

The author(s) shown below used Federal funds provided by the U.S. Department of Justice and prepared the following final report:

Document Title: Criminal Justice/Mental Health Consensus Project

Author(s): Council of State Governments

Document No.: 197103

Date Received: 10/29/2002

Award Number: 2002-DD-BX-0002

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Criminal Justice / Mental Health Consensus Project

Criminal Justice / Mental Health Consensus Project

Coordinated by

Council of State Governments

Project Partners

Association of State Correctional Administrators (ASCA)

Bazelon Center for Mental Health Law

Center for Behavioral Health, Justice & Public Policy

National Association of State Mental Health Program Directors (NASMHPD)

Police Executive Research Forum (PERF)

Pretrial Services Resource Center (PSRC)

June 2002

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ISBN#: 0-87292-896-9

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This report was prepared by the Council of State Governments in collaboration with the Association of State Correctional Administrators, the Bazelon Center for Mental Health Law, the Center for Behavioral Health, Justice & Public Policy, the National Association of State Mental Health Program Directors, the Police Executive Research Forum, and the Pretrial Services Resource Center.

The Criminal Justice / Mental Health Consensus Project was supported by grant number 2002-DD-BX-0002, awarded by the Office of Justice Programs, U.S. Department of Justice and grant number 01 M008529-01-D, awarded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. The Consensus Project also received support from the van Ameringen Foundation, the Melville Charitable Trust, the Robert Wood Johnson Foundation, the MacArthur Foundation, and the Open Society Institute, and Pfizer, Inc. and Eli Lilly, Inc.

Points of view, recommendations, or findings stated in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice, the U.S. Department of Health and Human Services, the other project supporters, or the advisory board members who provided input into this document.

Preface

The *Criminal Justice / Mental Health Consensus Project* is an unprecedented national, two-year effort to prepare specific recommendations that local, state, and federal policymakers, and criminal justice and mental health professionals can use to improve the criminal justice system's response to people with mental illness.

The goal of this project has been to elicit ideas from some of the most respected criminal justice and mental health practitioners in the United States, to develop recommendations that reflect a consensus among seemingly opposing viewpoints, and to disseminate these findings widely so they can make the greatest possible impact on a national problem that affects every community. Throughout the project, every effort has been made to provide concrete, practical approaches that can be tailored to the unique needs of each community.

The Council of State Governments (CSG)—in partnership with the Police Executive Research Forum, the Pretrial Services Resource Center, the Association of State Correctional Administrators, and the National Association of State Mental Health Program Directors—coordinated this project. The Bazelon Center for Mental Health Law and the Center for Behavioral Health, Justice & Public Policy provided CSG with extensive and valuable assistance. Together, representatives of these seven organizations made up the Steering Committee for this project.

Following two meetings of a focus group comprising various criminal justice and mental health stakeholders in 1999, project partners established four advisory boards. Collectively, these advisory groups included more than 100 leading state lawmakers, police chiefs, officers, sheriffs, district attorneys, public defenders, judges, court administrators, state corrections directors, community corrections officials, victim advocates, consumers, family members and other mental health advocates, county commissioners, state mental health directors, behavioral health care providers, substance abuse experts, and clinicians. A complete list of advisory board members appears on the following pages. In addition to the insights of these experts, the project benefited from surveys and document reviews that project partners conducted to identify relevant efforts from the field.

The policy statements, recommendations for implementation, and program examples described in this report are important products of the *Consensus Project*. The true value of this initiative, however, will be the extent to which policymakers replicate in their jurisdictions the substantive bipartisan, cross-system dialogue that this project has fostered, and the extent to which agents of change—whether elected officials, criminal justice and mental health professionals, or community leaders—implement the practical, specific suggestions contained in this document.

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Acknowledgments

So many people and organizations made the *Criminal Justice / Mental Health Consensus Project* possible. Although it is not feasible to recognize each of these contributions individually, the Council of State Governments (CSG) staff would like to highlight the special roles of several people involved in this two-year initiative.

First, CSG staff would like to thank the co-chairs of the project, Senator Robert Thompson of Pennsylvania and Representative Michael Lawlor of Connecticut. They initiated this effort, and they provided the leadership to realize a vision of bipartisan consensus around issues that initially seemed to many as hopelessly complex and controversial. Perhaps most importantly, through changes to policy in their respective states, they demonstrated how elected officials can use the report to effect real, systemic change.

The project partners that made up the Steering Committee have been the core strength of the *Criminal Justice / Mental Health Consensus Project*. CSG staff are immensely grateful to the staff of these organizations: the Police Executive Research Forum (PERF); Association of State Corrections Administrators (ASCA); the Pretrial Services Resource Center (PSRC); the National Association of State Mental Health Program Directors (NASMHPD); the Bazelon Center for Mental Health Law; and the Center for Behavioral Health, Justice, and Public Policy.

At PERF, Martha Plotkin and Melissa Reuland's experience with similar projects and reports always provided the group with a bedrock of strategic expertise. Under Bob Glover's stalwart leadership at NASMHPD, Bill Emmet incorporated the diverse and passionate perspectives of the mental health community into the report so deftly that many in the project almost forgot what an impossible assignment he had been handed. Fred Osher patiently educated the group about mental illness, the complexities of the mental health system, and the state of mental health research, and everyone always enjoyed learning from him. Alan Henry and John Clark of PSRC accomplished a feat essential to the credibility of the project, maintaining the confidence of perennial adversaries—prosecutors and defense attorneys—in the project's process and the final report. Chris Koyanagi consistently (but always constructively) challenged the group to make the report one that respected people with

mental illness. And George Vose and John Blackmore of ASCA made sure the Steering Committee never lost sight of the realities that confront corrections and community corrections practitioners—a primary target audience for the report.

CSG and the project partners are enormously indebted to the members of the law enforcement, courts, corrections, and mental health advisory boards, who are listed earlier in this report. They each volunteered, over the course of just 18 months, hundreds of hours from their extremely busy schedules. Reviewing draft after draft of the report and crisscrossing the country for meetings, they contributed expertise, ideas, and suggestions about how to improve the response to people with mental illness who come into contact with the criminal justice system. Although not individually endorsed, the recommendations and policy statements are based on their visions for better criminal justice and mental health systems.

No one person in the country knows more about mental illness, co-occurring substance abuse disorders, and the criminal justice system than Hank Steadman of the GAINS Center. His careful review of early drafts of this report, and his thoughtful comments about how to make it better, improved the *Consensus Project* report dramatically.

An initiative of the scope and complexity of the *Criminal Justice / Mental Health Consensus Project* never gets past the concept phase without considerable funding support. Indeed, a large, diverse group of federal and private grantmakers made this project possible. Officials from the Office of Justice Programs in the U.S. Department of Justice (specifically the Bureau of Justice Assistance, the Corrections Program Office, and the Office of Victims of Crime) and the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services demonstrated how the federal government can effectively partner with policymakers at the state and local levels. Program officers from nearly a half-dozen private foundations—the van Ameringen Foundation, the Melville Charitable Trust, the Robert Wood Johnson Foundation, the MacArthur Foundation, and the Open Society Institute—took a significant risk at the early stage of this project; their investments and votes of confidence made it pos-

sible for federal agencies to provide the resources to complete the initiative. CSG staff also thank Pfizer, Inc. and Eli Lilly, Inc. for their support of the *Consensus Project*.

CSG staff are grateful to Dan Sprague, the Executive Director of CSG, John Mountjoy, CSG's Chief Policy Analyst, and the Justice and Public Safety Task Force, for allowing and supporting a regional office to coordinate a national initiative.

CSG staff would also like to give special thanks to Alan Sokolow, the director of the Eastern Office of CSG. From the beginning—when it was not at all apparent that federal agencies and private foundations would provide funding support to offset many (but far from all) of the expenses that the project incurred—he put the resources of the office behind the initiative. And in the immediate aftermath of the destruction of CSG's office in the World Trade Center, Alan made temporary office space and other resources available to ensure that the project would continue without any disruption. That commitment to the project, and the faith he showed in his staff, was extraordinary and cannot be overstated.

Finally, CSG staff and the project partners thank the many criminal justice and mental health professionals who work daily to provide a better quality of life to people in their communities. It is for them that this report has been written. Their commitment to providing the best possible services to people with mental illness will save us from the enormous costs—in human lives and community resources—we all assume when their needs are not met.

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Executive Summary

I THE PROBLEM

Impact on People and Systems

People with mental illness are falling through the cracks of this country's social safety net and are landing in the criminal justice system at an alarming rate. Each year, ten million people are booked into U.S. jails; studies indicate that rates of serious mental illness among these individuals are at least three to four times higher than the rates of serious mental illness in the general population.

Because of sensational headlines and high-profile incidents, many members of the public and some policymakers assume, incorrectly, that the vast majority of people who are in prison or jail and have a mental illness have committed serious, violent crimes. In fact, a large number of people with mental illness in prison (and especially in jail) have been incarcerated because they displayed in public the symptoms of untreated mental illness. Experiencing delusions, immobilized by depression, or suffering other consequences of inadequate treatment, many of these individuals have struggled, at times heroically, to fend off symptoms of mental illness. Providers in the mental health system have been either too overwhelmed or too frustrated to help some of these individuals, who typically have a history of being denied treatment or refusing it altogether.

Whereas some of these individuals have no family, others have exhausted the resources or the patience (and often both) of their loved ones. Often, family members, fearful for their safety or because they are simply out of options, ask the police to intervene. In other cases, concerned members of the community alert law enforcement about situations such as these: a woman shouting obscenities at shoppers on Main Street; an unkempt man in the park making threatening gestures and urinating in public. Many times, police officers on their patrols encounter individuals with mental illness in various states of public intoxication. These are individuals who have attempted to self-medicate using alcohol or any illegal substance they could obtain.

There are also cases in which a person with a mental illness commits a serious, violent crime, making his or her incarceration necessary and appropriate. Still, almost all of these individuals will reenter the community, and the justice system has the legal obligation (and the obligation to the public) to prepare these individuals for a safe and successful transition to the community.

Given the dimensions and complexity of this issue, the demands upon the criminal justice system to respond to this problem are overwhelming. Police departments dedicate thousands of hours each year transporting people with mental illness to hospitals and community mental health centers where staff often have to turn away the individual or quickly return him or her to the streets. Jails and prisons are swollen with people suffering some form of mental illness; on any given day, the Los Angeles County Jail holds more people with mental illness than any state hospital or mental health institution in the United States.

Most troubling about the criminal justice system's response in many communities to people with mental illness is the toll it exacts on people's lives. Law enforcement officers' encounters with people with mental illness sometimes end in violence, including the use of lethal force. Although rare, police shootings do more than end the life of one individual. Such incidents also have a profound impact on the consumer's family, the police officer, and the general community. When they are incarcerated, people with untreated mental illness are especially vulnerable to assault or other forms of intimidation by predatory inmates. In prisons and jails, which tend to be environments that exacerbate the symptoms of mental illness, inmates with mental illness are at especial risk of harming themselves or others. Once they return to the community, people with mental illness learn that providers already overwhelmed with clientele are sometimes reluctant to treat someone with a criminal record.

Origins of the Problem

The origins of the problem are complex and largely beyond the scope of this report. During the last 35 years, the mental health system has undergone tremendous change. Once based exclusively on institutional care and isolation, the system has shifted its emphasis almost entirely to the provision of community-based support for individuals with mental illness. This public policy shift has benefited millions of people, effecting the successful integration of many people with active or past diagnoses of mental illness into the community. Many clients of the mental health system, however, have difficulty obtaining access to mental health services. Overlooked, turned away, or intimidated by the mental health system, many individuals with mental illness end up disconnected from community supports. The absence of affordable housing and the crisis in public housing exacerbates the problem; most studies estimate that at least 20 to 25 percent of the single, adult homeless population have a serious mental illness.

Not surprisingly, officials in the criminal justice system have encountered people with mental illness with increasing frequency. Calls for crackdowns on quality-of-life crimes and offenses such as the possession of illegal substances have netted many people with mental illness, especially those with co-occurring substance abuse disorders. Ill equipped to provide the comprehensive ar-

ray of services that these individuals need, corrections administrators often watch the health of people with mental illness deteriorate further, prompting behavior and disciplinary infractions that only prolong their involvement in the criminal justice system.

II ABOUT THE CRIMINAL JUSTICE / MENTAL HEALTH CONSENSUS PROJECT

The *Criminal Justice / Mental Health Consensus Project* is a unique effort to define the measures that state legislators, law enforcement officials, prosecutors, defense attorneys, judges, corrections administrators, community corrections officials, and victim advocates, mental health advocates, consumers, state mental health directors, and community-based providers agree will improve the response to people with mental illness who are in contact (or at high risk of involvement) with the criminal justice system.

The target audience of the *Consensus Project Report* is those individuals who can be characterized as agents of change: state policymakers who can have a broad systemic impact on the problem and an array of practitioners and advocates who can shape a community's response to the problem. Legislators, policymakers, practitioners, and advocates can champion the detailed recommendations in the report knowing that each has been developed and approved by experts from an extraordinarily diverse range of perspectives who work in and administer the department, agencies, and organizations trying every day to address the needs of people with mental illness involved (or at risk of involvement with) the criminal justice system.

