as opposed to community treatment providers, to monitor and supervise participants.
- They use jail more regularly to sanction nonadherence to court orders.[17]

These findings were published in 2004, and since then many of the "first-generation" courts have expanded the charges and pleas they accept. It is also not uncommon for new courts that would be labeled as second generation to begin as misdemeanor programs. Nevertheless, these general trends illustrate that as mental health courts become more commonplace and accepted, planning groups have more opportunities to focus on higher-risk populations than when mental health courts first emerged.

Outcome evaluations

In addition to describing mental health court operations generally, several studies have evaluated individual mental health courts and their impact on a range of participant and system outcomes. Their findings suggest the following:

- Mental health court participation resulted in comparatively fewer new bookings into jail and greater numbers of treatment episodes compared with the period prior to program participation.[18]
- Participants were significantly less likely to incur new charges or be arrested than a comparison group of individuals with mental illnesses who did not enter the mental health court program.[19]
- Participation increased the frequency of treatment services, as compared with involvement in traditional criminal court.[20]
- Mental health court participants improved their independent functioning and decreased their substance use compared with individuals who received treatment through the traditional court process.[21]
- Participants spent fewer days in jail than their counterparts in the traditional court system.[22]
- Mental health court participants reported more favorable interactions with the judge and perceived that they were treated with greater fairness and respect than in traditional court.[23]

Researchers have also begun to explore the fiscal impact of mental health courts. A recent study by the RAND Corporation assessed the Allegheny County Mental Health Court in Pennsylvania.[24] The study found that the program did not result in substantial added costs, at least in the short term, over traditional court processing for individuals with serious mental illnesses. The findings also suggested that over the longer term, the mental health court may actually result in net savings for the government.*

In assessing the impact of mental health courts, it is important to note that these findings draw on a handful of studies, many of which look at individual programs and so cannot be generalized. Furthermore, research has not yet explored how changes in a mental health court's program elements or procedures affect outcomes. A comparative study of outcomes across different mental health courts has yet to be completed.[25]

*This savings projection is based on an analysis of the anticipated costs associated with incarceration and utilization of the most expensive mental health treatment (hospitalization) and the expectation that mental health court participation would reduce both of the above.

What Issues Should Be Considered When Planning or Designing a Mental Health Court?

Fueled by emerging data on the utility of mental health courts, the popularity of problem-solving courts in general, and the desire to respond to a deep-rooted social problem, jurisdictions will likely continue to launch mental health courts in the coming years. Policymakers and practitioners interested in establishing or enhancing mental health courts should consider some important issues related to the formation and design of these courts.

Practicality in local context

Mental health courts may be impractical in some jurisdictions, either because of jurisdiction size and insufficient staff and resources or because of local resistance to problem-solving courts.[26] Accordingly, communities considering the development of a mental health court should also investigate the array of other court-based strategies being employed across the country, including postbooking jail diversion programs, specialized dockets within existing court structures, mental health–specific probation caseloads, and improved training for court personnel.

Limited data

As the previous section indicates, while only limited research has been completed, the available studies indicate that mental health courts may have more positive outcomes for people with mental illnesses than traditional criminal court processing. More research is nevertheless needed to compare different mental health court practices and evaluate outcomes across programs. Jurisdictions planning a mental health court should build data collection and evaluation into their program operations, so that the court will eventually be able to conduct its own basic data analyses.

Effect on overall service capacity

Though mental health courts have arisen in part because of the inadequate treatment services and resources in community mental health systems, implementing a program does not usually result in expanded service capacity.

Instead, mental health court staff works within the existing framework of local resources and treatment providers. As a result, if mental health courts are effective in linking their participants with services, they can actually reduce the availability of treatment options for people with mental illnesses outside the criminal justice system. To avoid disadvantaging individuals in the community, therefore, mental health court administrators, other criminal justice professionals, and mental health and substance use treatment providers should ensure the availability of services for all people with mental illnesses and work collaboratively to fill gaps in the treatment system.

Need for a continuum of response strategies

Some communities have developed mental health courts without considering alternatives across the criminal justice continuum. In these communities mental health courts might be viewed as the only strategy needed to improve outcomes for people with mental illnesses in the justice system, when in fact no single initiative can address the driving factors behind this problem. Focusing solely on mental health courts can also lead to a lack of coordination with law enforcement–based diversion programs, drug courts, reentry programs, and other initiatives at the intersection of the criminal justice, mental health, and substance use systems. Without cooperation among different criminal justice/mental health programs, limited resources cannot be shared and efforts may be duplicated. To avoid these pitfalls, policymakers and practitioners should work together to coordinate responses to their shared clientele.

Integration with traditional case processing

Regardless of their effectiveness, mental health courts alone cannot respond to the vast numbers of people with mental illnesses who enter the criminal justice system. Traditional court officials must adopt the principles and policies at the core of mental health courts to ensure that these approaches are not limited to the small number of individuals who enter specially tailored programs. Accordingly, traditional court judges and administrators should strive toward three goals: making training available to all court personnel on mental health issues; integrating mental health information into pretrial and presentence reports and responses to violations of community supervision conditions; and improving collaboration among all criminal justice agencies and mental health and substance use treatment systems.

Design considerations

Many complex issues related to mental health court design and implementation deserve greater scrutiny. For example, mental health court practitioners and observers differ on the types of participants mental health courts should

accept, the plea agreements courts should offer, appropriate program length, and how program success should be measured. Readers interested in these issues should consult this guide's companion document, *A Guide to Mental Health Court Design and Implementation* (www.consensusproject.org/mhcp/info/mhresources/pubs).

What Resources Can Help Communities Develop Mental Health Courts?

Jurisdictions interested in developing a mental health court can benefit from a range of resources and documents offering support.

Federal grant support

Although many mental health courts emerged as community-level responses to locally identified problems, they have also been supported at the federal level.

- *Justice and Mental Health Collaboration Program*

  In 2004, Congress authorized the creation of the Justice and Mental Health Collaboration Program (JMHCP).[27] This program strives to increase public safety by facilitating collaboration among the criminal justice, juvenile justice, mental health treatment, and substance use systems and to improve access to effective treatment for people with mental illnesses involved with the criminal justice system.

  The JMHCP does not exclusively support mental health courts; nevertheless, of the 27 grantees selected in 2006 and the 26 selected in 2007, approximately one-third have focused on court-related initiatives. Congress appropriated $5 million for both 2006 and 2007 and increased appropriations to $10 million for the program in 2008.

  The JMHCP is administered by the Bureau of Justice Assistance (BJA).[28] At this writing, technical assistance is provided to the grantees by the Justice Center, as well as the Pretrial Justice Institute and the National Association of Counties (NACO).[29]

  To learn more about the JMHCP and grantees, see www.consensusproject.org/jmhcp.

- *Targeted Capacity Expansion Program*

  In addition to funds from criminal justice agencies, mental health courts have also received support from federal health agencies, namely, the Substance Abuse and Mental Health Services Administration (SAMHSA).

  Since 2005, SAMHSA has supported several mental health courts directly through its Targeted Capacity Expansion (TCE) program.[30] The

Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion provides technical assistance to TCE grantees.[31]

State grant support

Several states have developed broad programmatic support to address the prevalence of people with mental illnesses in the criminal justice system. As with the JMHCP, these grant dollars can be used for mental health courts. Such programs can be found in California and Florida, and many states are considering similar proposals.

- *Mentally Ill Offender Crime Reduction Grant Program (California)*

  The California Mentally Ill Offender Crime Reduction (MIOCR) program seeks to (1) support the implementation and evaluation of county efforts to increase access to community-based services and supports, (2) facilitate successful transitions from incarceration to the community, and (3) reduce recidivism among both adults and juveniles with mental illnesses involved with the criminal justice system.

  In 2006, 44 grants were awarded to 28 different counties, totaling $44.6 million. Many of these counties have used the funding to plan or improve mental health court programs. Nearly $30 million was appropriated for MIOCR in 2007. For more information, see www.cdcr.ca.gov/Divisions_Boards/CSA/CPP/Grants/MIOCR/MIOCRG.html.

- *Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program (Florida)*

  In 2007, the Florida Substance Abuse and Mental Health Corporation announced the availability of $3.8 million under the newly created Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program. In 2008, planning or implementation grants were given to counties to develop initiatives to improve public safety, avoid an increase in spending on criminal and juvenile justice, and better connect individuals with mental health or substance use disorders who are involved with the criminal justice system to treatment. More information can be found at www.samhcorp.org/RFA/index.htm.

In addition to federal and state grants, a number of other resources are available to jurisdictions interested in planning a mental health court.

BJA mental health court learning sites

Besides its work with the Justice and Mental Health Collaboration Program, BJA has designated five mental health courts as learning sites to provide a

peer support network for local and state officials interested in planning a new—or improving upon an existing—mental health court:

- Akron Municipal Mental Health Court (Ohio)
- Bonneville County Mental Health Court (Idaho)
- Bronx County Mental Health Court (New York)
- Dougherty Superior Court (Georgia)
- Washoe County Mental Health Court (Nevada)

These courts serve as a resource for jurisdictions across the country looking to develop or refine their approach to individuals with mental illnesses. Since each mental health court has a unique set of policies and procedures, the learning sites program allows jurisdictions to observe different models and the flexibility needed to tailor a program to a specific community. The learning sites also work with the Justice Center, the technical assistance provider for this program, to assess and improve their own court operations and to develop tools for the mental health court field.