The *Consensus Project Report* addresses the entire criminal justice continuum, and it recognizes that actions taken by law enforcement, the courts, or corrections have ramifications for the entire criminal justice system. The report also recognizes that people with mental illness who are involved with the criminal justice system live in or return to communities, each of which has distinct issues, challenges, assets, and potential solutions to enable people with mental illness to avoid or minimize involvement with the criminal justice system.

The report provides 46 policy statements that can serve as a guide or prompt an initiative to improve the criminal justice system's response to people with mental illness. Following each policy statement is a series of more specific recommendations that highlight the practical steps that should be taken to implement the policy. Woven into the discussion of each recommendation are examples of programs, policies, or elements of state statutes that illustrate one or more jurisdiction's attempt to implement a particular policy statement. While

promising, many of these initiatives are so new that they have yet to be evaluated to certify their impact on individuals and systems. Still, they demonstrate how partnerships and resourcefulness can be successfully replicated or tailored to the unique needs of a variety of communities. These examples should also help communities to build on the achievements without duplicating the failures or inefficiencies of others.

State and local government officials and community leaders can use these policy statements, recommendations, and examples to get beyond *discussing* the issue and to begin developing initiatives that will *address* the problem.

III. CONSENSUS PROJECT POLICY STATEMENTS

The policy statements in the *Consensus Project Report* reflect that—from a person’s first involvement with the mental health system to initial contact with law enforcement, to pretrial issues, adjudication, and sentencing, to incarceration and re-entry—there are numerous opportunities for an agent of change to focus his or her efforts to improve the response to people with mental illness who come in contact with criminal justice system. These policy statements are summarized in the chart below.

The first half of this chart corresponds to Part One of the report. These policy statements explain the opportunities available to practitioners in the criminal justice and mental health systems to identify a person who has a mental illness and to react in way that both recognizes the individual’s needs and civil liberties and promotes public safety and accountability. In addition, these policy statements summarize elements of programs and policies that would enable law enforcement, court officials, corrections administrators, and mental health providers to provide access to effective treatment and services and to maintain the individual on a path toward recovery.

Policy statements describing the overarching themes (Part Two) of the report appear in the second half of the chart below. They reflect that the recipes for implementing each of the policy statements in part one of the report call for many of the same ingredients: collaboration, training, evaluations, and an effective mental health system.

The policy statements concerning collaboration recognize that neither the criminal justice system nor the mental health system can, on its own, implement many of the recommendations in the report. For example, law enforcement officials need information about and access to mental health resources to respond effectively to individuals with mental illness in the community. To make informed decisions at pretrial hearings, adjudication, and sentencing, court officials need some information about an individual’s mental illness. Cor-

rections and community corrections administrators should be able to tap a clinician's expertise when evaluating whether a person eligible for parole meets the criteria for release.

The chapter regarding training calls for criminal justice practitioners to become familiar with the signs and symptoms of mental illness, the appropriateness of various responses, and the resources and organization of their local mental health system. Similarly, the implementation of many of the recommendations throughout the report depends on mental health clinicians and service providers who understand the criminal justice system and are willing to look beyond the stigma associated with a criminal record.

Successful implementation of the policy statements throughout the report requires the delivery of mental health services to individuals who have complex needs and a long history of unsuccessful engagement in the community-based mental health system. The chapter concerning an effective mental health system discusses the need for mental health services that are accessible, easy to navigate, culturally competent, and integrated; treatment provided should adhere to an evidence base. A community mental health system that does not meet these criteria is unlikely to maintain an individual with mental illness engaged in treatment, and thus will quickly cause criminal justice officials to lose confidence in the community's capacity to support people with mental illness.

The last set of policy statement in the following chart recognize that measuring the outcomes of programs designed to improve the response to people with mental illness involved in the criminal justice system is also of paramount importance. Program administrators must monitor the impact of a new initiative. Such information is essential to determine whether a program or policy is successful and how it can be improved. It also facilitates continued support for promising initiatives.

Report Chapter	EVENT/ISSUE	POLICY STATEMENT Number	POLICY STATEMENT
Involvement with the Mental Health System	Involvement with the Mental Health System	1	Improve availability of and access to comprehensive, individualized services when and where they are most needed to enable people with mental illness to maintain meaningful community membership and avoid inappropriate criminal justice involvement.
Contact with Law Enforcement	Request for Police Service	2	Provide dispatchers with tools to determine whether mental illness may be a factor in a call for service and to use that information to dispatch the call to the appropriate responder.
	On-Scene Assessment	3	Develop procedures that require officers to determine whether mental illness is a factor in the incident and whether a serious crime has been committed—while ensuring the safety of all involved parties.
	On-Scene Response	4	Establish written protocols that enable officers to implement an appropriate response based on the nature of the incident, the behavior of the person with mental illness, and available resources.
	Incident Documentation	5	Document accurately police contacts with people whose mental illness was a factor in an incident to promote accountability and to enhance service delivery.
	Police Response Evaluation	6	Collaborate with mental health partners to reduce the need for subsequent contacts between people with mental illness and law enforcement.
Pretrial Issues, Adjudication, and Sentencing	Appointment of Counsel	7	Make defense attorneys aware of the following: (a) the mental health condition, history and needs of their clients as early as possible in the court process; (b) the current availability of quality mental health resources in the community; and (c) current legislation and case law that might affect the use of mental health information in the resolution of their client's case.
	Consultation with Victim	8	Educate individuals who have been victimized by a defendant with a mental illness, or their survivors, about mental illness and how the criminal justice system deals with defendants with mental illness.
	Prosecutorial Review of Charges	9	Maximize the use of alternatives to prosecution through pretrial diversion in appropriate cases involving people with a mental illness.
	Modification of Pretrial Diversion Conditions	10	Assist defendants with mental illness in complying with conditions of pretrial diversion.
	Pretrial Release/ Detention Hearing	11	Maximize the use of pretrial release options in appropriate cases of defendants with mental illness so that no person is detained pretrial solely for the lack of information or options to address the person's mental illness.
	Modification of Pretrial Release Conditions	12	Assist defendants with mental illness who are released pretrial in complying with conditions of pretrial release.
	Intake at County/ Municipal Detention Facility	13	Ensure that the mechanisms are in place to provide for screening and identification of mental illness, crisis intervention and short-term treatment, and discharge planning for defendants with mental illness who are held in jail pending the adjudication of their cases.
	Adjudication	14	Maximize the availability and use of dispositional alternatives in appropriate cases of people with mental illness.
	Sentencing	15	Maximize the use of sentencing options in appropriate cases for offenders with mental illness.
Modification of Conditions of Probation/Supervised Release	16	Assist offenders with mental illness in complying with conditions of probation.	

Report Chapter	EVENT/ISSUE	POLICY STATEMENT Number	POLICY STATEMENT
Incarceration and Reentry	Receiving and Intake of Sentenced Inmates	17	Develop a consistent approach to screen sentenced inmates for mental illness upon admission to state prison or jail facilities and make referrals, as appropriate, for follow-up assessment and/or evaluations.
	Development of Treatment Plans, Assignment to Programs, and Classification / Housing Decisions	18	Use the results of the mental health assessment and evaluation to develop an individualized treatment, housing, and programming plan, and ensure that this information follows the inmate whenever he or she is transferred to another facility.
	Subsequent Referral for Screening and Mental Health Evaluation	19	Identify individuals who—despite not raising any flags during the screening and assessment process—show symptoms of mental illness after their intake into the facility, and ensure that appropriate action is taken.
	Release Decision	20	Ensure that clinical expertise and familiarity with community-based mental health resources inform release decisions and determination of conditions of release.
	Development of Transition Plan	21	Facilitate collaboration among corrections, community corrections, and mental health officials to effect the safe and seamless transition of people with mental illness from prison to the community.
	Modification of Conditions of Supervised Release	22	Monitor and facilitate compliance with conditions of release and respond swiftly and appropriately to violations of conditions of release.
	Maintaining Contact Between Individual and Mental Health System	23	Ensure that people with mental illness who are no longer under supervision of the criminal justice system maintain contact with mental health services and supports for as long as is necessary.
Improving Collaboration	Obtaining and Sharing Resources	24	Determine how the partners will make resources available to respond jointly to the problem identified.
	Sharing Information	25	Develop protocols to ensure that criminal justice and mental health partners share mental health information without infringing on individuals' civil liberties.
	Institutionalizing the Partnership	26	Institutionalize the partnership to ensure it can sustain changes in leadership or personnel.
Training Practitioners and Policymakers and Educating the Community	Determining Training Goals and Objectives	27	Determine training goals and objectives and tap expertise in both the criminal justice and mental health systems to inform these decisions.
	Training for Law Enforcement Personnel	28	Establish new skills, recruit, in-service, and advanced skills training requirements for law enforcement personnel about responding to individuals with mental illness, and develop curricula accordingly.
	Training for Court Personnel	29	Provide adequate training for court officials (including prosecutors and defense attorneys) about appropriate responses to criminal defendants who have a mental illness.

Report Chapter	EVENT/ISSUE	POLICY STATEMENT Number	POLICY STATEMENT
Training Practitioners and Policymakers and Educating the Community <i>continued</i>	Training for Corrections Personnel	30	Train corrections staff to recognize symptoms of mental illness and to respond appropriately to people with mental illness.
	Training for Mental Health Professionals	31	Develop training programs for mental health professionals who work with the criminal justice system.
	Educating the community and Building Community Awareness	32	Educate the community about mental illness, the value of mental health services, and appropriate responses when people with mental illness who come into contact with the criminal justice system.
	Identifying Trainers	33	Identify qualified professionals to conduct training.
	Evaluating Trainers	34	Evaluate the quality of training content and delivery; update training topics and curricula annually to ensure they reflect both the best practices in the field as well as the salient issues identified as problematic during the past year.
Elements of an Effective Mental Health System	Evidence-Based Practices	35	Promote the use of evidence-based practices and promising approaches in mental health treatment, services, administration, and funding.
	Integration of Services	36	Initiate and maintain partnerships between mental health and other relevant systems to promote access to the full range of services and supports, to ensure continuity of care, and to reduce duplication of services.
	Co-Occurring Disorders	37	Promote system and services integration for co-occurring mental health and substance abuse disorders.
	Housing	38	Develop and enhance housing resources that are linked to appropriate levels of mental health supports and services.
	Consumer and Family Member Involvement	39	Involve consumers and families in mental health planning and service delivery.
	Cultural Competency	40	Ensure that racial, cultural, and ethnic minorities receive mental health services that are appropriate for their needs.
	Workforce	41	Determine the adequacy of the current mental health workforce to meet the needs of the system's clients.
	Accountability	42	Establish and utilize performance measures to promote accountability among systems administrators, funders, and providers.
	Advocacy	43	Build awareness of the need for high quality, comprehensive services and of the impact of stigma and discriminatory policies on access to them.
Measuring and Evaluating Outcomes	Identifying Outcome Measures	44	Identify outcome measures that will enable policymakers to assess the value and efficacy of the initiative.
	Collecting Data	45	Ensure mechanisms are in place to capture data consistent with the process and outcome measures identified.
	Disseminating Findings	46	Publicize program successes as appropriate to the media, public, and appropriators.

IV. USING THE REPORT AND NEXT STEPS

The *Consensus Project Report* should be used as a compendium of ideas that will help individuals identify and frame practices and programs that will improve the response to people with mental illness who are in contact with—or at risk of becoming involved with—the criminal justice system.

Deciding where to start—especially when familiar with the existing obstacles to improving the systems—is difficult. In more than one community, reform efforts have been derailed before getting underway because those involved could not decide where to begin. Similarly, attempting to implement many, if not all, of the policy statements in this report could overwhelm a community.

The single most significant common denominator shared among communities that have successfully improved the criminal justice and mental health systems' response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders—one from the criminal justice system and the other from the mental health system.

Indeed, the *Consensus Project* report reflects, on a national level, the value of substantive, bipartisan, cross-system dialogue regarding mental health issues as they relate to the criminal justice system. At a minimum, such discussions should be replicated in communities across the country. Where those discussions have already begun, agents of change should capitalize on the window of opportunity that now exists. The lives of people with mental illness, their loved ones, and the health and safety of communities in general depend on it.

***The Criminal Justice/
Mental Health Consensus
Project***

Introduction

The *Criminal Justice/Mental Health Consensus Project* is a broad-based, national effort to improve the response to people with mental illness who come into contact (or are at risk of coming into contact) with the criminal justice system. This report provides policymakers, practitioners, advocates, and others determined to address this issue with an array of options and ideas, many of which have emerged in communities across the country.

This report has a broad target audience best characterized as “agents of change.” Defined as a wide range of leaders in communities and states, change agents may be state elected officials such as legislators or appointed administrators and their staffs who can consider and address the broad policy issues that have profound implications at the community level. Because this is a community problem, however, the change agents must also include a wide range of community players, starting with those most closely affected by the problem. They can use the recommendations found in this report

to strengthen community structures, and they can work with policymakers to ensure that solutions they craft are practical and effective.

Perhaps the most valuable aspect of this report is that it reflects a consensus among the stakeholders in the criminal justice and mental health system. Police professionals, district attorneys, public defenders, judges, state corrections directors and jail administrators, community corrections officials, state mental health directors, local mental health and substance abuse treatment providers, clinicians, crime victims, consumers, mental health advocates, and others have all had input into the report. Legislators, policymakers, practitioners, and other agents of change can champion and implement the detailed recommendations in this report knowing that each has been developed and approved by experts from an extraordinarily diverse range of perspectives who work in and administer the departments, agencies, and organizations trying every day to address the needs of people with mental illness in the criminal justice system.

What, exactly, is the problem? How did it develop? Who can fix it? What can they do? And where do they start? This report addresses these questions. State and local government officials and community leaders can use the policy statements provided in this report to get beyond discussing the issue and to begin developing initiatives that will address the problem. Furthermore, the report enables agents of change to cite programs and practices that demonstrate that there are in fact jurisdictions that have already taken steps to implement a particular policy statement.

Having all of this information in one document, which reflects countless hours of counsel from over 100 of the most respected criminal justice and mental health practitioners and policymakers in the United States, is unprecedented. While this report by itself cannot change a community or system, it is an extraordinary resource in the hands of a person committed to improving the criminal justice system's response to people with mental illness.

THE PROBLEM

People with mental illness are significantly overrepresented among the segment of the population in contact with the criminal justice system. Approximately 5 percent of the U.S. population has a serious mental illness.¹ The U.S. Department of Justice reported in 1999, however, that about 16 percent of the population in prison or jail has a serious mental illness.² Of the 10 million people booked into U.S. jails in 1997, at least 700,000 had a serious mental illness; approximately three-quarters of those individuals had a co-occurring substance abuse disorder.³ A study conducted in New York State found that men involved in the public mental health system over a five-year period were four times as likely to be incarcerated as men in the general population; for women, the ratio was six to one.⁴

Impact of the Problem on People and Systems

How elected officials and the public understand mental illness as it relates to the criminal justice system often is informed by newspaper and television headlines, which typically focus only on the most egregious manifestations of the problem: a screwdriver-wielding woman with mental illness shot dead by officers who subsequently tell of being frightened and confused themselves; a crime victim outraged that, before assaulting her, a person with a history of untreated mental illness bounced between community mental health centers, state hospitals, and the local jail.

Although these tragedies sometimes drive policymaking, they are not the cases involving mental illness most familiar to police officers, prosecutors, defense attorneys, judges, corrections administrators, parole and probation officers, and other criminal justice personnel. These criminal justice practitioners are all too familiar with the following scenarios:

- A police officer returns countless times to a house or street corner in response to a call for assistance involving the same person with a history of mental illness; each time, the officer is unable to link the person to treatment.
- Month after month, a prosecutor charges the same person with committing a different public nuisance crime, and, each time, the defendant with mental illness pleads guilty to time served.

1. R. C. Kessler et al., "A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness," In *Mental Health United States 1999*, edited by R.W. Manderscheid and M.J. Henderson, Rockville, MD, Center for Mental Health Services.

2. Paula. M. Ditton, *Mental Health Treatment of Inmates and Probationers*, Bureau of Justice Statistics, U.S. Department of Justice, July 1999. The prevalence statistic for mental illness in U.S. jails and prisons was gathered through a combination of inmate self-reporting and mental health treatment history. Inmates in the sample qualified as having a mental illness if they met one of the following two

criteria: "They reported a current mental or emotional condition, or they reported an overnight stay in a mental hospital or treatment program." To account for inmate underreporting of their mental health problems, admission to a mental hospital was included as a measure of mental illness. Ten percent of inmates reported a current mental condition and an additional six percent did not report a condition but had stayed overnight in a mental hospital or treatment program.

3. Linda Teplin and Karen Abram, "Co-Occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy," *American Psychologist* 46:10, October 1991, pp. 1036-45.

- Jail and prison administrators watch their systems swell with these individuals, who spin through the revolving door of the institution. Corrections officials' job is to keep these inmates alive, even if that means isolating them in administrative segregation with no outside contact for weeks on end. When the release date comes around, freedom for many prisoners is only temporary, unless they are among the few for whom reentry has meant planning and linkage with community supports.
- A parole officer already struggling with an overwhelming caseload is assigned an individual with mental illness released from prison; the officer receives only limited support from the community-based mental health program. The parolee is rearrested and returned to prison when he commits a new crime—urinating on a street corner and making lewd gestures to frightened people passing by—displaying in public the symptoms of his untreated mental illness.

Each of these situations frustrates criminal justice officials; they know they are failing the person who suffers from mental illness and his or her loved ones. Encounters between people with mental illness and law enforcement sometimes end in violence, jeopardizing the safety of consumers and officers. Once incarcerated, people with mental illness become especially vulnerable to assault or other forms of intimidation by predatory inmates.⁵ People with mental illness also tend to decompensate in prisons and jails—environments that exacerbate the symptoms of mental illness—and there they are at especial risk of harming themselves or others. Upon their return to the communities they left behind during their incarceration, they discover that their criminal records have, in many cases, made it even harder to obtain access to treatment.

Criminal justice officials may lose sight, however, of the lives these individuals lead. These are sons and daughters, fathers and mothers, who struggle daily to fend off symptoms of mental illness. Without adequate treatment, their disease may disable them significantly. Some experience delusions and may be convinced that strangers are planning to attack them. In other cases, depression immobilizes them; overcome with a sense of hopelessness, their physical strength deteriorates. Many of them are people who've spent years trying to mask torments or hallucinations with alcohol or any street drug they could scrape together enough money to buy and now are dependent on these substances to avoid withdrawal states and further decompensation. Often, their

"Inmates, families, guards, judges, prosecutors and police are in unique agreement that our broken system of punting the most seriously mentally ill to the criminal justice system must be fixed."

**U.S. CONGRESSMAN
TED STRICKLAND**
Ohio

Source: U.S. House Committee on the Judiciary, Subcommittee on Crime, Terrorism, and Homeland Security. *The Impact of the Mentally Ill on the Criminal Justice System*. 107th Congress, September 21, 2001

4. Judith F. Cox, Pamela C. Morschauser, Steven Banks, James L. Stone, "A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems," *Journal of Behavioral Health Services & Research* 28:2, May 2001, pp. 177-87. This study used data from the mental health and criminal justice systems of 25 upstate New York counties. The study defines individuals who have been in the public mental health system as having been in a state-run psychiatric inpatient facility or a local psychiatric inpatient facility, or having received mental health services from a local, general hospital using Medicaid coverage. Incarceration was defined as having spent at least one night in jail during the five-year study period.

5. See testimony of Reginald Wilkinson, then vice president, Association of State Correctional Administrators and director, Ohio Department of Rehabilitation and Correction, before the House Judiciary Committee, Subcommittee on Crime, Terrorism and Homeland Security, oversight hearing on "The Impact of the Mentally Ill on the Criminal Justice System," September 21, 2000, available at: www.house.gov/judiciary/wilk0921.htm .

exhausted families have run out of the funds and emotional resources to take care of them.

Sometimes, when the criminal justice and mental health systems let someone with mental illness fall through the cracks, a stranger is harmed and justifiably motivated to demand accountability from the person with the mental illness and the public health system that failed. More often, when a person with a mental illness does assault someone, the victim is a family member, friend, or acquaintance.⁶ Whether relatives or strangers, the victims are usually left to make sense of the baffling interface between the criminal justice system and the mental health system.⁷

The current situation not only exacts a significant toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system. Police departments dedicate thousands of hours each year transporting people with mental illness to hospitals and community mental health centers where staff often are unable to admit the individual or quickly return him to the streets. Judges, prosecutors, and defense attorneys race through backlogged dockets, disposing of most cases in minutes, but find that the symptoms and behaviors of the growing numbers of defendants with mental illness who appear in their courtrooms cannot be processed as quickly. On any given day, the Los Angeles County Jail holds as many as 3,300 individuals with mental illness—more than any state hospital or mental health institution in the United States.⁸ Without adequate planning to transition inmates with mental illness back into the community, many will quickly return to jail or prison; recidivism rates for inmates with mental illness can reach over 70 percent in some jurisdictions.⁹

Every criminal justice professional would agree that the system has inherited a problem of enormous scope and complexity. Police, courts, and corrections officials feel they're boxed in. Resources are stretched to the limit: they're tight on money and even tighter on time. Under the circumstances, many have tried to find a way to serve people with mental illness more efficiently. But with limited options and resources, especially in rural areas, many criminal justice practitioners are frustrated because they know what they're doing isn't enough.

"It is unacceptable that Los Angeles County and New York jails have essentially become the largest mental health care institutions in our country—these are jails, after all, not mental health facilities."

**U.S. SENATOR
MIKE DEWINE**
Ohio

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*. September 21 2001

6. Ditton, *Mental Health and Treatment*, 4. More than 60 percent of the victims of violent crimes committed by state prisoners with mental illness were known to the offenders.

7. People with mental illness who themselves are the victims of a crime are a notable subset of this population. While especially in need of support services, they in particular suffer from insufficient coordination between criminal justice and mental health systems. Although some recommendations in this report address this population, the issue of victims with mental illness is generally beyond the scope of this report.

8. *Sacramento Bee*, "Treatment Not Jail: A Plan to Rebuild Community Mental Health," March 17, 1999, Section B, p. 6.

9. Lois A. Ventura, Charlene A. Cassel, Joseph E. Jacoby, Bu Huang, "Case Management and Recidivism of Mentally Ill Persons Released From Jail," *Psychiatric Services* 49:10, Oct. 1998, 1330-37. This study examined the effect of community case management on recidivism for jail detainees who have mental illness. The study followed releasees for 36 months. Within the 36 months, 188 of 261

Origins of the Problem

Understanding why this problem has become so acute in recent years requires some familiarity with the dramatic shifts in mental health and criminal justice policy over the course of recent decades.

Few institutions have attempted so complete a change over the previous 35 years as has the nation's public mental health system. Once based exclusively on institutional care and isolation, the system has shifted its emphasis almost entirely to the provision of community-based support for individuals with mental illness. In 1955, state mental hospital populations peaked at a combined 559,000 people; in 1999 this number totaled fewer than 80,000.¹⁰ There are many reasons for this change; fiscal reality, political realignment, philosophical shifts, and medical advances, in no particular order, have all played a part. These forces and others have converged to create a reality that few could have envisioned when the Community Mental Health Centers Act was signed into law in 1964.¹¹

For many clients who utilize this system, successful community integration has indeed been achieved. Reliable data on the success of community mental health are difficult to find, but anecdotal experience shows that many people with active or past diagnoses of mental illness live and work "normally" in communities across the country. Their very success in achieving recovery helps them to mix unremarkably with their families, neighbors, and coworkers.

The mental health system today has powerful and effective medications and rehabilitation models with which to work. The professionals in the system know much about how to meet the needs of the people it is meant to serve. The problem comes, however, in the ability of the system's intended clientele to access its services and, often, in the system's ability to make these services accessible. The existing mental health system bypasses, overlooks, or turns away far too many potential clients. Many people the system might serve are too disabled, fearful, or deluded to make and keep appointments at mental health centers. Others simply never make contact and are camped under highway overpasses, huddled on heating grates, or shuffling with grocery carts on city streets.

The lack of affordable, practicable housing options for individuals with mental illness compounds the difficulty of providing successful treatment. Without housing that is integrated with mental health, substance abuse, employ-

subjects (72 percent) were rearrested.

10. T.A. Kupers, *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*, San Francisco, Jossey-Bass Publishers, 1999.

11. The public, the media, and even some in the criminal justice and mental health system, suggest that there is a causal connection between the dramatic reduction in the number of people in mental health institutions and the extraordinary growth of the prison and jail population. Some present two straight-line graphs to illustrate the point, implying that the very same people who used to be

in mental health institutions are now in prison or jail. In fact, no study has proven that there has been a transition of this population from one institution to another. Indeed, while the gross number of people with mental illness incarcerated has increased significantly in recent years, there is no evidence that the *percentage* of people in prison or jail who have a mental illness is any greater than it was 35 years ago when the *Community Mental Health Centers Act* was passed. See Henry J. Steadman et al., "The Impact of State Mental Hospital Deinstitutionalization on United States

ment, and other services, many people with mental illness end up homeless, disconnected from community supports, and thus more likely to decompensate and become involved with the criminal justice system. Most studies estimate that at least 20 to 25 percent of the single adult homeless population suffers from some severe and persistent mental illness.¹²

It is against this backdrop that officials in the criminal justice system have in recent years encountered people with mental illness with increasing frequency. Because of sensational news headlines or other sources that stigmatize mental illness, some criminal justice professionals may be prone to making the incorrect assumption—which most of the public makes—that mental illness by definition incorporates violent behavior.¹³ They may respond to situations on the street, in a courtroom, or at a parole board hearing on the basis of common but erroneous perceptions. In such instances, police, judges, and releasing authorities may be especially wary about releasing people with mental illness into the community.