The five learning sites are indeed representative of the great variability in mental health court models. For example, the Bronx County Mental Health Court started with only felony charges and began accepting misdemeanors in 2007, whereas the Akron Municipal Mental Health Court has continually focused on misdemeanor charges. Similarly, the Bonneville County Mental Health Court serves a rural jurisdiction and averages approximately 35 participants at a time, whereas the Washoe County Mental Health Court—located in a more urban area—has an estimated 200 people under its supervision at a given time. As a dual mental health court and drug court, the Dougherty Superior Court uses a different program model than all of the other learning sites. Interested jurisdictions are encouraged to visit the learning site most similar to the program model envisioned or to contact several or all of the courts to compare their models and processes.[32]

Policy guides

As part of the Mental Health Court Program and with support from BJA, the Justice Center has produced a number of practical policy guides to aid mental health courts across the country. The following publications explore in more depth a number of issues and lessons presented in this primer. They can be found at www.consensusproject.org/mhcp/info/mhresources/pubs.[33]

- *The Essential Elements of a Mental Health Court*
- *A Guide to Mental Health Court Design and Implementation*
- *A Guide to Collecting Mental Health Court Outcome Data*
- *Navigating the Mental Health Maze*

Web resources

The Consensus Project website, which the Justice Center maintains, is a helpful place to begin exploring criminal justice/mental health issues or gathering information on mental health courts. The homepage can be found at www.consensusproject.org, and the following web pages also provide relevant information.

- *Consensus Project Report*

  The landmark *Criminal Justice/Mental Health Consensus Project* report, a comprehensive discussion of the involvement of people with mental illnesses in the criminal justice system, from before arrest to after reentry from prison or jail, is available at www.consensusproject.org/the_report. A chapter of the report has been dedicated to issues that must be considered when looking at possible court-based strategies.

- *Mental Health Court Web Page*

  Within the Consensus Project website, the Justice Center maintains a page specifically for mental health courts, www.consensusproject.org/mhcp/. Many of the publications described above can be found on this page, as well as information on the learning sites and other relevant materials and websites.

- *Criminal Justice/Mental Health Information Network*

  A number of relevant mental health court resources can be found on the Criminal Justice/Mental Health Information Network (InfoNet) website, www.cjmh-infonet.org, an online database that provides a comprehensive inventory of collaborative criminal justice/mental health activity across the country and serves as a platform for peer-to-peer networking.

  At this writing, the InfoNet contains approximately 175 mental health court profiles, which are added to the site once a court fills out a survey about its program. Viewers can sort by type of program (in addition to courts, the InfoNet contains information on law enforcement, corrections, and community support programs) or by state to find the mental health courts closest to them. Users can also get a sense of the type of model these courts follow, the participants and charges they accept, and how long they have been up and running. The InfoNet also contains information on mental health court research, as well as relevant media articles.[34]

- *JMHCP Web Page*

  Grantees and nongrantees alike can find useful resources on the JMHCP web page, www.consensusproject.org/jmhcp. JMHCP provides access to

grantee snapshots and technical assistance resources, as well as links to detailed program profiles for each grantee represented on the InfoNet.

- *Center for Court Innovation Website*

  The Center for Court Innovation, which helps courts and criminal justice agencies aid victims, reduce crime, and improve public trust in criminal justice, has worked extensively with mental health courts. Relevant publications are available on its website, www.courtinnovation.org.

- *National Center for State Courts Website*

  The National Center for State Courts (NCSC) strives to improve the administration of justice through leadership and service to state courts and courts around the world. The NCSC website contains a number of materials for specialty courts, including mental health courts, which can be found at www.ncsconline.org.

- *National Drug Court Institute Website*

  Readers interested in learning more about drug courts should visit the website of the National Drug Court Institute (NDCI), www.ndci.org. NDCI promotes education, research, and scholarships for drug court and other court-based intervention programs.

- *National GAINS Center Website*

  The National GAINS Center works to collect and disseminate information about effective mental health and substance abuse services for people with co-occurring disorders involved with the justice system. Within the GAINS Center, the TAPA Center for Jail Diversion focuses on policies related to jail diversion, and both GAINS and TAPA resources can be found at www.gainscenter.samhsa.gov.

Notes

1. The Justice Center catalogues mental health court programs on its Criminal Justice/Mental Health Information Network (InfoNet) website: www.cjmh-infonet.org.

2. For a comprehensive discussion, see the *Criminal Justice/Mental Health Consensus Project* report (New York, NY: Council of State Governments, 2002).

3. Paula M. Ditton, *Special Report: Mental Health and Treatment of Inmates and Probationers* (Washington, DC: U.S. Department of Justice, 1999). *The Prevalence of Co-occurring Mental and Substance Use Disorders in Jails* (Delmar, NY: National GAINS Center, 2002). Revised Spring 2004. L. Teplin, K. Abram, and G. McClelland, "Prevalence of Psychiatric Disorders among Incarcerated Women: Pretrial Jail Detainees," *Archives of General Psychiatry* 53 (1996): 505–512. A study released by the Bureau of Justice Statistics in 2006 (*Mental Health Problems of Prison and Jail Inmates*) found that more than half of all prison and jail inmates studied reported having mental health "problems," a measure that had not been used previously.

4. Paula M. Ditton, *Special Report: Mental Health and Treatment of Inmates and Probationers* (Washington, DC: U.S. Department of Justice, 1999), www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf.

5. Linda Teplin, *Keeping the Peace: Police Discretion and Mentally Ill Persons* (Washington, DC: U.S. Department of Justice, 2000). Fox Butterfield, "Asylums behind Bars: A Special Report: Prisons Replace Hospitals for the Nation's Mentally Ill," *New York Times,* March 5, 1998, section A, p.1.

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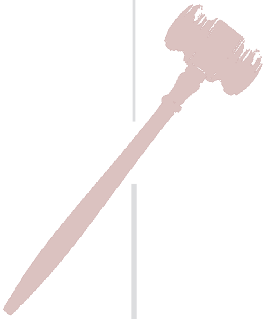
9. The Council of State Governments Justice Center, with support from the National Alliance on Mental Illness and the National GAINS Center, developed three annual surveys on mental health courts between 2004 and 2006.

10. Adapted by Henry J. Steadman from Henry J. Steadman, Susan Davidson, and Collie Brown, "Mental Health Courts," *Psychiatric Services* 52 (2001): 457–458.

11. Linda Teplin and Karen Abram, "Co-occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy," *American Psychologist* 46, no. 10 (1991): 1036–1045.

12. John Petrila, Norman G. Poythress, Annette McGaha, and Roger A. Boothroyd, "Preliminary Observations from an Evaluation of the Broward County Mental Health Court," *Court Review* (Winter 2001): 14–22.



13. Joseph J. Cocozza and Jennie L. Shufelt, *Juvenile Mental Health Courts: An Emerging Strategy* (Washington, DC: National Center for Mental Health and Juvenile Justice, 2006).

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20. R. Boothroyd, N. Poythress, A. McGaha, and J. Petrila, "The Broward Mental Health Court: Process, Outcomes, and Service Utilization," *International Journal of Law and Psychiatry* 26 (2002): 55–71.

21. M. Cosden, J. Ellens, J. Schnell, Y. Yasmeen, and M. Wolfe, "Evaluation of a Mental Health Treatment Court with Assertive Community Treatment," *Behavioral Sciences and the Law* 21 (2003): 415–427.

22. Boothroyd, Poythress, McGaha, and Petrila, "The Broward Mental Health Court."

23. Ibid.

24. M. Susan Ridgely et al., *Justice, Treatment, and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court* (Santa Monica, CA: RAND Corporation, 2007).

25. At this writing, Policy Research Associates is working on such a study, which is being funded by the John D. and Catherine T. MacArthur Foundation and is projected to be published in 2010.

26. For information on how to build political support and assess whether mental health courts are appropriate for a community, see the Criminal Justice/Mental Health Consensus Project's *Essential Elements of a Mental Health Court* (www.consensusproject.org/mhcp/info/mhresources/pubs).

27. The Justice and Mental Health Collaboration Program was authorized through the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA). This program replaced the Mental Health Court Program, which funded 37 mental health court initiatives over the course of 2002–2004.

28. BJA is a component of the Office of Justice Programs, U.S. Department of Justice, and the former administrator of the Mental Health Court Program. BJA provides leadership, funding, training, and technical assistance to states, local governments, and other justice and prevention agencies to reduce crime, violence, and drug abuse and improve the functioning of the criminal justice system.

29. The Justice Center coordinates the Criminal Justice/Mental Health Consensus Project, a national effort to help local, state, and federal policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses involved in the criminal justice system. Through the Consensus Project, the Justice Center works closely with

BJA on a number of criminal justice/mental health issues and served as the technical assistance provider for the Mental Health Court Program. For more information on the Consensus Project and technical assistance opportunities, see www.consensusproject.org. For more information on the Pretrial Justice Institute and NACO, see their respective websites: www.pretrial.org and www.naco.com.

30. SAMHSA originally coordinated the TCE Jail Diversion Program with BJA's Mental Health Court Program and helped to provide technical assistance to the grantees, but mental health courts were not eligible to apply directly for TCE grants until 2005. The TCE program is intended to expand the community's ability to provide a comprehensive, integrated response to substance use treatment capacity issues and to improve the quality of services.