Compounding the problems stemming from the stigma associated with mental illness, changes to criminal justice policies during the course of the last two decades have prolonged the involvement of people with mental illness in the criminal justice system. For example, in response to community or government leaders' demands to increase quality of life and to reduce crime and fear of crime, many police departments have instituted "zero tolerance" policies, arresting people committing offenses such as loitering, urinating in public, and disturbing the peace.¹⁷ Many individuals netted as a result of these tactics were people demonstrating in public the symptoms of untreated mental illness. The majority of these people also have a co-occurring substance abuse problem. As legislatures have increased the length of prison sentences (and frequently made them mandatory) for the possession or sale of some illegal substances, growing numbers of people with mental illness have been incarcerated—and for longer periods of time.

Already overcrowded and overburdened, prisons and jails typically are without the resources to ensure the availability of effective mental health treatment and appropriate medications. In these cases, a person with mental illness is likely to decompensate, exacerbating the symptoms of his or her mental ill-

Violence and Mental Illness

Popular beliefs about violence and mental illness do not jibe with reality. The results of several recent, large-scale research projects conclude that only a weak statistical association between mental disorder and violence exists.¹⁴ Serious violence by people with major mental disorders appears concentrated in a small fraction of the total number, and especially among those who use alcohol and other drugs and those without access to effective services.¹⁵ Indeed, the vast majority of people with mental illness are not violent; they are more likely to be victims of crime than they are likely to harm others.¹⁶

Prison Populations, 1968-1978," *Journal of Criminal Law & Criminology* 75:2, 1984, pp. 474-90.

12. Paul Koegel et al., "The Causes of Homelessness," in *Homelessness in America*, 1996, Oryx Press. However, according to the Federal Task Force on Homelessness and Severe Mental Illness, only approximately 5 percent of people with severe mental illness are homeless on a given day. Federal Task Force on Homelessness and Severe Mental Illness, 1992, *Outcasts On Main Street: A Report of the Federal Task Force on Homelessness and Severe Mental Illness*, Washington, D.C., GPO. For more information on homelessness and mental illness see A.D. Lezak and E. Edgar, *Preventing Homelessness Among People with Severe Mental Illness*, Rockville, MD, Center for Mental

Health Services, 1999 and The National Resource Center on Homelessness and Mental Illness, *National Organizations Concerned with Mental Health, Housing, and Homelessness*, Delmar, NY, 2001, available at: www.nrchmi.com

13. U.S. Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, Available at: www.surgeongeneral.gov.

14. H. Steadman, E. Mulvey, J. Monahan, P. Robbins, P. Applebaum, T. Grisso, L. Roth, and E. Silver, "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods." *Archives of General Psychiatry* 55, 1998, 393-401. See also K.T. Meuser, et. al., "Trauma and Post-Traumatic Stress Disorder in Severe Mental Illness," *Journal of Consulting and*

ness. As a result, the person may act out and fail to follow prison rules, which in turn extends the period of incarceration for the individual. For these reasons, people with mental illness tend to stay in jail or prison considerably longer than other general population inmates. For example, on Riker's Island, New York City's largest jail, the average stay for all inmates is 42 days, but it is 215 days for people with mental illness.¹⁸

Inmates with a mental illness who leave prison or jail are typically provided with just a short (two weeks or less) supply of medications and enough money to take a one-way trip on public transportation. Without housing, linkage to a community-based mental health treatment program, or other much needed services, the person typically returns to the type of behavior that originally contributed to his or her incarceration.

REASONS FOR HOPE

The good news is that the urgency of the problem has bred numerous workable options—within a framework of limited resources—in many communities across the country. These efforts span the criminal justice continuum, preceding arrest and continuing past incarceration and the individual's reentry into the community, and their success is often a function of the creation of partnerships, especially between the criminal justice and mental health systems. By forming partnerships police officers on the street, booking officers in the stations, jailers, judges, public defenders, prosecutors, probation officers, prison administrators, and parole officers have created service and diversion options that support their public safety functions, and, at the same time, ensure appropriate care of people with mental illness who come into their systems. Along with mental health providers, these partnerships may also include housing agency officials, substance abuse treatment providers, business owners, families, and people who themselves have a mental illness. Identifying and engaging others with a stake in the problem builds a support network for its solution. Partnerships create a framework for moving forward. They help identify community strengths and resources as well as deficits and needs. Most important,

Clinical Psychology 66:3, 1998, 493-99..

15. Ibid.

16. Virginia Hiday, Marvin S. Swartz, Jeffrey W. Swanson, Randy Borum, and H. Ryan Wagner, "Criminal Victimization of Persons with Severe Mental Illness," *Psychiatric Services* 50, 1998, pp. 62-68. This study tracked 331 involuntary mental health outpatients. The rate of nonviolent victimization for the study cohort (22.4 percent) was similar to that in the general population (22.1 percent). The rate of violent criminal victimization, however, was two and a half times greater than in the general population—8.1 percent compared to 3.1 percent. In multivariate analysis, substance use and transient living

conditions were strong predictors of criminal victimization.

17. Ditton, *Mental Health and Treatment*, 4. According to the Bureau of Justice Statistics, over one-quarter of the inmates with mental illness in local jails were incarcerated for a public order offense.

18. Fox Butterfield, "Prisons Replace Hospitals for the Nation's Mentally Ill," *New York Times*, March 5, 1998, A1. Refers to testimony of Dr. Arthur Lynch, director of Mental Health Services for the NYC Health and Hospitals Corporation, before the Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse Service (April 22, 1998).

"As a member of the Senate Appropriations Committee in Pennsylvania, I am acutely aware of the unsustainable rate at which the budgets for our county jail system and Department of Corrections are growing. We want to continue ensuring that we throw away the key when we lock up violent offenders. We cannot afford to maintain that practice if we continue incarcerating nonviolent offenders or misdemeanants who are in prison or jail only because they have a mental illness."

SENATOR ROBERT J. THOMPSON

Chair, Appropriations Committee, PA

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*. September 21 2001

perhaps, a community partnership becomes a single voice that demands attention and appeals convincingly for assistance needed to solve the problem.

The extent to which a partnership at the community level changes systems depends on the extent to which leaders emerge at the state level. State legislatures raise and appropriate money. They write laws that affect who gets into the criminal justice system and how they are treated. Public mental health systems are administered and funded at the state level, so decisions made there affect every community statewide. If the criminal justice system's encounters with people who have mental illness are to be changed, community partners and state policymakers must work together. This report should be exceptionally helpful in that regard.

HOW TO USE THIS REPORT

This report comprises 46 policy statements, each of which can serve as a guiding principle or as the underpinning of an initiative to improve the criminal justice system's response to a person with mental illness. Each policy statement is followed by a series of recommendations—lettered statements in bold text—highlighting the steps that should be taken to implement the corresponding policy. The policy statements and recommendations will help agents of change to focus their efforts on particular aspects of the interaction between individuals with mental illness and the criminal justice system.

Woven into the discussion of each recommendation are examples of programs, policies, or elements of state statutes that illustrate one or more jurisdiction's attempt to implement a particular policy. By highlighting certain approaches, however, the report is not promoting them as “best practices.” They are simply efforts that involve partnerships, resourcefulness, or even longtime practices for other communities to consider. (Programs, policies, and statutes highlighted in the text are, with some exceptions, described in more detail in Appendix B: Program Examples Cited in the Report.) Just as this report recognizes that each person with mental illness is unique, the report's authors understand that communities, their problems, and potential solutions vary considerably across the country. What works in one community may not be a perfect fit for its neighbor, let alone for a community halfway across the continent. Indeed, this report emphasizes that each community must find its own solutions to these complex and interwoven problems. The practices and approaches chosen for examples in this report are themselves continuing to evolve and adapt to changing community conditions.

The Target Population

Policy statements in this report address individuals whose behavior—not diagnosis alone—reflects some type of severe or serious mental illness. In addition, the target population for this project includes individuals who exhibit symptoms of brain injury, mental illness relating to aging (i.e., dementia), coexisting developmental disability, or co-occurring substance abuse problems. The target population excludes individuals who exhibit symptoms of character disorder, developmental disability, or substance abuse *only*.

The age of the target population is adult, with two exceptions. Recommendations that deal with local law enforcement contemplate juveniles whose age is often not immediately apparent to an officer. In addition, those recommendations developed for corrections administrators target adults as well as juveniles incarcerated in adult correctional facilities. (The situation involving juveniles with mental illness who come into contact with the criminal justice system is no less serious and in need of policymakers' attention than those problems regarding adults with mental illness who come into contact with the criminal justice system. Nevertheless, the systems that deal with the two age populations are distinct, and there were not sufficient resources available in this project to evaluate the problems regarding both adults and juveniles.)

Common Language, Common Terms

The two worlds of justice and mental health each have their own language, with terms that do not always easily translate into broader, more familiar words; for this reason, a comprehensive glossary is included as Appendix A. There are some terms, however, that appear throughout the document, and warrant explanation up front.¹⁹

co-occurring disorders. The term co-occurring disorders used throughout this manuscript refers to the combination of a substance use disorder with a non-addictive mental disorder. Although there may be other "co-morbid" conditions, especially in those with co-occurring disorders (e.g. HIV/AIDS, Hepatitis, or diabetes), because of the high frequency that addictive behavior occurs in individuals with mental disorders, co-occurring disorders are extremely relevant to this report. Other frequently used terms for this condition include; dual diagnosis, MICA (mentally ill substance abuser), and CAMI (chemical abuse and mental illness).

diversion. There are two distinct definitions that apply to the usage of the word in the text. The first, and most prevalent, means removing someone from the traditional track or expected process of the criminal justice system; police diversion (or pre-arrest diversion) means that the person is not taken into custody but either taken home, to some treatment or support system, or simply released in lieu of charging the person with a crime. Jail diversion means a judicial decision that pretrial release or probation is more appropriate than incarceration.

In Chapter 3: Pretrial Issues, Adjudication and Sentencing, however, there is a narrower definition employed, usually called "pretrial diversion". This term of art describes a process whereby prosecutors—and only prosecutors—may decide that bringing the full force of the justice process to bear in a particular instance is not warranted. This can occur for a number of reasons; the prosecutor might decide that since the defendant is a first-time offender and the charge is minor, it is simply not worth the systems time and resources to prosecute. Or the prosecutor might feel that having an offender go through the system would do the person more harm than good and society would, in the end, pay the price.

Usually when this second definition is used, there is a program that the defendant enters as part of a contract entered into between the defendant and the prosecutor. The defendant agrees to comply with certain conditions on his behavior for a fixed period of time; the state agrees to drop the charges if the defendant is successful.

jails and prisons. Jails are usually defined as the facility of incarceration that is used primarily for people awaiting trial and for those sentenced to short-usually one year or less-terms of incarceration. Jails are typically run by the county. The average

length of stay in jails is brief, measured in days rather than months or years, when compared with prisons. In most instances it is difficult to predict how long an individual will remain in jail, since many are there simply because they have not yet been able to make bail. Jails over the period of a year will have a much higher number of discrete individuals entering and leaving the facility than do prisons.

Unlike jails, prisons are state-operated and typically hold only those persons sentenced to over a year. Unlike jails, where there is a mix of pretrial and sentenced persons in the population, all people entering prison have fixed sentences defining how long they will remain incarcerated. The average lengths of stay in prison is always measured in years.

The inmate with a mental illness in a jail is there for a short period of time, is exposed to large numbers of inmates coming and going, is rarely able to become involved in an effective treatment protocol since their stay is likely to be short, and may have little understanding of why they are incarcerated, all contributing to a high level of stress and anxiety. The prison inmate on the other hand has time to develop a pattern for his days and usually has access to treatment for his illness. On the other hand, he will likely be incarcerated for years and will face numerous difficulties in adjusting to the outside world when finally released.

mental health. A state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with diversity. One person's understanding of mental health may differ from another's based on cultural values and other factors.

mental illness. The term that refers collectively to all diagnosable mental disorders.

mental disorders. Health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning such as Alzheimer's disease, depression, and Attention-Deficit/Hyperactivity Disorder.

Serious Mental Illness (SMI). A term defined by federal regulations that generally applies to mental disorders that interfere with some area of social functioning.

Severe and Persistent Mental Illness (SPMI). About half of those with serious mental illness were identified as being even more seriously affected, with diagnoses that includes schizophrenia, severe depression, bipolar disorder, panic disorder, and obsessive-compulsive disorder. Approximately 5.4 percent of the adult population is affected by SMI while roughly 2.6 percent of the population is affected with SPMI.

19. Definitions concerning mental health and mental illness are courtesy of the U. S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General, Rockville, MD: 1999, pp. 4-5; 46.

The policy statements in the report are divided into two parts. Part One is organized according to events on the criminal justice continuum that provide significant opportunities to change the course of involvement a person with mental illness might have with the criminal justice system.²⁰ The first event (and the corresponding policy statement) addresses the obligation of the mental health system to minimize the frequency with which a person with mental illness comes into contact with police. Subsequent policy statements describe options that should be available and policies that should be in place for law enforcement, courts, corrections, and community corrections officials encountering people with mental illness.