31. For more information on TAPA, see www.gainscenter.samhsa.gov/html/tapa/cmhs/role.asp.

32. For more information on BJA mental health court learning sites, see www.consensus project.org/mhcp/.

33. Hard copies of all of these policy guides (except for *Essential Elements*) can be requested from the Justice Center.

34. The Justice Center coordinates the InfoNet and developed it with assistance from key partners, namely, the National GAINS Center, the National Alliance on Mental Illness (NAMI), and the Police Executive Research Forum (PERF). The InfoNet is made possible through the support of BJA, National Institute of Corrections (NIC), Office for Victims of Crime (OVC), SAMHSA, the Center for Mental Health Services (CMHS), and the John D. and Catherine T. MacArthur Foundation.

The Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice, provides leadership training, technical assistance, and information to local criminal justice agencies to make America's communities safer. Read more at www.ojp.usdoj.gov/BJA/.

The Council of State Governments Justice Center is a national nonprofit organization serving policymakers at the local, state, and federal levels from all branches of government. The Justice Center provides practical, nonpartisan advice and consensus-driven strategies, informed by available evidence, to increase public safety and strengthen communities. Read more at www.justicecenter.csg.org.

The Criminal Justice/Mental Health Consensus Project is an unprecedented national effort coordinated by the Justice Center to improve responses to people with mental illnesses who become involved in, or are at risk of involvement in, the criminal justice system. Read more at www.consensusproject.org.

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Reentry for Safer Communities

Effective County Practices in Jail to Community Transition Planning for Offenders with Mental Health and Substance Abuse Disorders

September 2008

NACo National Association of Counties
The Voice of America's Counties

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A Publication of the Community Services Division of the County Services Department

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About NACo – The Voice of America's Counties

The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo provides essential services to the nation's 3,066 counties. NACo advances issues with a unified voice before the federal government, improves the public's understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money. For more information about NACo, visit *www.naco.org*.

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Special thanks to the counties featured as model programs for submitting information on their programs and coordinating our site visits.

Table of Contents

Introduction

In an effort to reduce recidivism and properly address individuals with co-occurring disorders, there has been an emergence of collaborative reentry practices at the county level. These system practices set out to provide interventions that will improve the chances of a successful reintegration into the community for offenders leaving jails. Because jails are locally run and operated and there is such a variance in population and resources in each community, there are many different ways to approach the creation of an effective transition strategy.

This publication is designed for county elected officials, administrators and staff, social service and community providers, local law enforcement, jail and corrections professionals, and other relevant members of the community who are interested in reentry options for offenders with mental health and substance abuse disorders. In most cases, the county board of commissioners is responsible for the jail operating budget; therefore, these local officials are key policymakers in advancing successful reentry practices.

Background

In counties across the country, jails have become our nation's de facto mental health providers. Increasingly overcrowded jails compounded by high rates of mental illness and substance abuse disorders among inmate populations have left community mental health providers unable to meet the demand for mental health services, while county jails struggle with their new role as the primary providers of care to mentally ill offenders. More Americans receive mental health treatment in prisons or jails than in hospitals or treatment centers. The Los Angeles County Jail and New York City's Riker's Island have become our country's largest psychiatric facilities, holding more people with mental illness than the largest psychiatric inpatient facility in any hospital.[1]

There are 3,365 local jails that admit and release an estimated 12 million people annually.[2] A majority of individuals stay in jail less than a month, some for just a couple of hours before they are released. With 73 percent of jail inmates having been previously sentenced to probation or incarceration, it is clear that recidivism is playing a major role in the core population of jails across the country.[3]

The numbers of individuals with mental illnesses cycling through our nation's jails represent an acute crisis of public health and safety, resulting in steep costs to county jails, criminal justice agencies, and the individuals themselves. Because differing criteria are used to determine mental health problems or mental illness, estimates of its prevalence in correctional populations tend to vary.

- The U.S. Bureau of Justice Statistics estimated in 2006 that 24 percent of jail inmates and 15 percent of state prisoners suffered from a serious mental illness, resulting in approximately two million mentally ill individuals admitted to county jails annually. [4]
- The same report found that up to 64 percent of jail inmates suffered from "mental health problems," a rate much higher than the approximately 10 percent of adults in America who suffer from mental health disorders. [5]
- The Center for Mental Health Services' National GAINS Center estimates that 72 percent of persons with mental illness admitted to county jails also meet the clinical criteria for co-occurring mental health and substance abuse disorders. [6]

A co-occurring disorder, also called a dual diagnosis, occurs when an individual has both mental health and substance abuse treatment needs. The overwhelmingly disproportionate rates of mental illness and co-occurring substance abuse disorders among inmate populations have placed additional pressures on overcrowded, overextended, and under-funded county systems.

Benefits of Reentry

This publication focuses on defining the essential components of effective transition planning for this population and showcases studies of promising county practices from across the country. These examples demonstrate that successful reentry practices can:

- Enhance public safety through reducing offender's risk to the community upon release
- Demonstrate cost-savings through a decrease in incarceration and in a wide array of government programs
- Improve the quality of life of individuals suffering from mental health and substance abuse issues
- Promotes safe, orderly, and secure correctional institutions

Analysis conducted by the Urban Institute indicates that regardless of the cost environment or offender population, a modest, publicly funded reentry program could generate considerable net benefits to the community. The study showed that only small reductions in recidivism rates were necessary for public agencies to recover their initial investment in the reentry program; for some counties, less than a percentage point drop in recidivism would initiate cost-savings.[7]

The Urban Institute also conducted an evaluation of the Maryland Re-entry Partnership, which provides transition planning for offenders leaving prison through community-based case management. The evaluation found that with just a 5 percent drop in re-arrest rates exhibited by the program that the state saw a cost savings of $7.2 million, returning a benefit of about $3 for every dollar of cost associated with the program.[8] This research shows the value of prevented costs to potential crime victims and to public agencies that can result from reentry programs. However, these studies are not able to measure the possible decrease in health costs and benefits to the individuals exiting jail and their families.

There are several points at which a person suffering from a co-occurring disorder can come into contact with the criminal justice system. The National Gains Center for People with Co-occurring Disorders in the Justice System has developed the "Sequential Intercept Model," a conceptual tool to illustrate the interface between the criminal justice and mental health systems. The Sequential Intercept Model outlines five points, or "intercepts," at which the criminal justice and mental health systems interact:[9]

1) Law enforcement and emergency services
2) Initial detention and initial hearings
3) Jail, courts, forensic evaluations, and forensic commitments
4) Reentry from jails, state prisons, and forensic hospitalization
5) Community corrections and community support services

This model can be seen as a series of filters (see Figure 1) in which the intercepts represent different opportunities to intervene to prevent the cycling in and out of the criminal justice system that occurs with mentally ill individuals who often have co-occurring substance abuse disorders. This model has proven to be an effective tool for localities in developing promising practices that provide services designed to help these individuals transition back into the community. The ultimate aim is to reduce rates of recidivism and improve public health and safety by ending the unnecessary incarceration of individuals with mental illness.

Components of Effective Transition Planning for Individuals with Co-occurring Disorders

Developing a transition plan for individuals with co-occurring disorders and linking them to the proper treatment and services in the community upon release from incarceration is integral to reducing the rate of return of these individuals to the criminal justice system.

This publication will focus on local promising practices that address the final two intercepts of the Sequential Intercept Model: (4) reentry from jails, state prisons, and forensic hospitalization and (5) community corrections and community support services.

Role of NACo

In April 2005, the National Association of Counties (NACo) and the U.S. Department of Justice, Bureau of Justice Assistance convened a "Reentry Focus Group," which included experts from both the criminal justice and mental health fields. The group focused on the issue of transition planning, from jail to the community, of individuals who suffer from co-occurring mental health and substance abuse disorders. Representatives from federal, state, local, private, and nonprofit agencies (a list of all the organizations represented is included in the Acknowledgements) met to discuss the key components of model county practices in transitioning jailed persons with co-occurring disorders to the community as well as to identify possible model sites across the country.

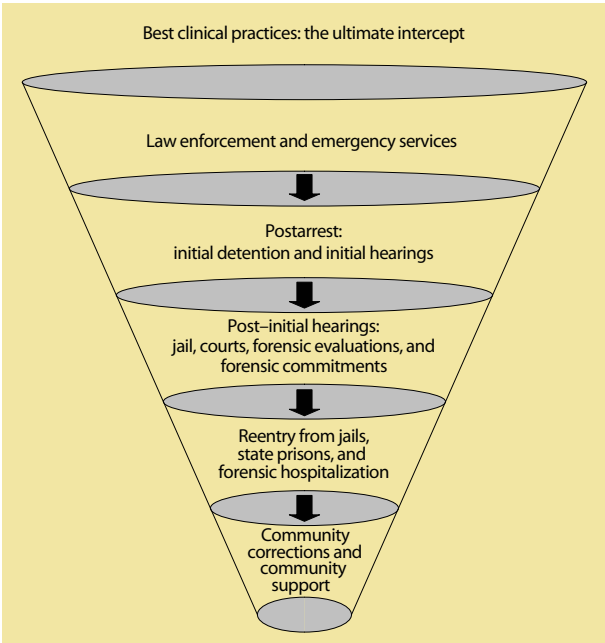
The Reentry Focus Group identified and defined five major characteristics of promising practices in local transition planning:

1) Collaboration - At the forefront of any successful reentry program is a strong collaborative structure between criminal justice and mental health agencies in the community. No single community organization is solely responsible for facilitating reentry practices, it requires partnerships across jurisdictional boundaries. Information sharing between partnering organizations in this process and offering collaborative/individual case management with aid from groups like local law enforcement, the jails, community mental health providers, faith-based organizations, probation and parole, and other social service providers is critical in establishing an effective transition from jail back into the community.
2) Access to Benefits – An important component to reentry for offenders with co-occurring disorders is ensuring access to benefits such as social securities income/ social securities disability income and Medicare/Medicaid prior to release so that individuals can access medication, health care, housing, food, and employment opportunities.

   When individuals are charged with a crime and incarcerated, they lose all access to federal benefits such as Medicare/Medicaid and Social Security. This often results in a burden on county governments, as locals are left to pay for medical care of jail inmates even if they have yet to be convicted of a crime. When they are released from jail, the reinstatement of these benefits can be difficult to navigate and can cause a significant lag before these services are readily available again.
3) Sustainability – A characteristic of any promising prac-

Figure 1: The Sequential Intercept Model Viewed as a Series of Filters

Source: Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness, Psychiatric Services, 2006.



tice is sustainability. The program needs to surpass a temporary status, locate consistent funding, develop performance measures, and become common practice in the locality.

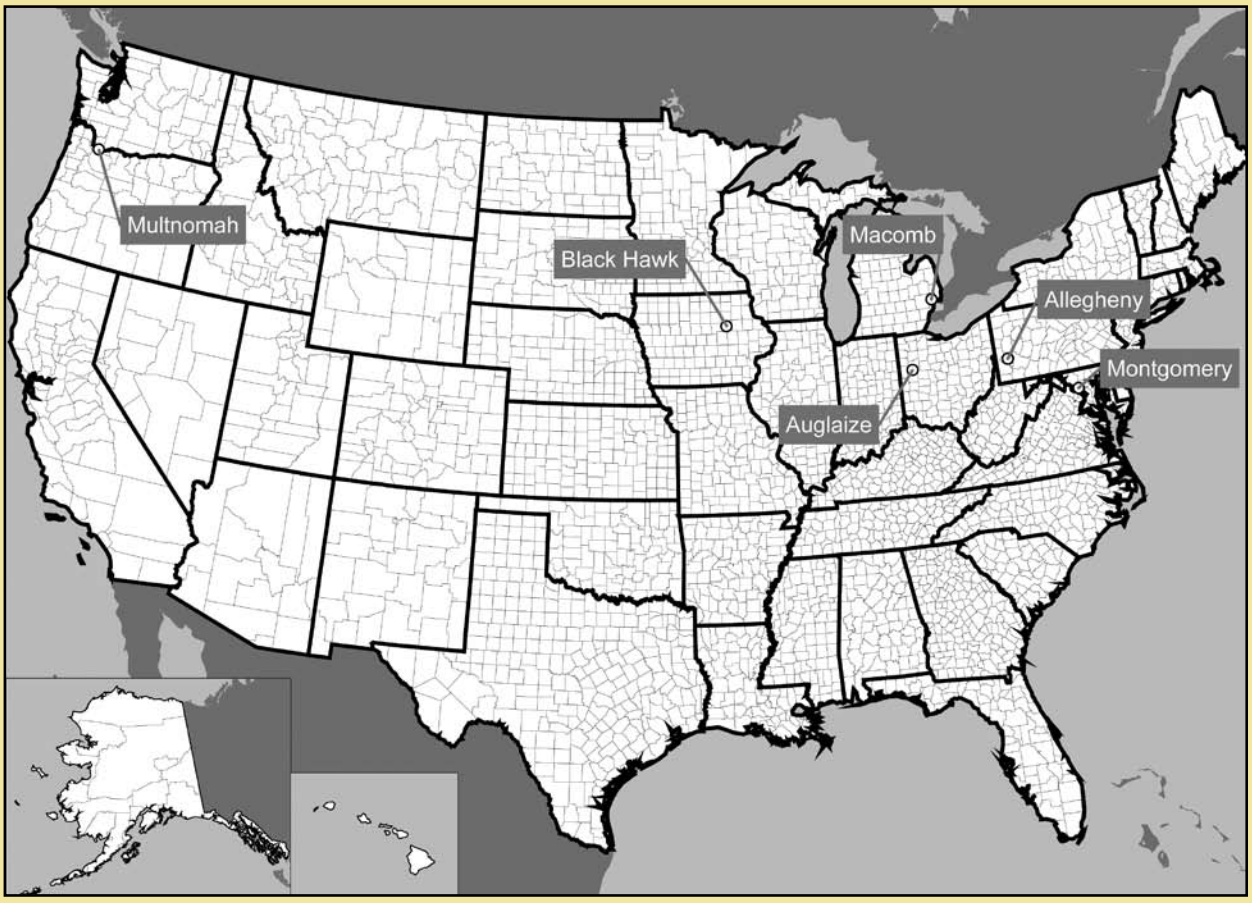
4) Cultural/Gender Components – Sensitivity to ethnicity, culture, and gender is integral in addressing the reentry of individuals with co-occurring disorders. Offering gender-specific programming as part of their treatment plan is important in properly addressing these offenders leaving jail.
5) Community Linkages – The final piece of the reentry process is connecting the offender to the appropriate services and support in the community to ensure the individual does not cycle back into the criminal justice system. This includes family reunification, access to housing, employment, transportation, and general aftercare and follow-up as part of the transition plan.

Having established these criteria, NACo sent out a "Call for Nominations" to solicit examples of model sites that exhibit these essential elements. Based on the nominated programs NACo received and on the recommendations that emerged from the Reentry Focus Group, six models were selected for further review. NACo program staff then conducted an intensive study, which included on-site visits to each selected county to meet with county elected officials, key staff, and other partner stakeholders.

This publication, based on the national study by NACo, features six effective practices for transition planning for incarcerated individuals with co-occurring disorders. These sites represent rural, suburban, and urban counties in different regions of the country (see Figure 2). These programs differ in the focal points of their reentry efforts, but exhibit strong partnerships between the jail and the community, treatment and transition planning within the jail, and some level of follow-up after release. The six sites are:

1) Allegheny County, Pennsylvania
2) Auglaize County, Ohio
3) Black Hawk County, Iowa
4) Macomb County, Michigan
5) Montgomery County, Maryland
6) Multnomah County, Oregon

Figure 2: Jail to Community Transition Planning Model Sites



Six model county programs

Allegheny County, Pennsylvania
Allegheny County Jail Collaborative

Allegheny County is an urban county with well over one million residents; the county seat is Pittsburgh. The Allegheny County Jail, located in downtown Pittsburgh, holds about 2,500 inmates and usually receives over 25,000 offenders a year to serve sentences or await trial. On an average day, approximately 100 arrestees come through the Intake Department. Additionally, the jail receives inmates from Constables, federal authorities, and Sheriff's Deputies. With the number of permanent releases being slightly less than admissions, the population of the jail has been steadily growing over the past decade.[10]

The Allegheny County Jail Collaborative (ACJC) has been a joint effort between the Allegheny County Jail (ACJ), the Allegheny County Department of Human Services (DHS), and the Allegheny County Health Department (ACHD) since 2000. The Collaborative was established at this time to address public safety, recidivism, successful reintegration, and duplication of services throughout government agencies within the county. In particular a County Executive had raised concerns that the county was duplicating services and could reduce recidivism and increase public safety by forming a collaborative body to work on these issues.

The Collaborative focuses on comprehensive reentry planning that includes family reunification, housing, substance abuse and mental health treatment, employment, and community engagement. This group has utilized screening tools to identify the needs of inmates and to develop creative solutions to address these needs. The Collaborative has built an infrastructure specifically to provide the supports and services to fill the gaps and remove the barriers that relate to the high rate of recidivism. The partners of the Collaborative meet monthly and work to plan all in-jail, transitional, and post-release services.

Collaboration

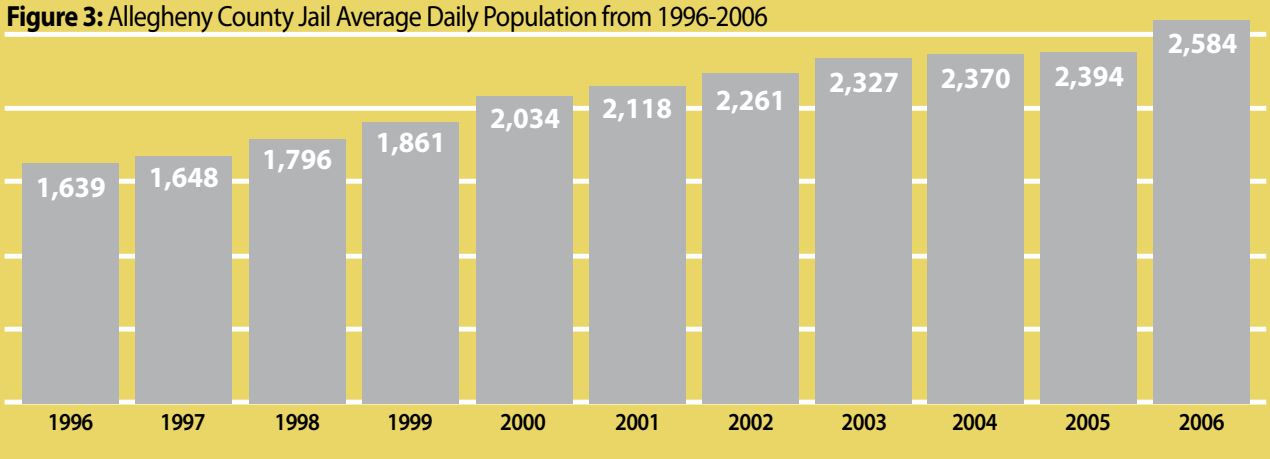
The ACJC partners meet monthly with departmental management as well as representatives from the court, probation/parole, and an evaluation team. The evaluation team is composed of academic staff from the University of Pittsburgh - School of Social Work and Center for Race and Social Problems staff who keep statistics and measuring the results of the Collaborative.