Four themes recur throughout the first part of the report: 1) improving collaboration; 2) training staff; 3) building an effective mental health system ; and 4) measuring and evaluating outcomes. The policy statements in Part Two of the report are organized according to these overarching themes.

About the Target Population

The policy statements and recommendations for implementation in this report contemplate a broad spectrum of the population with mental illness in contact with the criminal justice system.

The report identifies approaches for addressing issues related to the inappropriate involvement of people with mental illness with the criminal justice system. It does not, however, set out to exonerate all people with mental illness of any wrongdoing, nor does it intend to insulate them from the consequences of their actions. Some people with mental illness may commit crimes for which they, like anyone else, should be arrested, prosecuted, or imprisoned. In these, as in all serious criminal cases, prosecutors, judges, and juries should consider all available evidence and decide accordingly. With this in mind, this report

Understanding the Target Population

Every person with mental illness who comes into contact with the criminal justice system is in some way unique. Many of the report's recommendations are based on this premise. The report also recognizes that the vast majority of people with mental illness function appropriately in the community and commit no crimes. Just the same, some generalizations can be made about the people with mental illness who are the focus of this report. They frequently are the poorest and most disabled citizens in the community.²² Many are homeless or inadequately housed.²³ In many communities, they are overwhelmingly people of color.²⁴ They face multiple stigmas, especially if they have histories of criminal justice involvement overlaid on their histories of mental illness. In many cases, they are detained or arrested for actions over which they have little choice or control, at least at the moment of apprehension. The majority uses and abuses street drugs or alcohol. Many have received little or no treatment for their mental illness.

20. This report does not attempt to discuss every event along the criminal justice continuum. Rather, specific events are discussed for which there is opportunity to change the typical interaction between a person with mental illness and the criminal justice system.

21. People who are found not competent to stand trial (and the process by which this occurs) are not the focus of this report. Although the public and some policymakers may be most familiar with cases involving pleas of not guilty by reason of insanity (or under new state laws, a conviction of "guilty but insane"), these cases in fact represent a very small fraction of the overall number of people with mental illness who come into contact with the criminal justice system. A 1996 study of the Baltimore Circuit Court estimated that of 60,432 indictments filed during one year, only eight defendants (.013 percent) ultimately pleaded not criminally responsible. All eight pleas were uncontested by the state. Jeffrey S. Janofsky, Mitchell H. Dunn, Erik J. Roskes, Jonathan K. Briskin, Maj-Stina Rudolph Lunstrum, "Insanity Defense Pleas in Baltimore City: An Analysis of Outcome," *American Journal of Psychiatry* 153:11, November, 1996, pp.1464-68.

22. P.M. Ditton, *Mental Health Treatment*. 38 percent of state and federal inmates with mental illness and 47 percent

of jail inmates with mental illness reported being unemployed in the month before their arrest.

23. Ibid. Though only approximately 5 percent of individuals with severe mental illness are believed to be homeless, Ditton found that 30 percent of jail inmates with mental illness and 20 percent of state prison inmates with mental illness reported living in a shelter in the 12 months prior to arrest; see also note 12.

24. One 1997 survey estimates that nearly 35 percent of the individuals receiving some form of mental health treatment (inpatient, residential, outpatient, etc.) are either black or Latino. Laura J. Milazzo-Sayre et. al., "Chapter 15: Persons Treated in Specialty Mental Health Care Programs, United States, 1997." The Center for Mental Health Services. An even greater percentage of the population in jail or prison that has a mental illness is disproportionately black or Latino. Sixty-two percent of prison inmates in 1999 were people of color. Black males have a 29 percent chance of serving time in prison at some point in their lives; Hispanic males have a 16 percent chance; white males have a 4 percent chance. Mark Mauer, *Intended and Unintended Consequences, State Disparities in Imprisonment*, The Sentencing Project, 1997.

How Can We Afford these Programs?

addresses people with mental illness who are at risk of involvement with the criminal justice system, people with mental illness who are charged with (or convicted of) committing misdemeanors and those who have been charged with (or convicted of) committing serious felonies.²¹

GETTING STARTED

The policy statements in this report make up a compendium of ideas, recommendations, and innovative examples that have worked well in different places around the country and therefore should at least be considered for implementation in other communities. Collectively, they provide a comprehensive vision for the criminal justice and mental health systems' response to people with mental illness. To appreciate this vision (and the range of measures that exist to begin to address the problem) and to inform an agent of change's decision of where to start, reading the entire report—regardless of the reader's area of expertise—is essential.

Unless efforts in a jurisdiction to improve the response to people with mental illness who are in contact with criminal justice system are already well-advanced, simply becoming familiar with the report's organization and the target population will not make it clear which policy statement to implement first. In fact, each policy statement is a possibility for an agent of change to consider; no single one is an essential first step to initiating change.

It will be tempting for some readers to focus only on the implementation of those policy statements over which they have the most influence. Police professionals, for example, will likely gravitate toward those policy statements that address law enforcement's contact with people with mental illness. Prosecutors may quickly fast-forward to Policy Statement 9: Prosecutorial Review of Charges.

Although focusing the application of the report in a community to a limited number of policy statements, at least at the outset, is probably advisable, readers should not overlook a central message of this document: actions that law enforcement, courts, or corrections officials take have ramifications for the entire criminal justice system. For example, how a police officer responds to an incident involving a person with a mental illness informs the decision that a

State and local government officials will likely be wary of implementing many of the policy statements in this report, which may appear to hinge on the infusion of new federal, state, or local funds. Practitioners, policy-makers, and advocates, however, should not allow such concerns to stifle plans for new programs, policies, and legislation.

As indicated earlier in the introduction, the resources that the criminal justice and mental health systems currently allocate to arrest, hospitalize, prosecute, and incarcerate people with mental illness who are in contact with the criminal justice system is staggering. For example, officials in King County, Washington determined that, over the course of one year, 20 individuals were repeatedly hospitalized, jailed, or admitted to detoxification centers, costing the county approximately \$1.1 million.²⁵

Experience in Chicago, Illinois is one of the many examples that demonstrate that an effective program can have a dramatic impact on jail and hospital expenditures. Staff from the Thresholds Jail Program, which provides case management for people with mental illness released from jail, calculated the number of days that 30 people who had been through the program were incarcerated and/or hospitalized in the year after their participation in the program. In total, the 30 individuals spent approximately 2,200 days less in jail (at \$70/day) than they had during the year preceding their participation in Thresholds. These same 30 people also spent about 2,100 fewer days (at \$500/day) in hospitals.²⁶ Although this significant savings in jail and hospital days (which, on paper, equals about \$1.1 million) is not necessarily realized in reduced budget costs to any agency, it does effect a vastly improved use of resources for the jail and area hospitals.

Many of the examples cited in this report have demonstrated a reduction in jail and hospital days for people with mental illness who had formerly cycled among various institutions. These jail, prison, and hospital beds are among the most expensive resources available to the criminal justice and public health systems. In sum, when it comes to people with mental illness and the criminal justice system, policymakers simply can't afford not to do business differently.

25. Information provided by Patrick Vanzo, Section Chief, Crisis and Engagement Services, Mental Health, Chemical Abuse and Dependency Services Division, King County Dept. of Community and Human Services.

26. Information available at: www.thresholds.org.

prosecutor makes in charging the defendant, which, in turn, is an important factor a judge will take into account when setting bail. Corrections administrators rely on information obtained during the pretrial phase and at sentencing to develop a treatment plan while the inmate is incarcerated; reports regarding the extent to which such a plan is successful inform community corrections authorities' release decisions and plans for supervision of a person with mental illness released to the community.

Considering the implementation of the policy statements that, on their face, appear to address the mental health system only is also essential. Just as criminal justice professionals must appreciate a system-wide response to the problem, so must they appreciate what needs to happen for the mental health system to be *accessible* and *effective*. A community mental health system that does not meet these two criteria is unlikely to successfully engage an individual with mental illness in treatment, and thus will quickly cause criminal justice officials to lose confidence in the community's capacity to support people with mental illness.

Policy makers (such as legislators or county executives) whose authority spans many or all of the recommendations in the report, will wonder which policy statement to implement first. For them and other agents of change, deciding where to start—especially when familiar with the existing obstacles to improving the systems—can be difficult. In more than one community, reform efforts have been derailed before really getting under way because those involved could not decide where to begin. Similarly, attempting to implement many or all of the policy statements in this report at once could overwhelm a community.

Aside from differences in the size and nature of the jurisdictions where the problem plays out, there is great variability in the history, politics, resources, and leadership of each community. These are the factors that typically steer agents of change to distinct policy statements.

The single, most significant common denominator shared among communities that have successfully improved the criminal justice and mental health systems' response to people with mental illness is that each started with some degree of cooperation between at least two key stakeholders—one from the criminal justice system and the other from the mental health system. Accordingly, deciding where to begin will depend on the people brought together to address the problem and the resources available to them in their community.

In sum, sparking a dialogue and cultivating a relationship between criminal justice and mental health stakeholders is, for those communities where such collaboration does not already exist, where the agent of change should start. Similarly, criminal justice or mental health professionals should avoid forging ahead with the implementation of a particular policy statement with-

out first ensuring that their action plan has taken into account the implications for the entire criminal justice and mental health systems.

For these reasons, getting started translates into facilitating communication and building cooperation among criminal justice and mental health stakeholders. A precedent for such cooperation and communication that involves criminal justice or mental health stakeholders exists in nearly every community. Indeed, policymakers and practitioners typically appreciate the value of collaboration, and they invariably have some experience seeding or maintaining an effort that depends on two or more organizations working together.

Still, effecting collaboration between the criminal justice and mental health systems can be particularly vexing. Accordingly, the remainder of this introduction reviews important issues to consider for communities where representatives of the two systems have yet to begin working together or where such efforts have stalled.

Recognizing the Complexities of the Mental Health System

Exploratory discussions with stakeholders in the mental health system will, sooner or later, focus on their capacity to make mental health services available to those who need them most. Before an agent of change reaches out to representatives of the mental health system, it is essential that he or she appreciate how the mental health system works.

As mentioned earlier, the advent of new treatments and service system models is, in many ways, revolutionizing the mental health system. No less dramatic has been the change in orientation from grim acceptance of the supposed irreversibility of the decline associated with mental illness that characterized all thinking about the condition just a few decades ago to the burgeoning belief in recovery today expressed by researchers, clinicians, advocates, families, and—most of all—consumers. Recognition that people with mental illness can and do get better has given hope to many individuals. It is also changing the way people think and talk about mental illness and thus altered the course of policy.

With a foundation of hope and recovery, the system sees reintegration into the community as perhaps its highest priority. Clinical decisions, funding structures, and other incentives are aligned in many places to direct people with mental illness toward community integration. Administrators, advocates, consumers, and experts see hospitalization as a costly alternative residing at the far end of a continuum that should include a rich offering of community-based interventions. Agreement in the field dissolves, however, when stakeholders discuss where to turn when mental health treatment systems have failed to successfully engage an individual in treatment. Conflicting views on involun-

"Remarkable treatments exist, and that's good. Yet many people—too many people—remain untreated. Some end up addicted to drugs or alcohol. Some end up on the streets, homeless. Others end up in our jails, our prisons, our juvenile detention facilities."

**PRESIDENT
GEORGE W. BUSH**

Source: Remarks by the President on Mental Health, April 29, 2002.

University of New Mexico Continuing Education Conference Center
Albuquerque, New Mexico

tary commitment illustrate this tension. Some see involuntary inpatient or outpatient treatment as the ultimate intrusion, a dehumanizing deprivation of rights to be avoided at all costs. Others hail involuntary treatments as necessary and lifesaving tools that must be employed when an individual's judgment is impaired. Most in the field feel torn and seek a balance that respects both realities.

The trend away from hospitalization and the embrace of recovery have led to a new view of the place of control in mental health treatment. Just as laws and policies in effect in most states steer mental health clients toward treatment in the "least restrictive setting," so do treatment professionals speak of ensuring patients the greatest possible degree of control over their own treatment choices. In recent years, mental health advocates and professionals have reexamined the use of coercive measures in mental health treatment settings. Many practitioners have worked hard, for example, to reduce the use of restraints and punitive seclusion in clinical settings, recognizing that they have no therapeutic value and can only be justified when physical safety is at issue, and laws and regulations have been rewritten to reflect this new understanding. Appreciating the mental health system's views regarding coercion may be particularly difficult for someone working in the criminal justice system, where coercion is inherent at every juncture to ensure people obey laws and follow rules. Yet, the use—and perceived use—of coercion has become the subject of much concern and debate within the mental health community. Most of the recommendations offered in this report address issues that arise when people with mental illness are in contact with—or are under control of—the criminal justice system, and they reflect the powers at that system's disposal. By the same token, the report takes into account the mental health system's values and largely steers away from making recommendations that would apply coercive measures to people with mental illness on whom the criminal justice system has no hold.