The Collaborative's partnership formed several committees to focus on certain aspects of the reentry process. The Allegheny County Reintegration Advisory Committee is a group of community-and jail-based service providers and ex-offenders who meet monthly to discuss barriers and solutions to the unified reintegration efforts in Allegheny County. The concerns and recommendations of this group are sent to the County Collaborative Management Team for review.

Access to Benefits

The Collaborative begins reentry planning as soon as an individual enters the jail. Inmates are screened upon intake and referred to jail-based programs and treatments such as GED preparation and testing, job training, life-skills class, mental health treatment, and in-patient substance abuse. Allegheny County Forensic Services works with the county jail, the District Courts, Service Coordination Units, and other community providers to assist these offenders with co-occurring mental health and substance abuse disorders prior to their preliminary hearing. They provide coverage at jail intake for processing involuntary or emergency commitments, divert the appropriate individuals from incarceration or extended jail stays, and create and present service plans to the court.

Figure 3: Allegheny County Jail Average Daily Population from 1996-2006



Several programs inside the Allegheny County Jail provide reintegration supports and services to inmates. Intensive case management during incarceration and after release involves building a service plan with the inmate along with service providers and court officials, coordinating services and applying for medical assistance inside the jail, and beginning to facilitate supports for release. The intensive case management is also responsible for contacting any pre-existing community supports, spiritual supports, or family members to include in the transition planning.

The Collaborative has built an infrastructure specifically to provide the supports and services to fill the gaps and remove the necessary barriers that directly relate to lowering the rate of recidivism in Allegheny County. ACJC has implemented reintegration programs, drug and alcohol treatment, GED programs, a "Three Quarter Way House" that acts as a hybrid of a halfway house and transitional housing, and the intensive programs that the county provides such as mental health forensics, Narcotics Anonymous (NA) and Alcoholics Anonymous (AA), and HIV/AIDS prevention and education. Forensic Services also runs the Community Reintegration of Offenders with Mental Illness and Drug Abuse (CROMISA) initiative, a separate facility that provides a therapeutic community for men who suffer from co-occurring disorders and are on probation or parole.

Sustainability

ACJC receives funding from numerous different sources including federal, state, and local agencies, and private foundations. ACJC receives funding support from the Pennsylvania Commission on Crime and Delinquency and other state resources; locally, from the Allegheny County Department of Human Services; and from five different foundations located in the county. Attending the monthly meetings of ACJC and its subcommittees has become common practice for the contributing organizations.

Gender/Cultural Components

The Collaborative manages 18 service providers within the Allegheny County Jail. Many of these providers offer gender-specific treatment programs. Zoar is a service provider that focuses on female inmates. The Community Reintegration of Offenders with Mental Illness and Substance Abuse (CROMISA) initiative is a separate facility working only with male offenders. The Three Quarter Way House is for male offenders and the county is working on the creation of one for women. Both Goodwill and Strength, Inc. work with men and women on reintegration projects.

Community Linkages

A major focus of ACJC is family reunification. In 2003, the Pittsburgh Child Guidance Foundation commissioned a study on the children of incarcerated parents in Allegheny County. The study found that 7,000 children in every zip code and school district in the county have a parent in jail or prison. The study also found that these children were significantly more likely than their peers to fail out of school, suffer emotional distress, commit serious delinquent acts, and be incarcerated themselves as adults.[11]

Figure 4: Allegheny County Jail
Source: Allegheny County Bureau of Corrections, 2006 Annual Report

In response to these findings, Lydia's Place, Inc., in partnership with the Allegheny County Bureau of Corrections, the Pittsburgh Child Guidance Foundation, by 100 other community organizations and individuals, is creating a Family Activity Center in the lobby of the Allegheny County Jail. The Center will assist families waiting to visit loved ones who are incarcerated as well as help keep the link between the incarcerated individuals and their family when they leave jail. Allegheny County has also been addressing this issue by working with the Urban Institute's Children of Incarcerated Parents Project.

Upon release from jail, a majority of individuals follow their transition plan and receive treatment, live in alternate housing in the Collaborative's Three Quarter Way House, transitional housing, or their own home. The intensive case manager follows the individual for up to a year after release to assist with family reunification, employment, housing, legal matters, transportation, child support issues, and obtaining logistical items such as a driver's license or other photo identification.

Results

A researcher from the University of Pittsburgh has been collecting data on the effectiveness of the Collaborative and conducting interviews with ex-offenders in a three-year study to show the benefit to public safety, to improve individual's lives, and save taxpayer dollars. The preliminary findings show an overall 15 percent reduction in recidivism compared to the rate before the Collaborative was established. The Collaborative is also working with Carnegie Mellon University to analyze the needs of the recidivating population and the communities most affected in the process.

Auglaize County, Ohio
Auglaize County Transition Program

Auglaize County is a rural county of just over 46,000 residents, located in Western Ohio. The Auglaize County Transition (ACT) Program is a joint project of the Auglaize County Sheriff's Office and the Community Connection for Ohio Offenders, a private, non-profit agency focusing on reentry services throughout Ohio. Although some aspects of ACT have been in place for a number of years, the program formally began in 2003. ACT takes a reentry case management approach to reducing crime in the community.

The Auglaize County Correctional Center is a 72-bed facility that holds pre-trial, pre-sentenced, and sentenced inmates for up to 18 months. The facility receives approximately 1,200 inmates a year, half of whom will be released within 72 hours. Of the 600 remaining inmates, about 200 actively participate in the correctional center's programming every year.

Collaboration

The ACT Program created an interdisciplinary collaboration board of partners called the Reentry Case Management Team. This team meets monthly and is composed of a number of organizations throughout the community:

1) Auglaize County Sheriff's Office
2) Auglaize County Municipal Court
3) Auglaize County Probation Department
4) Auglaize County Department of Jobs and Services
5) Community Connection for Ohio Offenders
6) Lutheran Social Services
7) ASTOP (a local substance abuse provider)
8) Mercy Unlimited (a faith-based outreach group)
9) Tri-County Mental Health and Recovery Services Board (Allen, Auglaize, and Hardin counties)
10) St. Mary's School District Adult Basic Education/ GED Program
11) Auglaize County Community Corrections Planning Board
12) Westwood Behavioral Center (a local mental health provider)
13) Ohio Adult Parole Authority

The ACT Program uses a case manager as the primary staff manager in coordinating transition plans for the inmates. In addition, a facility classification team- consisting of the case manager, the facility commander, the staff sergeant, one corrections officer from each shift, the mental health/chemical dependency counselor, and two individuals from the Ohio Department of Job and Family Services- meet monthly to review the list of inmates and discuss issues and treatment options for individual offenders.

Auglaize County Commissioner Douglas Spencer commented, "If I had to sum up why this program is a success in one word, it would be collaboration. Getting all these groups involved as partners in this program is really what has made it so effective."

Figure 5: Auglaize County Jail
Source: Staff Sergeant Charles Fuerstenau, Auglaize County Jail

Access to Benefits

All inmates are screened upon intake to the jail for any possible mental health or substance abuse disorders. The Mental Health and Recovery Services Board of Allen, Auglaize and Hardin counties provides a therapist certified for dual diagnosis assessments to administer a full and formal assessment for any inmates exhibiting mental health or substance abuse disorders. From this point, the ACT Program uses a case manager to link inmates to the appropriate services, both inside the jail and in the community upon release.

Substance abusing individuals are directed into a chemical dependency program, which includes Moral Reconation Therapy (MRT), a 12-step/chapter substance abuse treatment program, and individual and group therapy. Inmates with mental health issues or who are suffering from co-occurring disorders are routed into the chemical dependency program when appropriate and are seen by the facility therapist for individual and group programming. The mental health and chemical dependency programs are provided through an agreement with the Mental Health and Recovery Services Board of Allen, Auglaize, and Hardin counties. The Sheriff also contracts with Westwood Behavioral, a local provider, of mental health counseling for individuals who are not residents of one of the three counties served by this board.

The case manager also can admit inmates into the facility's GED program. Since 1999, over 80 individuals have received a GED while incarcerated; 14 received their GED in 2006 alone. The program has a 100 percent success rate, with individuals passing the GED exam, not necessarily on their first attempt, but in completing the program before they are released from jail. The case manager also facilitates an anger management group for inmates. The case manager works closely with the local adult probation and parole authorities to incorporate treatment programming into the conditions of release for offenders who have post-release control in their transition plan.