In addition to understanding key values of the mental health system, an agent of change should become familiar with its complex organizational structure. Understanding how a system is organized largely depends on learning how it is funded. When it comes to the mental health system, this can be a true challenge. No rational organization chart can possibly be drawn that accurately depicts the administration and delivery of mental health services in this country. In contrast to the criminal justice system, which has a fairly straightforward structure, the mental health system draws revenue from a dizzying variety of sources: Medicaid, Medicare, state general revenue funds, local matches, federal Mental Health Block Grants (grants administered by three or more federal agencies), and patient fees, just to name those most common. In some states, funds are funneled through managed-care frameworks. In others,

counties present an additional level of administration. “System,” indeed, may be a misnomer for what is often a patchwork of programs, services, and complex funding structures.

Solutions to many of the problems encountered by the criminal justice system might logically be found in the mental health system. Sadly, the mental health system in too many places has been too beset by internal challenges and lack of support to address some of the most visible signs of its failure. For the public mental health system to assist the criminal justice system in addressing the needs of people with mental illness, policymakers and community change agents will need to ensure that it has sufficient resources and public support.

Getting Criminal Justice and Mental Health Stakeholders to the Table

In some jurisdictions, the greatest challenge to initiating successful cross-system collaboration is simply getting prospective partners to the table. Often, successfully assembling key leaders in the jurisdiction depends on the stakeholders appreciating what the improved collaboration can produce.

Benefits likely to appeal to key leaders in the mental health and criminal justice system include the following:

- Improve the lives of people with mental illness and reduce the frequency of their contact with the criminal justice system
- Enhance public safety
- Use criminal justice resources more efficiently
- Improve the safety of line staff and of the environment in which they work
- Reduce taxpayer expenditures
- Increase public confidence in the justice system
- Gain access to resources
- Enlist allies capable of attracting support from policymakers previously unmoved by the need to bolster the mental health system.

In addition to these gains, collaborative discussions will themselves increase understanding and reduce the assignment of blame. Tight budgets and growing problems have led to friction among criminal justice practitioners, mental health professionals, and advocates in many communities. Bringing all parties together to address the problems can be painful, but it is the only way to engage in problem solving effectively.

27. California Board of Corrections, *Mentally Ill Offender Crime Reduction Grant Program: Annual Report June 2000*, Available at: www.bdcorr.ca.gov/cppd/miocrg/miocrg_publications/miocrg_publications.htm

There are concrete means of eliciting commitments from stakeholders to work together. Making funding support contingent on such cooperation is one way. For example, in California, the legislature sought to foster a collaborative response to the inappropriate involvement of individuals with mental illness with the criminal justice system by establishing crime reduction grants. To receive these grants, counties must create a diverse strategy committee to develop a comprehensive plan of cost-effective measures to reduce crime and the criminal justice costs associated with individuals with mental illness.²⁷

Legislation also can prompt joint ventures through the establishment of task forces, which bring together all relevant stakeholders and develop a foundation for future cross-system partnerships to improve the criminal justice system's response to people with mental illness. An increasing number of state legislatures (and in some cases governors) have taken such steps.

For example, in Colorado, following several independent studies of mental illness in the criminal justice population, the state general assembly created a task force to examine how people with mental illness in the criminal justice system are treated. This task force consisted of more than two dozen members, including representatives from the judicial system, the corrections system, local law enforcement, mental health services, the legal community, consumers, and family members of consumers. The general assembly also established a six-member legislative oversight committee that monitors the work of the task force and submits annual reports, including legislative proposals.²⁸

Sometimes opportunities to engage potential partners and to form a core group of prospective partners emerge from a high-visibility incident. A well-publicized tragedy involving a person with a mental illness and the criminal justice system often generates an atmosphere of crisis, in which elected officials feel pressured to promote quick solutions, which are likely to overlook complex, effective responses. Accordingly, decision makers should use such incidents to stimulate follow-up responses that are long term and thoughtful. To that end, in the wake of such tragedies, community and government leaders should ensure that organizations begin discussions about working together more closely.

A tragedy in Seminole County, Florida, in 1998 prompted such a response. A deputy in the sheriff's office was shot and killed as he approached the residence of Alan Singletary, who had a history of mental illness and whose family had for years sought help for him. After a 13-hour standoff, Singletary was also killed. This tragic incident highlighted many of the deficiencies of Seminole County's mental health delivery systems that are common to many communities: inadequate coordination of services, lack of resources, and insufficient information available to officers in the field and at the scene of a crisis. In

28. The task force was subsequently instructed to examine ways to improve the treatment of persons with mental illness who are detained in pretrial detention facilities. The task force was also instructed to examine the treatment of

mentally ill individuals in the juvenile justice system. See www.state.co.us/gov_dir/leg_dir/lcsstaff/2001/comsched/01MICJSched.htm#committee

response, the sheriff established a task force that meets monthly to discuss system coordination issues as well as potential legislative proposals. The task force includes the state attorney, the public defender, probation officials, the Seminole Community Mental Health Center, representatives of the judiciary and the County Commission, and other various stakeholders. The slain deputy's widow, Linda Gregory, and Alan Singletary's sister, Alice Petree, also serve on this task force.

Defining the Scope of the Problem(s)

Once a core group of stakeholders has made a commitment to improve the criminal justice and mental health systems' response to individuals with mental illness, they need to identify and focus their shared objectives. Leaders of successful partnerships state time and again that, long after launching their joint venture, reminding each other of the mission that originally focused the initiative has enabled them to overcome disagreements or missteps that subsequently threatened the collaboration.

In defining the problem, stakeholders may agree on a limited number of discrete goals, and the problem-solving approach may require a partnership between just two organizations. For example, in Connecticut, the court and the Department of Mental Health and Addiction Services (DMHAS) focused their attention on the inability of judges to obtain a mental health assessment of a defendant or to gain access to mental health treatment for the defendant in a timely manner. (In attempting to address the problem independently, judges were ordering an examination for competency to stand trial, which resulted in the hospitalization of the defendant for a minimum of three weeks.) The partnership between the judiciary and the DMHAS led to the deployment of mental health clinicians to each court to conduct on-site assessments shortly after arrest and to arrange for treatment in the community as a condition of pretrial release.

In some cases, agents of change may determine that the circumstances call for a coalition comprising a diverse group of stakeholders spanning much of the criminal justice and mental health systems. Such a coalition may be necessary when the core group of stakeholders establishes that the problem is large in scope and requires multiple responses. In other cases, leaders in the community may have succeeded in narrowly defining the problem, but they recognize that potential responses (or the issue itself) are controversial and certain to draw the attention of the media. In this event, a broad coalition ensures diverse support for an initiative that could attract criticism.

The success of such groups depends, in part, on the number of stakeholders involved and on the diversity of perspectives—including representatives of criminal justice and mental health entities from state and local government, private mental health professionals, victims, advocates, and consumers and their families—committed to the coalition’s success.

Conducting a Community Audit

A community audit will enable criminal justice officials to identify the mental health system representatives in their jurisdiction—including large and small service providers and those that serve isolated, ethnic, or low-income communities. In conducting this audit, partners should also identify providers outside of the mental health community who deliver services to some of the same clients. Drug treatment providers and low-income housing administrators are two examples.

Good sources for conducting the audit include larger mental health clearinghouses or providers, the Internet, the yellow pages, the news media, and staff within the criminal justice agency. Criminal justice officials should also contact agencies and organizations of which they are members, officers, board members, or trustees. The audit should apply a snowball approach, where identified contacts are asked to contribute names of additional relevant stakeholders.

In addition to leads identified during the local audit, organizations with a national perspective, including national membership associations, can provide some additional valuable referrals.

Ensuring the Investment of the Principals

Whether part of a collaborative effort between just two organizations or a member of a broad-based coalition, each organization should be represented by the chief executive or his or her designee. Involvement by the principals signals to their subordinates and other stakeholders that the organization is committed to the initiative.

The chief executive for a police department (chief, sheriff, or public safety director), the courts (presiding judge), the prosecutor’s office (district attorney), the local jail, or another criminal justice entity is likely to be fairly obvious. The lead individual in mental health circles, however, may be less apparent. Agents of change should turn to existing cross sections of mental health organizations, such as county-level mental health planning committees, for assistance in identifying an appropriate leader in the mental health community.

NEXT STEPS

With a coalition in place and the principals invested in improving the criminal justice system's response to people with mental illness a window of opportunity now exists. Capitalizing on this momentum is essential. In this regard, the subsequent chapters of this report can be extremely helpful. They provide a thorough discussion of the opportunities available to law enforcement professionals, court officials, corrections administrators, and mental health providers to identify and respond appropriately to people with mental illness.

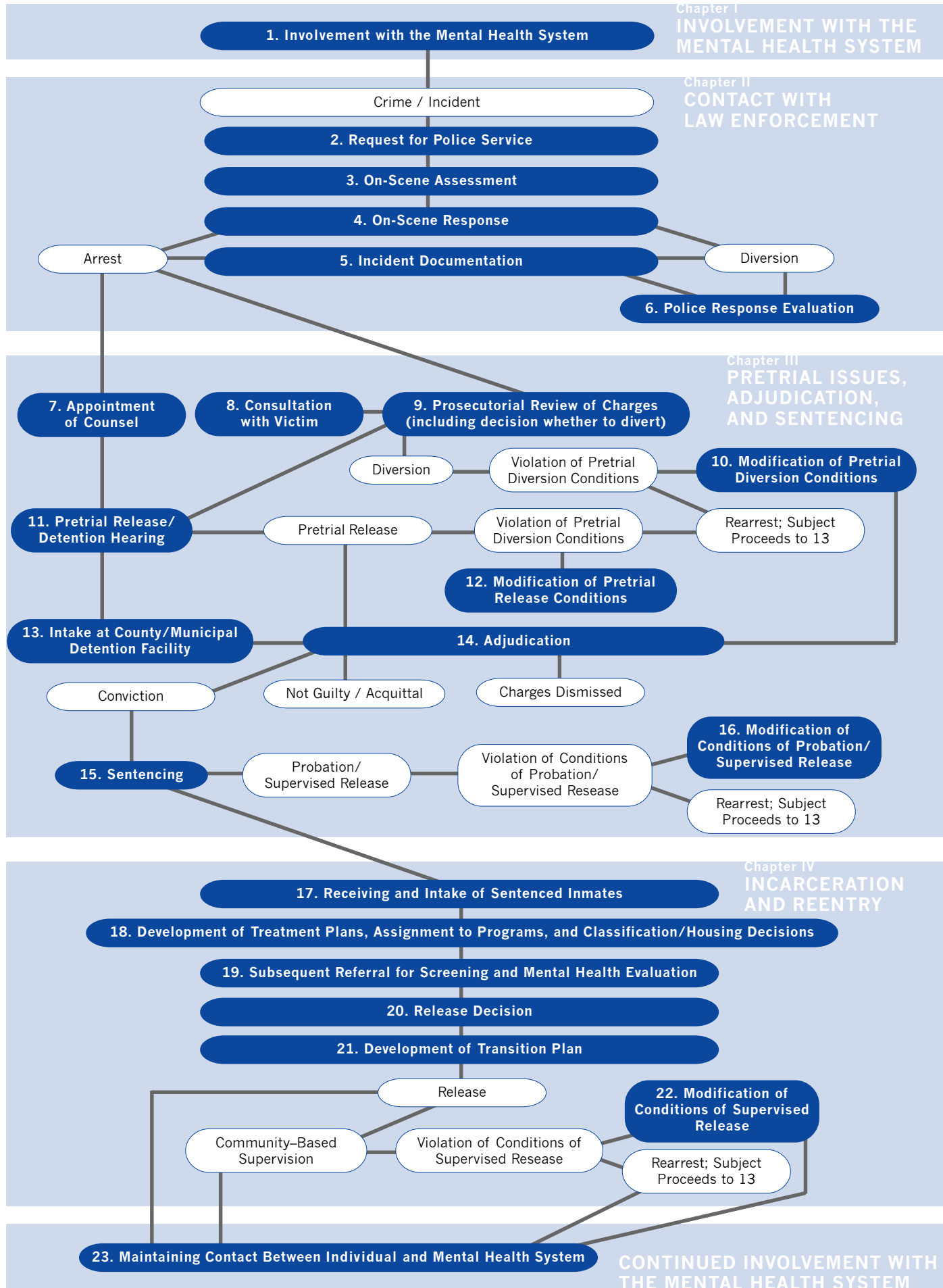
Part ONE:

Select Events on the Criminal Justice Continuum

The following section of the report presents policy statements corresponding to various events on the criminal justice continuum. The report does not address every possible event on the continuum. Instead, particular events were selected because of the opportunity each presents to improve the response to people with mental illness who are in contact with (or at risk of coming in contact with) the criminal justice system.

The flowchart on the next page serves as a useful guide when reading part one. Each event addressed in the report appears on the flowchart in a blue bubble and is preceded by an Arabic numeral. Events that appear in clear bubbles are not specifically addressed in the report (e.g., acquittal). They are included in the flowchart to help the reader follow the course of an individual's progress through the criminal justice system.