Sustainability

The ACT Program is funded by a Justice Assistance Grant from the Ohio Office of Criminal Justice Services, the inmate telephone fund, and the profit from the facility commissary fund. The facility commissary fund is composed of food sales and other miscellaneous items. The inmate telephone fund was established through an arrangement with a local phone company wherein the jail receives revenue from all inmate phone calls. This inmate commissary fund provides enough funding to sustain all of the alternative services that the jail provides its inmates.

Gender/Cultural Components

The Auglaize County Jail is designed to have 11 beds for female inmates, but has experienced an influx of female offenders recently. ACT has responded by offering gender-specific programming.

Community Linkages

A majority of ACT's services are offered inside the jail facility while the inmate is incarcerated. The case manager works closely with local adult probation and parole to work on transition plans for persons exiting the jail and remains an important contact after individuals are released. The case manager also coordinates with an employment specialist provided through the Ohio Department of Job and Family Services to help ex-offenders obtain a job and appropriate housing immediately after their release. Joe Lynch, jail administrator at the facility says that ACT is "grassroots crime prevention at the local level."

The ACT Program has brought community groups together and worked with inmates with mental health or substance abuse needs to provide the appropriate services and improve their chances of becoming more productive citizens. Staff Sergeant Charles M. Fuerstenau of the ACT Program remarked on the effect of the program, "I used to think if someone came back into the jail after having been previously incarcerated that the program had failed. Now I realize that you have to measure your progress in terms of improving the lives of the entire community."

Results

Since the program was put in place in 2003, the jail has seen an 80 percent drop in incidents of violence within the facility. Also, the work release program at the facility has generated $385,000 in income since its inception. The Ohio Department of Health has funded a $20,000 evaluation of the ACT Program by a criminal justice professor from the University of Texas at San Antonio and a professor from Tiffin University (Ohio) who was formerly the director of the Ohio Bureau of Adult Detention. They hope to produce statistically significant results from the past three years they have been monitoring the effort.

Black Hawk County, Iowa

Mental Health Assessment and Jail Diversion Program

Black Hawk County has a population of approximately 120,000 people living predominately in the Waterloo/Cedar Falls region. The jail averages 250 inmates with approximately 28 percent taking psychiatric medications. The Black Hawk County Jail was experiencing constant overcrowding, and in 2004 the county's Department of Correctional Services received funding from the Central Point of Coordination (CPC) office, which oversees local mental health spending in the county, to address this population.

The Department of Correctional Services, with input from various community organizations including the county attorney's office, put together the Mental Health Assessment and Jail Diversion Program. The goal was to establish a structured means of screening and early intervention for individuals with mental health issues and to pursue the best possible supervision/treatment options for mentally ill offenders coming back into the community.

The Mental Health Assessment and Jail Diversion Program is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) "APIC Model" which includes the following components:

Assess

Assess the inmate's clinical and social needs and public safety risks

Plan

Plan for the treatment and services required to address the inmate's needs

Identify

Identify required community and correctional programs responsible for post-release services

Coordinate

Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services[12]

Collaboration

The Mental Health Assessment and Jail Diversion Program is a collaborative effort among the Department of Correctional Services, the Sheriff's Office, the county attorney's office, the public defender, the local courts system, the mental health center, Pathways Behavioral Services (mental health professionals working within the jail), and other community agencies in and around Black Hawk County. In 2004, the Department of Correctional Services hired a Community Treatment Coordinator who has been integral in coordinating the organizations and agencies involved in this program.

Upon the inception of the program, the county decided to place the Community Treatment Coordinator within the Department of Correctional Services. The connection between the mental health community and an offender's parole or probation added accountability, which helped gain support from judges in the local court system. There are weekly meetings with the Sheriff's Office, the County Attorney, Pathways Be-

havioral Services and the Community Treatment Coordinator to discuss and plan for releases from the Black Hawk County Jail.

Access to Benefits

The Mental Health Assessment and Jail Diversion Program provides the opportunity for identified mentally ill inmates in the Black Hawk County Jail to be screened and provided assistance in establishing a transition plan. Referrals for inmates to enter this program come from a variety of sources, including jail staff, probation/parole officers, the Mental Health Center, the offender and their family, public defender/county attorney, case managers, and other involved community agencies.

The Community Treatment Coordinator provides assessment, referral to the appropriate services, and works to facilitate the transition plan for these individuals. The Department of Correctional Services partners with Black Hawk Grundy Mental Health and Pathways Behavioral Services to offer the referral option of gender-specific services in the Dually Diagnosed Program for Men and the Women's Co-Occurring Disorder Program at the county's Residential Correctional Facility. The partners make every effort to get medication to those inmates in need.

Sustainability

The Mental Health Assessment and Jail Diversion Program began with a grant from Black Hawk County's CPC, an office that assists with referrals and placement to appropriate service providers in the community. The program quickly produced results for the community, and the county has been very supportive of the program by providing funding.

Gender/Cultural Components

The Department of Correctional Services offers two gender-specific programs for treating individuals with co-occurring disorders: the Dually Diagnosed Program for Men and the Women's Co-Occurring Disorder Program. Both programs incorporate an integrated treatment approach by addressing both the mental health and substance abuse disorders. Simultaneously, in the same setting, cross-trained staff from mental health, substance abuse, and correctional services work together to provide the services.

The Dually Diagnosed Program for Men, a 16-bed residential facility for male offenders with co-occurring issues, was established by the county in 1998. Clients participate in treatment during a six to twelve month period, and continue to receive case management, individual counseling, and group therapy services following their discharge from the facility. Two respite beds are set aside in the residential facility for clients encountering difficulty adjusting to their release while under the program's continuing care supervision.

The Women's Co-Occurring Disorder Program began in 2003 and has many similarities to the men's dual diagnosis program. A number of these female offenders spend time in the Waterloo Residential Correctional Facility as a condition of their probation or on work-release status. The overall goal of both these programs is to provide gender-specific treatment programs so that offenders can establish law-abiding lifestyles with a stabilized mental condition free of chemical dependency.

Community Linkages

The Community Treatment Coordinator works with Probation/Parole Officers in coordinating the transition of the offender back into the community. They focus on connecting the individuals with access to medications, housing options, finances, and employment. A unique feature of Black Hawk County's program is the Community Accountability Board, a group composed of various agencies and individuals from the community who have a vested interest in persons with mental illness. The board assists the Department of Correctional Services and the correctional consumers in reviewing potential program participants, developing comprehensive treatment plans, and identifying what needs to be done to have the greatest chance for a successful community transition. The Department of Correctional Services is trying to secure funding to hire an outreach worker whose duties would be based solely on narrowing gaps in aftercare when offenders are released from jail.

Results

The Community Treatment Coordinator position has also enabled the Mental Health Assessment and Jail Diversion Program to track data and show the community results in improving public safety, improving people's lives, and saving money.

Based on 34 months of data (i.e., since inception of program)

- 415 men and women assessed
- 282 men = 68%
- 133 women = 32%
- 74% (309 people) were transitioned successfully into the community/diverted from jail and prison
- Re-arrest rate is 26%
- Surveyed 10 specific individuals in the program and estimated cost savings over $54,500

Based on the average stay in jail, data from November, 2006

A neighboring county, Dubuque, is using Black Hawk County's program as a model in developing its own jail diversion and transition planning efforts. As Sara Carter, the Community Treatment Coordinator, commented, "We have gotten to the point we are not just reacting to the problem, but we have put some planning into how to ease overcrowding in the jails, treat mentally ill individuals appropriately, and increase awareness of the issue throughout the community."

Macomb County, Michigan
Dual Diagnosis & Mental Health Jail Reduction Programs

Macomb County is the third largest county in Michigan, with a population of over 800,000. The largely suburban county is within metropolitan Detroit, covers 482 square miles, and is the fastest growing county in the state. The Macomb County Jail houses over 1,438 adult men and women; approximately 14 percent have mental health issues. Seventy percent of those identified as having mental health issues were incarcerated for non-violent crimes and 80 percent also have substance abuse issues.

Macomb County Community Corrections operates two programs for offenders with mental health and substance abuse issues: the Dual Diagnosis Program and the Mental Health Jail Reduction Program. The Dual Diagnosis Program has been working to address the needs of those with mild to moderate mental illness both in and outside the Macomb County Jail since October 2001. In response to a growing need for earlier, more intensive intervention for individuals suffering from co-occurring disorders in the jail, the Mental Health Reduction Program began in 2004.

Collaboration

The Dual Diagnosis and Mental Health Jail Reduction Programs are run by Macomb County Community Corrections, a county department that develops and maintains community-based alternatives to incarceration for non-violent offenders aimed at relieving prison and jail overcrowding. Community Corrections administers these programs in coordination with the Community Mental Health Department and works to build the community collaboration necessary to help meet the needs of the co-occurring population in the Macomb County Jail.

The group's Advisory Board includes a circuit court judge, a district court judge, a prosecuting attorney, a defense attorney, the county sheriff, chief of police, representatives from the chamber of commerce, the county's office of substance abuse, Community Mental Health, and members of the public. Community Corrections has a number of both formal and informal agreements with organizations throughout the community to assist the program's clients. These include a partnership of more than two dozen local human services agencies that have pledged to provide resources including health care, education, vocational training, family counseling, childcare, and transportation to populations with mental illness. Macomb County Commissioner Joan Flynn remarks, "Macomb County has been encouraging collaboration; that's what makes these programs work."

Access to Benefits

Macomb County Community Corrections works to place non-violent offenders into community supervision, rather than jail or prison, to free up corrections space for more serious offenders. Through the Dual Diagnosis and Mental Health Jail Reduction Programs rehabilitative and monitoring options include substance abuse inpatient and outpatient treatment, daily reporting services, urine testing, community service work, cognitive restructuring, and pre-trial release supervision.

The Dual Diagnosis Program is designed to fill the gap between release from incarceration and the inductions of community services by providing treatment and case management. Participants can be felons or misdemeanants who have a primary diagnosis of substance abuse and a secondary diagnosis of a mental health disorder. Before the existence of the Dual Diagnosis Program, it was difficult to place individuals with co-occurring disorders in treatment programs, because of the complexities of dealing with the combinations of issues. Emergency psychiatric evaluations and medications are provided to participants while they wait for their federal benefits and an appointment with a community mental health provider.

The Mental Health Jail Reduction Program, established in 2004, was designed to reduce the jail population by diverting non-violent, less severe mentally ill inmates who previously would not have been eligible for community-based programs. Those who participate in the program are chosen based on specific eligibility criteria. They are then assessed and screened for appropriateness for the program. A request is made to the courts for early release from jail into various residential facilities or intensive outpatient treatment. While involved in this program, the offender is seen by a contracted psychiatrist, provided with medication, and given assistance with housing and transportation costs.

Both of these programs focus on the needs of those with mild to moderate mental illness previously ineligible for placement through the Macomb County's Community Mental Health Department. The Community Mental Health Department has funding to address the remaining offenders with severe and persistent mental illness with secondary substance abuse issues. Community Corrections has two staff whose jobs are primarily transition planning. In addition, Community Mental Health has two case managers assigned to the jail for this purpose.

Figure 6: Macomb County Advisory Board
Source: Linda Verville, Assistant Director, Macomb County Corrections

Sustainability

The Dual Diagnosis program began with funding through the Bureau of Justice Assistance and is currently being financed by Macomb County. The Mental Health Jail Reduction Program is funded through the Michigan State Office of Community Corrections. The Macomb County Board of Commissioners has put on hold plans for a jail expansion project that would

cost upwards of $93 million and is currently investing in the jail diversion programs to address the needs of this growing population.

Gender/Cultural Components

The Dual Diagnosis and Jail Reduction Programs fund a women's treatment facility, called the Home of New Vision, for long-term dual diagnosis treatment and transition back into the community. This provides specialized residential treatment that can address the gender specialized needs of the co-occurring population. Group services include a 12-week Women's Empowerment Series designed for survivors of domestic violence, as well as other open support groups.

Community Linkages

Once an individual is leaving jail or residential treatment, Community Corrections addresses the lag in time between the release from jail and the intake process at community agencies. In this crucial period, the programs fund necessary psychological evaluations, prescription medications, housing assistance, transportation, and other basic needs.

The coordinator meets with the offender to review the individualized plan and make appointments for community case management meetings before the offender is released from jail. After release, the coordinator meets with the client for employment screenings, health care eligibility screenings, long-term housing options, and enrollment into outpatient treatment programs or other services identified by the initial needs assessment. Community Corrections works with the local Michigan Works! Office and the state's workforce development association to coordinate employment and training options.

Communication with treatment and service providers is ongoing. The Program Coordinator updates the probation department and the courts on progress and compliance. Substance abuse testing is part of the treatment plan to ensure compliance. The average time in the program is between seven and twelve months.

Results

Throughout 2006, 111 individuals went through the full transition planning program, were released from jail, and provided case management and individualized treatment and services. The average reduction in jail stay for these individuals is estimated to be 78 days. By reducing their incarceration time, the county estimates it saves 10,400 jail bed days for a cost savings of $733,200.[13]

With a reduction in recidivism and extending the time for re-arrest, if it does occur, additional jail beds are saved in the long term. Documented outcomes from the programs indicate that the average time between incarcerations before program intervention for this population was 128 days; after completing the program, the time was extended to 309 days. Macomb County Commissioner Keith Rengert says, "These programs are proving to be effective not only in saving the county money, but in helping people improve their lives."

Montgomery County, Maryland
Pre-Release and Reentry Services Division

Montgomery County is a large suburban county of over 870,000 residents, located just north of Washington, DC. The Montgomery County Department of Correction and Rehabilitation oversees four major operational divisions:

1) The Pre-Release Center (PRC)– a pre-release facility that holds an average of 172 inmates and coordinates with an average of 50 offenders in home confinement.
2) The Correctional Facility – a jail with a capacity of 1,029 inmates.
3) The Detention Center – responsible for intake and processing of offenders with a capacity of 200 inmates.
4) The Pre-Trial Services Unit – a pre-trial community supervision program of about 1,500 defendants a year.

The Pre-Release and Reentry Services Division (PRRS) coordinates the PRC, a complex of four correctional units, each operated by a separate staff treatment team: a co-ed unit, two men's units, and an honor's unit. The first stand-alone PRC was opened in 1972. The program was expanded over the years and in 1990 the PRRS developed a highly structured non-residential pre-release component. The PRC is a highly structured residential work release and treatment facility for up to 177 male and female offenders, and offers a comprehensive array of services that provide offenders and their families an opportunity to address problems, make lifestyle changes, and manage the issues of reentry as offenders begin their return to the community.

The PRRS serves local, state, and federal offenders who are within 12 months of release and are primarily returning to Montgomery County. PRRS works closely with the offender's family in designing the transition plan and PRRS staff provide intensive case management, employment services, and treatment planning. The program conducts a thorough screening and assessment of individuals before they are deemed eligible to participate.

Collaboration

The PRRS works closely with the Montgomery County Department of Health and Human Services, the courts, local employers, housing agencies, the local faith community, the Maryland State Division of Corrections, and the federal Bureau of Prisons. PRRS partners with the Department of Health and Human Services in designing treatment plans for individuals with co-occurring disorders or mental health services. The Archdiocese of Washington's Welcome Home Program and St. James Aftercare Ministries offer mentoring services and the Montgomery County Housing Opportunity Commission and other faith-based organizations provide offenders with federally subsidized housing.

Access to Benefits

PRRS staff screen individuals weekly in each of Montgomery County's detention facilities. Referrals are typically received from defense and prosecuting attorneys, judges, probation agents, case managers within the Maryland Division of Corrections, and community corrections officials within

the federal Bureau of Prisons. At the time of initial screening, each case undergoes a thorough review to determine if an offender is best served by residential services through the PRC, non-residential through the home confinement program, or a combination of both.

PRRS provides a comprehensive array of services including:

- Individualized assessment and treatment planning
- The intensive Job Readiness and Retention Program, job counseling, and placement
- Comprehensive substance abuse and addiction services, education, counseling, relapse prevention planning, and Twelve Step programming
- Work-release or educational release
- Individual, group, and family counseling
- Community-based therapy
- Life Skills seminars

Sustainability

Montgomery County fully funds PRRS. The program operates under the premise that public safety is enhanced when individuals are released through the PRC rather than through the jail. Residents of the PRC provide support for their families and save money for their release by obtaining employment. Residents also pay 20 percent of their salaries for room and board, which generates over $250,000 for the county annually.

Gender/Cultural Components

Programming in the PRC includes gender-specific treatment through the TAMAR Program, which stands for Trauma, Addictions, Mental health And Recovery. TAMAR is a voluntary trauma treatment and education program for women and men. The TAMAR Program is in place in eight counties throughout the state of Maryland, offering trauma treatment centers within the detention centers as well as peer support groups within the community. The program also offers connection to community agencies providing mental health, substance abuse, and social and domestic violence services.

Community Linkages

The PRRS Division has a strong work-release program in which individuals are assigned a Work Release Coordinator whose primary functions are to assist in finding long-term employment, provide vocational guidance and counseling, facilitate the Job Readiness/Retention Seminar, and ensure that their clients maintain positive performance and accountability at work. The Work Release Coordinators are engaged in community outreach with local businesses, prospective employers, and vocational training programs.

Case managers help individuals suffering from co-occurring disorders link up with the proper community based mental health and substance abuse treatment. They also work with the offender's family member designated as their "sponsor" to ensure the offender is having a smooth transition back into the community. PRRS will provide the sponsor information on enabling, limit-setting, domestic violence, and family roles. Sponsors are seen as an integral part of the reentry process.

Results

PRRS collects data and demographic information on individuals successfully released from PRRS; jail beds saved; cost savings; and percentage released with employment, housing, and other appropriate services.

In 2006, PRRS:

- Managed almost 30 percent of all locally sentenced inmates in the corrections system in Montgomery County
- Served 624 individuals, and 83 percent successfully completed the program.
- Collected $400,000 in program fees. Program participants paid over $200,000 for family and child support and $30,000 in federal taxes.
- Saw 99 percent of program participants released with housing.
- Saw 88 percent of program participants were released with employment.

Multnomah County, Oregon
Transition Services Unit

Multnomah County is an urban county of over 660,000 containing the city of Portland. Multnomah County contains two operating jails: the Multnomah County Detention Center, a 676-bed maximum security adult facility in downtown Portland, and the Multnomah County Inverness Jail, a 1,014 bed medium security facility in the Northeast part of the city.