A Person with Mental Illness in the Criminal Justice System: A Flowchart of Select Events



Involvement with the Mental Health System

Law enforcement officers, prosecutors, defenders, and judges—people on the front lines every day—believe too many people with mental illness become involved in the criminal justice system because the mental health system has somehow failed. They believe that if many of the people with mental illness received the services they needed, they would not end up under arrest, in jail, or facing charges in court. Mental health advocates, service providers, and administrators do not necessarily disagree. Like their counterparts in the criminal justice system, they believe that the ideal mechanism to prevent people with mental illness from entering the criminal justice system is the mental health system itself—if it can be counted on to function effectively. They also know that in most places the current system is overwhelmed and performing this preventive function poorly.

Policy Statement 1 and the recommendations that follow describe the role that should be played

by the mental health system *should* play in helping people with mental illness avoid inappropriate contact with the criminal justice system. For the most part, they reflect general principles and do not delve into areas of detail similar to those found elsewhere in the report. Readers may know whether the services described in this section are available in their communities; if large numbers of people with mental illness are in contact with the criminal justice system, it is likely that necessary services are lacking.

Chapter VII contains a comprehensive examination of the elements of an effective mental health system, upon which implementation of many of the policy statements throughout the report depend.

1

Involvement with the Mental Health System

POLICY STATEMENT #1

Improve availability of and access to comprehensive, individualized services when and where they are most needed to enable people with mental illness to maintain meaningful community membership and avoid inappropriate criminal justice involvement.

There are communities across the country where appropriate and necessary mental health services were never developed, have closed down, or for some other reason are not available. In large cities, the wait for an appointment with a mental health professional may be measured in months, while in small rural communities the responsible agency may be based in a town many miles across the county. In either case, it cannot be said that mental health services are available when or where they are most needed.

To be effective, services must meet the immediate needs of those who seek them. They must be comprehensive, meaning they must be prepared to

address the full range of issues presented by an individual with mental illness. They must also be flexible enough to be tailored to each person who enters the system. In highlighting the need for improved access to mental health services, advocates, providers, and others in the mental health field frequently use these two phrases. On first glance, these terms may appear to be contradictory, but the two concepts can be entirely complementary. A wrong door policy addresses the critical need to engage people in care while a single point of entry is a mechanism for integrating services in response to an individual's complex needs. (See sidebars on the following pages for more on the concepts.)

RECOMMENDATIONS FOR IMPLEMENTATION

a Provide user-friendly entry to the mental health system for those who need services.

It is sometimes said that the mental health system has many doors and all of them are closed. To address this problem of access, some systems have found it most effective to designate a single agency as the gatekeeper or controller of entry to the system. Depending on such variables as geography and governmental structure, gatekeepers can take many forms. In some states, for

example, a county-based system may be structured so that a single multiservice agency is responsible for all mental health services. By virtue of its franchise, it becomes responsible for gatekeeping as well as for providing services. In other states, multiple agencies may provide services, but one may be designated as the point of entry, with responsibility for linking each client to those services appropriate to his or her needs. There are many manifestations of this concept, but the organizing idea is to make entrance into the system as user-friendly as possible.

This kind of arrangement encourages service integration, cuts down on conflicts and redundancies, and promotes more efficient use of resources. Most of all, it works to create a pathway through the system that, ideally, delivers to each client the mix of services that best meets his or her needs.

Example: New York State Office of Mental Health

The New York State Office of Mental Health has asked local governments in the state to establish a single point of entry (SPOE) system covering case management and housing services. Intended to coordinate services for individuals with multiple needs, the SPOE system is intended to allow communities to build on the strengths of their existing systems. In addition to the primary purpose of coordinating and integrating services, SPOE provides a platform from which improved data collection can take place, leading to identification of performance indicators for evaluating system outcomes.

“Without better mental health care, better partnerships and an improved focus in criminal justice, we can expect unacceptable outcomes to continue...inappropriate police encounters; unnecessary arrests and incarcerations; delayed release from jails and prisons; increased recidivism of persons with mental illnesses to the criminal justice system; and delayed or lack of needed mental health treatment.”

MIKE HOGAN

Director, Ohio Department of Mental Health and Chair, New Freedom Commission on Mental Health

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*. September 21 2001

b

Expand priority service definitions to include more people with mental illness who are at risk of criminal justice involvement or who have histories of criminal justice involvement.

One way many states have limited the potential cost of mental health services is by identifying and defining a priority population for those services and then targeting resources to that population. Only by meeting the priority population definition can one access mental health services in most states. Usually, the priority population has been defined by such characteristics as diagnosis and functional limitation, which in theory translate easily to a hierarchy of need. Sometimes, however, focusing services on a priority population has a perverse ancillary effect. The complicated diagnostic picture of many of those who are homeless and/or coming into contact with the criminal justice system at times pushes the boundaries of existing priority population definitions. Where financial or capacity pressures are straining the system, people with complex problems are sometimes screened out in favor of those who only have a mental illness that clearly fits within the priority definition.

Policymakers and providers need to address the questions of who falls within the priority service population and what to do for those people with serious problems who do not fit established priority categories. It is important that policymakers recognize not just the growing potential of science, medicine, and rehabilitative services, but also their limits. A thorough understanding of these dynamics is difficult for policymakers to achieve, not the least because this is an area in which change is occurring very rapidly. As science and mental

health practices advance, policymakers will need to keep pace so that our systems are not—as they are in so many states today—artifacts of a time when far less was known about mental illness and the treatments available for it.

One way to ensure that resources are available to serve people with complex problems who have typically been overlooked by the mental health system and thus are at risk of involvement with the criminal justice system is simply to identify them as a priority population and place them first in line for services instead of last. To do this would mean targeting resources that do not now go to this population. It is a very complicated task to find funding from a variety of federal and state sources for the comprehensive treatment this population is likely to need. Because practice in many places has been to ignore this population and therefore to avoid grappling with the difficulties involved with treating them, expansion of the priority service definition will need to be closely monitored for effectiveness as well as such unintended consequences as the deprioritizing of other needy groups.

Indeed, the possible consequence of expanding the priority population that most alarms advocates, consumers, and many others with a stake in the system is that services for people with mental illness who are law-abiding, adherent to treatment, and in many ways less obvious to those outside the system will fall in priority or even be supplanted by those for the criminal justice population. With mandates to serve more difficult patients and no increase in overall mental health system resources, this is one very possible outcome. It is an outcome to be avoided because this law-abiding population, easier to serve though they may be, has been less apparent precisely because the system has worked effectively for them.

Example: Maryland Mental Hygiene Administration

In developing services for people with mental illness who have been in county jails, Maryland's Mental Hygiene Administration, the state's public mental health authority, arrived at the assumption that one population was being served, regardless of an individual's history of incarceration. Such issues as treatment for mental illness or substance abuse as well as the need for housing were substantially the same for those who had been jailed as they were for others in the mental health system. By automatically including people with mental illness and histories of jail time in the priority population, Mental Hygiene Administration officials found they were able to deliver services more effectively, while at the same time reducing recidivism to local jails.

No Wrong Door

No wrong door refers to a service system that welcomes people in need wherever they try to gain access. Persons with mental illness often have a broad array of associated health, social service, and support needs. Not knowing the mission of an agency or the relationship between agencies, they may present different providers with any one of a number of concerns. "No wrong door" policies commit all service agencies to respond to the individual's stated and assessed needs through either direct service or linkage to appropriate programs, as opposed to sending the person from one agency to another until he is able to establish a connection with the system. Many people with mental illness lack the capacity to navigate the complicated array of services or they may feel rejected in their efforts to obtain help. Discouraged, they simply drop out of the system and join the ranks of untreated, homeless people with mental illness who come into frequent contact with the criminal justice system. A no wrong door policy accepts that the first step toward successful mental health care is engaging the individual.¹

C

Improve access to appropriate services by people with mental illness who are at risk of criminal justice involvement.

People with mental illness do not always seek treatment in the same way someone suffering from acute physical pain might. Sometimes they don't know where to turn for help, or perhaps they don't realize they need it. In fact, some-

1. See National GAINS Center, *Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System*, December, 1999, p. 12

Single Point of Entry

A single point of entry is a mechanism for ensuring an individual gets the appropriate range of services. The "single point of entry" system accepts the burden of integrating services rather than placing that burden on the individual. It places responsibility with a designated agency to oversee each client's movements through the different services and programs available in a given community. The care that person needs can then be coordinated, even when more than one agency is involved in providing it. An individual with multiple needs who seeks care in a community with a "no wrong door" policy may be referred to a "single point of entry."

times they actively avoid it. For this reason, providers of mental health services must be creative and opportunistic in their approach to some who are in need of treatment.

For many, the mental health system is invisible and unknown. A person who shows signs of a mental illness may have no idea where to call for information or treatment. More shockingly, family doctors and other professionals in the community may be unfamiliar with local mental health agencies. Mental health providers need to maintain and improve community contacts so that finding help is an easily navigated process. Referrals from other agencies, housing and homeless assistance agencies or substance abuse treatment and detox centers, for example, should be welcomed by mental health providers. Rather than apply rigorous screening so that all but a few are excluded from the system, mental health providers should actively seek out cases. To serve a community effectively, public mental health agencies should be as visible and active as any health care resource.

When the affected individual doesn't realize help is needed, a family member or someone else in the community may reach out to a provider agency. In such instances, the agency should be responsive. If the individual will not go to the agency's intake facility, outreach staff from the agency should visit the person wherever he or she is and, if appropriate, they should be able to access acute care hospital beds or crisis intervention services. Similarly, if the person is homeless or without apparent social support, agency staff should make efforts, repeated, if necessary, to engage him or her in a setting where that individual is most comfortable.

For outreach to be effective, it must be done in a culturally appropriate manner. Certainly, an outreach specialist must be able to use the individual's primary language. Yet, as has been increasingly understood throughout the mental health system, cultural competency involves the ability to listen to each individual and pick up cues that are culturally based. By meeting an individual's needs in a culturally sensitive manner, providers significantly increase the likelihood that that person will accept and continue services.

d Identify specific needs of individuals with mental illness who are at risk of criminal justice involvement or who have histories of criminal justice involvement and match services to those needs.

Each individual has needs that are particular to him or her. While the central need may be treatment for serious mental illness, other needs are frequently associated with it, including treatment for alcohol or substance abuse; treatment for HIV/AIDS or other illnesses or disorders; affordable housing; income assistance; and/or employment services. Not all needs are immediately evident, so a full assessment should be undertaken. This may certainly be focused on the need for mental health treatment and services, but it should by no means be limited exclusively to that arena. The use of illicit substances by a

person with mental illness markedly increases his or her risk of contact with the criminal justice system and must be assessed. The presence or absence of various supports in a person's life should always be thoroughly understood by treatment providers who are designing treatment plans. Similarly, as much as possible should be learned about the individual's history of treatment and incarceration. Not only will knowledge of this history be helpful in gaining a broad understanding of a person's condition and status, it could help in forging links with past or even current providers who can offer further insight useful in treatment. In building a person's history, mental health professionals should also try to learn whether or not the subject has been the victim of physical or sexual abuse. Understanding this part of a person's history can help immeasurably in designing effective services for that person.

Mental health treatment interventions are most effective when they are tailored to an individual's particular needs. It is clear that provider agencies must be staffed and organized to provide multiple interrelated services to the individuals they serve. For example, mental health agencies in many places have added staff expertise in the social supports needed by many clients with serious mental illness precisely so that services tailored to meet those needs can be offered. Substance abuse expertise is needed to address the large percentage of persons with co-occurring mental illness and substance abuse disorders. By providing an array of services that can be tailored to each individual's needs, agencies are more likely to keep clients engaged, enabling many to develop the skills or contacts necessary for them to live successfully in the community.

Ideally, the public mental health system should function as part of a broader public health system that identifies problems in their early stages and takes steps to prevent their exacerbation. To do this effectively, the system must include a full array of services, including linkage with community resources traditionally seen as residing outside the mental health system. A community in which a full range of services is not available will find itself facing preventable problems, evident in the numbers of encounters between people with mental illness and components of the criminal justice system.

When clients find the services they receive to be helpful and meaningful, they are far more likely to continue them. For many people with mental illness, developing this sense of connection is extremely important. Because individually tailored services lead to more sustained engagement in mental health treatment, they are a critical link in preventing inappropriate criminal justice involvement.

A person with mental illness needs to gain access to appropriate services repeatedly. Services are successful only if they are sustained over time. A provider agency's role, therefore, does not end with identifying services and providing referrals. Success of an intervention often rests on the level of support provided to a person with mental illness who is striving to follow his or her treatment plan. For the difficult-to-engage person who is most at risk for criminal justice involvement, this kind of support can often be quite intensive. Frequently, it

means repeated outreach to the individual, often through such treatment models as Assertive Community Treatment (ACT) or intensive case management. For very ill individuals, it can mean access to acute care and inpatient services when needed. And it cannot be emphasized enough that such support must go well beyond purely treatment-related needs to supports such as housing, employment or education assistance, and transportation supports that will enhance the likelihood of a person living successfully in the community.

e

Draw funding for mental health services from a variety of public sources.

Delivery of comprehensive mental health services at the community level requires a significant investment of public resources. Effective community mental health service providers have learned that they must draw from a variety of sources if they are to offer a full spectrum of services. As discussed later in this document, funding for mental health treatment and associated supports in a typical community may come from several different federal agencies, state general fund allocations, and local tax levies.