The Transition Services Unit (TSU), established in 2001, provides a comprehensive system of services designed to prepare, equip, and sustain offenders upon their release from jail or prison. The TSU conducts reach-in visits of inmates who are going to be released from state prisons back into Multnomah County. The program is responsible for linking recently released offenders to services, including pre-release planning, case coordination, housing, transportation, and medical and benefit assistance. The TSU provides transition planning services up to 120 days prior to release from prison or jail and 90 to 180 days post-incarceration.

The Department of Community Justice, a county agency in Multnomah County, runs the TSU. The program works on the "housing first" model and coordinates with Multnomah County and the city of Portland's 10-year plan to end homelessness. TSU's primary focus is on offenders with special needs, including those with mental, developmental, and physical disabilities; the elderly; and predatory sex offenders. TSU services cover a daily average of 35 recently released offenders from jail or prison, helping them to:

1) Locate and access safe and suitable housing
2) Identify and make an initial appointment for medical and/or mental health and substance abuse treatment
3) Receive medication assistance
4) Make first appointment for federal and state benefits
5) Receive employment referrals
6) Receive clothing
7) Receive case coordination parole/probation and connect to other service providers

Collaboration

The Department of Community Justice coordinates the TSU in and works with a number of community, state, and federal agencies and organizations.

TSU's Housing Services has contracts with six local housing providers and provides contracted/subsidy housing for individuals transitioning back into the community. The Department of Community Justice partners with Cascadia Behavioral Healthcare, a local treatment provider, to provide treatment for individuals suffering from co-occurring disorders.

Multnomah County also runs a Public Safety Coordinating Council where committees make recommendations on various criminal justice and mental health concerns. Multnomah County Commissioner Lisa Naito remarks, "A regular organizational meeting with all the appropriate stakeholders is a necessary first step. The Public Safety Coordinating Council is the foundational structure of Multnomah County's efforts; it's where the action stems from."

Access to Benefits

The TSU coordinates the Joint Access to Benefits (JAB) Program, a collaborative effort that helps offenders qualify for federal disability benefits that cover mental health services, psychiatric medications, and other care. This is a joint project among the Multnomah County Sheriff's Office, Multnomah County Aging and Disability Services, Social Security Administration, and Oregon Department of Corrections. The goal of the JAB Program is to initiate the application for Social Security benefits as early as possible after release so persons leaving jail can receive benefits as soon as possible in order to ensure stable housing and medication assistance.

Individuals with co-occurring disorders are connected with Cascadia Behavioral Healthcare before their release. A 30 day supply of medication is provided for individuals leaving prison and a 14-day supply for those exiting jail. The TSU also has available 20 slots a month to cover no charge offenders exiting prison or jail a full 12 months of coverage for medical services and insurance.

Snapshot of Special Needs for TSU Clients	
Mental Health	35%
Sex Offenders	51%
Offenders with Violent Histories	19%
Developmental Disabilities	6%
Medical Disabilities	11%
Alcohol and Drug Issues	78%

The Multnomah County Department of Community Justice also operates the Londer Learning Center, designed to enhance community safety by helping offenders develop literacy skills. The center collaborates with local treatment centers, courts, corrections counselors, and parole/probation officers to provide educational services for adults out of jail or prison, but on some form of community supervision.

Sustainability

The TSU is funded primarily by Multnomah County, with additional funding from the Oregon Department of Corrections. The Multnomah County Board of Commissioners has been supportive of the TSU program and has made the services the TSU offers common practice in the county.

Gender/Cultural Components

Multnomah County's Day Reporting Center is a highly structured, non-residential program that offers supervision and access to services while stressing accountability and community safety. The Day Reporting Center offers 90 to 120 days of intensive case management for offenders coming out of jail or prison. The Focus on Reentry (FOR) program offers a number of gender-specific groups; cognitive restructuring and life skills groups; and relapse prevention, education, and emotional management services. The FOR program works in 12 gender-specific sessions, and on the 13th session they bring in the appropriate community linkages for the individual.

Community Linkages

TSU works extensively in providing housing support for offenders transitioning back into the community. The program provides contracted/subsidy housing for a monthly average of 329 offenders who have no other resources or support. Multnomah County has contracts with local housing providers and also operates facilities like the Medford Building. The Medford Building- a co-operative effort of Multnomah County and Central City Concern, a non-profit group working to provide solutions to homelessness in Portland- houses male and female offenders released from substance abuse treatment programs and who currently undergoing outpatient treatment as well as indigent, post-prison parolees and probationers.

TSU works with the Day Reporting Center to form a hub of services for released offenders from jail or prison, including:

- Drug and alcohol assessments, referrals, and services
- Cognitive restructuring and life skills groups
- Case management
- Random urinalysis
- Employment services
- Referrals for education and GED testing
- Mental health services

Results

TSU corroborates research that finds that offenders who have access to supportive services and housing upon leaving incarceration are less likely to recidivate and more likely to find employment.

- TSU receives approximately 2,265 clients a month.
- TSU data also shows 78 percent of high-risk, high-need offenders were able to move into stable housing, obtain employment, complete their GED and/or obtain entitlements.

Multnomah County, Oregon
Department of Community Justice Transition Services Unit

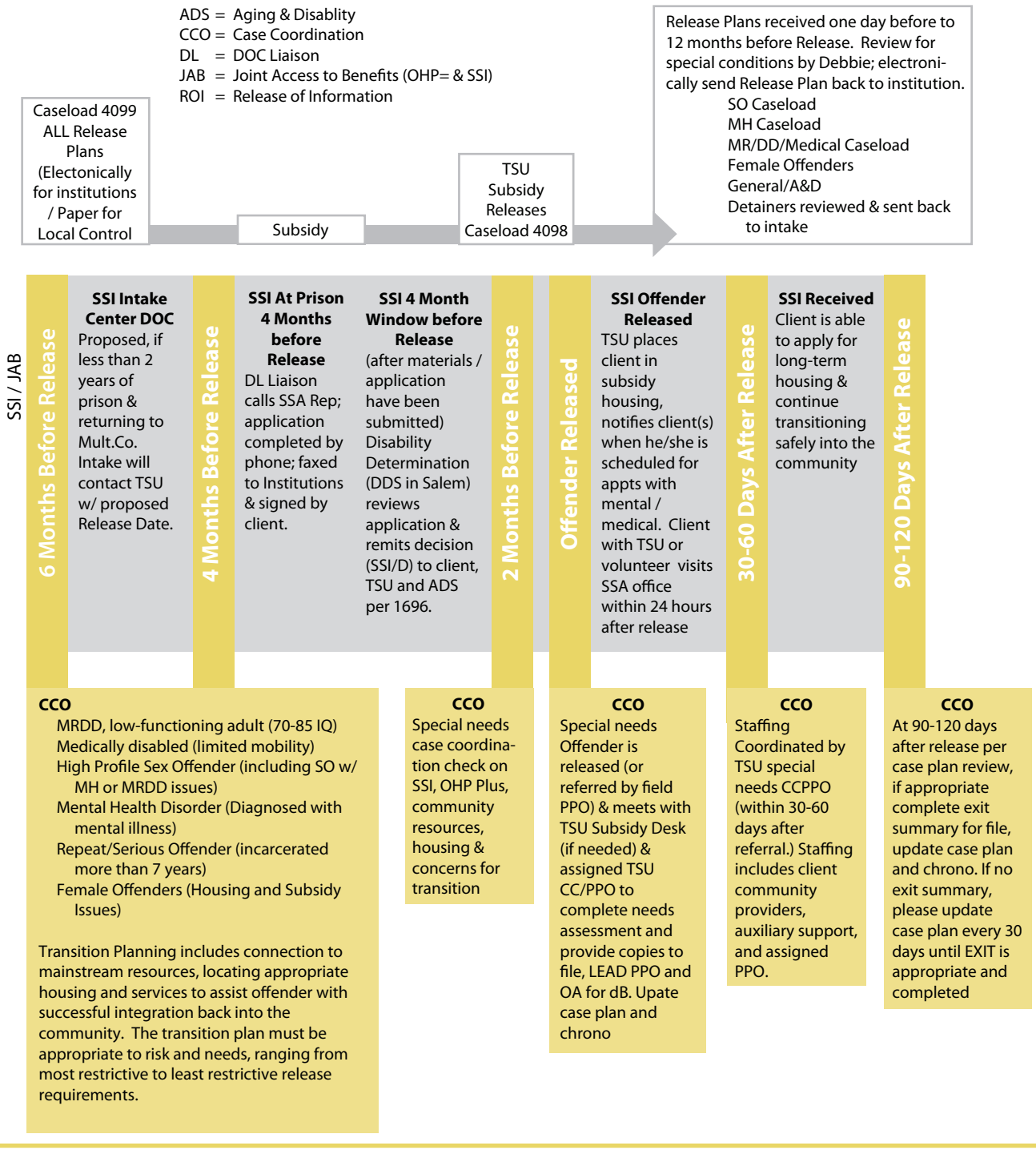


Figure 7: Diagram of the Transition Services Unit Services

Endnotes

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[12] National GAINS Center. "A Best Practice Approach to Community Reentry for Individuals with Co-occurring Disorders: the APIC Model." *http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf*. Sept. 2006.

[13] Macomb County Community Corrections estimates that with 100 participants multiplied by 104 days (the average stay in jail for individuals with co-occurring disorders) multiplied by $70.30 (the daily cost of incarceration in the Macomb County Jail) they save $733,200 a year in jail costs.

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