Resourceful administrators have learned how to use scant state and local funds to leverage money from other sources and to maximize revenues from federal programs such as Medicaid. They look to the U.S. Department of Housing and Urban Development for funds to provide housing for their clients, and they try to join federal block grant funds for mental health and substance abuse treatment with other sources in order to provide integrated services for co-occurring substance abuse and mental disorders. Even the most artful administrators at the provider, county, or state system levels have difficulty matching resources to need. While agencies and systems survive by identifying and tapping a range of sources, the inescapable conclusion is that funding limitations in many communities prevent the public mental health system from making a full range of effective services available.

Broad implementation of the kinds of comprehensive, individualized services briefly described in this section services that have been successfully implemented in some communities around the country will result in fewer people with mental illness coming into contact with the criminal justice system. Provision of necessary treatments and supports is the most effective precontact diversion from the criminal justice system for people with mental illness.

Contact with Law Enforcement

Law enforcement engaged in today's community policing efforts inevitably provide citizens with services that go well beyond enforcing laws or maintaining public safety and order. Police are first-line, around-the-clock, emergency responders, mediators, referral agents, counselors, youth mentors, crime prevention actors, and much more. Among their growing responsibilities have been responding to people with mental illness. All too often, individuals' inadequately treated mental illness is manifested in ways that can result in their contact with police—sometimes with tragic results.

What may begin as a call from a business owner to “do something” about the unkempt young man pacing in front of his store, or community demands to keep individuals from sleeping on park benches—to the more extreme 9-1-1 report from a frightened caller that his or her loved one is threatening to hurt someone, or him-or-herself—will prompt a police response that can result in myriad outcomes. Officers on patrol will themselves encounter those who seem to be in crisis or are in violation of some “quality-of-life” law, such as urinating in public or sleeping in doorways. How po-

lice respond to such individuals can have a tremendous impact on how encounters will be resolved and on what future these individuals can expect.

Many sections of this report focus on partnerships among criminal justice agencies, as well as between police and mental health professionals. Those partnerships may, indeed, have the greatest impact on police than on any other component of the criminal justice system. For it is police who will often provide the first contact with the criminal justice system for people with mental illness. Their actions and perceptions will often determine whether the individual will find much-needed treatment, continue in his or her current situation, or face the problems detailed in later sections that are inherent in a criminal justice system ill prepared to meet the needs of people with mental illness.

Police response at this critical first encounter will be shaped by whether they perceive a person's mental illness as a factor in the call for service; their knowledge of de-escalation techniques at the scene; and their understanding of when the nature of the crime necessitates criminal justice action or whether it is better to engage appropriate alterna-

tive resources. These and other decisions involve complex skills, knowledge, and other factors addressed in this chapter. But police simply cannot achieve meaningful reforms alone, no matter how well trained. They will need the kind of community-based mental health improvements, partnerships, and support outlined in this report if they are to have any success at all.

As mentioned earlier, it is the most sensational incidents, in which a person with mental illness kills an officer or citizen or is killed by police, that seem to shape policy, even though they are not the majority of cases that police see. In no way does this report minimize the importance of officer and public safety—they are of paramount importance. In fact, the policies outlined in this report are intended to prevent critical incidents through effective, earlier interventions. It also acknowledges those cases in which arrest is very appropriate, as with serious crimes. In those cases, the offender should be in the criminal justice system. This chapter, however, focuses most on what current policy often misses: the overwhelming number of cases in which minor nuisance crimes are largely the re-

sult of an individual's inadequately treated mental illness (and often co-occurring drug/alcohol abuse). These result in large drains on police resources, and often without any long-term solutions, for police, people with mental illness, or crime victims. This report is meant to address some of those gaps with practical guidelines for police professionals.

The following sections acknowledge that police cannot be diagnosticians or pseudo-mental health professionals—but they can help stabilize a situation, work to keep all involved parties safe (including responding officers), make effective referrals when appropriate, and improve the lives of people with mental illnesses and their loved ones by keeping them out of a system ill equipped to meet their needs. The policy statements and recommendations for implementation are meant to be tailored to the unique needs and resources of a community and police agency. They were developed to make more efficient and effective use of police resources. Most of all, they are designed to support all those police personnel who want to do the right thing, as part of their commitment to treat all citizens with dignity and fairness and to serve all members of their community.

2

Request for Police Service

POLICY STATEMENT #2

Provide dispatchers with tools to determine whether mental illness may be a factor in a call for service and to use that information to dispatch the call to the appropriate responder.

Requests for police service generally come in one of two ways: through a personal contact with an officer who happens to be near the scene or through a call to the department. This section concerns calls that are made to law enforcement agencies and handled by a dispatcher. The dispatcher is responsible for gathering information about the situation and dispatching the call to a patrol officer. The dispatch function can be managed by the police department alone or through a system shared with other emergency services.

While some law enforcement agencies will not have the power to affect dispatch policy directly, due to constraints such as shared dispatch, they may be able to change procedures through dispatcher training and memoranda of understanding between the police and dispatch service. The following recommendations address important dispatch protocols that should include policies for information gathering regarding whether mental illness is a factor in the call and the potential for violence, and using appropriate language when dispatching calls.¹

RECOMMENDATIONS FOR IMPLEMENTATION

a Provide dispatchers with questions that help determine whether mental illness is relevant to the call for service.

Determining that mental illness is a factor in a call for service is an essential first step to providing appropriate police response. The person with a mental illness may be a crime victim, an offender, a witness, or involved in a mental health crisis. Dispatchers should use standardized questions to aid the information-gathering process. These questions can appear on the computer screen or be provided in booklet format. These questions should also assess, when

1. Law enforcement agencies should document information about mental illness only when it is relevant to the encounter. Agencies should not develop databases that contain information about all people with mental illness in their community.

possible, if co-occurring disorders (especially involving substance abuse) or other issues are relevant to the call for service. Departments should collaborate with mental health providers to determine the appropriate questions dispatchers should ask callers.

Example: Pinellas County (FL) Police Department

Communications center personnel at Pinellas County Police Department receive training from the Mental Health Commission of Pinellas County on interacting with callers who may have mental illness. This training ensures that dispatchers are able to identify characteristics of mental illness and better inform responding officers.

Example: Houston (TX) Police Department

The Houston Police Department provides specialized training to its dispatchers to enable call takers to determine if the call involves a person with mental illness. This program has been combined with officer training to significantly reduce the time between the call for service and the officer arrival at the scene and to decrease the average time that people with mental illness spend in police custody.

b

Provide dispatchers with tools that determine whether the situation involves violence or weapons.

As in all calls, dispatchers should gather information to assess safety issues that the responding officer might encounter, including whether weapons are involved, whether the person poses a danger, if the person with mental illness is at risk of being victimized, and whether there is a history of violence. To further facilitate effective information gathering, some departments “flag” certain locations in the Computer Aided Dispatch (CAD) system. These flags appear when a repeat call for service is made to that location. The dispatcher then reads the text of the “flag” when dispatching the call to provide additional information to the responding officers. These flags are placed *only* on those call locations that pose a particular threat or unresolved problem, such as potential for violence or as a repeat location. Personnel are designated to review these flags periodically to ensure a need for each flag remains.

Example: Baltimore County (MD) Police Department

In the Baltimore County Police Department, supervisors make written requests to the communications center to place a flag on certain locations where police have responded to repeat calls for service or where there is a significant potential for violence—as determined by knowledge of weapons in the home, previous reports of violence, or other information. These flags are used for a wide variety of calls, not just those related to mental health issues.

c Provide dispatchers with a flowchart to facilitate dispatch of the call to designated personnel.

Dispatchers should be given a flowchart that states clearly who should respond when calls for service may involve people with mental illnesses. Dispatchers should provide all of the essential information to the appropriate responding officer, including whether mental illness may be a factor, so that officers are able to respond effectively to a call for service.

d Use designated codes and appropriate language when dispatching the call.

Some agencies use a code system when dispatching calls for service over the radio, others use what is called “plain speech,” and still others use a combination of the two. Some may be concerned that information broadcast over the radio violates the privacy of the person who is the subject of the call and who may have a mental illness. The police department does have an obligation, however, to provide officers with meaningful information on the type of call to which he or she is responding as a means of protecting the safety of both the officer and the consumer. To reduce possible harm that could come to the person who is the subject of the call, dispatchers and officers should avoid the use of slang terms and use only designated codes and/or appropriate language when communicating over the radio. Department personnel should concentrate on describing the person’s behavior rather than guessing at a diagnosis or using a label that carries with it stigma and potentially misleading information.

3

On-Scene Assessment

POLICY STATEMENT #3

Develop procedures that require officers to determine whether mental illness is a factor in the incident and whether a serious crime has been committed—while ensuring the safety of all involved parties.

The police encounter people with mental illness of all ages in five general situations: as a victim of a crime; as a witness to a crime; as the subject of a nuisance call; as a possible offender; and as a danger to themselves or others. It is also true that the person with a mental illness may fall into more than one category at a time. It is critical for the officer who responds to the scene to recognize whether mental illness may be a factor in the incident, and to what extent, before deciding which response is best.

Several different approaches have been developed to enable officers to effectively assess situations involving people with mental illnesses that both reduce their contacts with the criminal justice system and ensure on-scene safety. The safety of all involved parties—the victim, person with mental illness, family members, bystanders and, police—is of paramount importance. The desired outcome of these contacts should be problem resolution that entails fair and dignified treatment of people with mental illness.

The first step for law enforcement in developing protocols is to learn about successful approaches adopted by other law enforcement agencies. A group of key stakeholders should be designated as a plan-

ning group to investigate and assess the different responses so that community leaders can develop response protocols that meet the unique needs of the community. (For more information on these committees, see the discussion in this report's Introduction as well as Chapter VI: Improving Collaboration.) Planning groups can accomplish this research and investigation using a variety of sources, including reviewing the literature; speaking with other law enforcement agencies about their promising approaches and any barriers to their success; or attending the training of a department that employs a response that could be effective in their community.

Approaches to consider include the following. They may be adapted to the specific needs of a community.

- **Crisis Intervention Team (CIT).** The CIT approach employs specially trained uniformed officers to act as primary or secondary responders to every call in which mental illness is a factor. Ideally, officers are chosen to participate based on their willingness to enhance services to people with mental illness within the community. CIT officers are available for each shift to provide assistance to consumers and their families and to facilitate emergency mental health assessments.

- **Comprehensive Advanced Response.** This response model can be described as a traditional response modified by mandating advanced, 40-hour training for all officers within the department. Some of the departments that use this approach address responses to people with mental illness as part of their training and responses to “special populations.”
- **Mental health professionals who co-respond.** Some law enforcement agencies hire licensed mental health workers as secondary responders. These civilians serve in units that are either located in the police department—where civilian workers are under the chief’s supervision—or reside outside the department because staffing is shared with other county or city mental health providers. These civilian workers may either ride along with officers in special teams or respond when called by an officer after the scene has been secured for various crisis calls, including those involving people with mental illness. The civilian employees are responsible for developing relationships with community-based organizations and finding available services within the community.
- **Mobile Crisis Team (MCT) co-responders.** Generally, Mobile Crisis Teams are composed of civilian personnel employed by mental health organizations, who are licensed mental health professionals. For an effective, safe

response, MCTs should act only as secondary responders who are called out once the scene has been secured by law enforcement. Law enforcement officers call MCTs if it is believed that there is a person involved who may be a danger to him- or herself or others, or if the person needs services. Also, in some jurisdictions, if no crime has been committed, MCTs can provide transport to a mental health facility (if it appears the person might meet the criteria for civil commitment) or other services (such as counseling or drug treatment). MCT personnel are knowledgeable about criteria for involuntary commitment, bring extensive information to the scene, and are able to provide follow-up services.

Regardless of the particular approach chosen, the officers must ensure the following: stabilize the scene; recognize signs or symptoms of mental illness; determine whether a serious crime has been committed; consult with personnel who have mental health expertise; and, when indicated, determine whether the person might meet the criteria for emergency evaluation. Once these determinations have been made, the responders must decide what, if any, action should follow. (See Policy Statement 4: On-Scene Response; also Policy Statement 28: Training for Law Enforcement Personnel).

RECOMMENDATIONS FOR IMPLEMENTATION

a Stabilize the scene using deescalation techniques appropriate for people with mental illness.

Officers should approach and interact with people who may have mental illness with a calm, non-threatening manner, while also protecting the safety of all involved. Several de-escalation techniques (see Table 1) have been shown to assist in calming a person who is not rational or who is experiencing an emotional crisis.

Most people with mental illness are not violent, but for their own safety and the safety of others officers should be aware that some people with mental

Table 1. Deescalation Techniques**Officers should do the following:**

- Remain calm and avoid overreacting.
- Provide or obtain on-scene emergency aid when treatment of an injury is urgent.
- Follow procedures indicated on medical alert bracelets or necklaces.
- Indicate a willingness to understand and help.
- Speak simply and briefly, and move slowly.
- Remove distractions, upsetting influences, and disruptive people from the scene.
- Understand that a rational discussion may not take place.
- Recognize that the person may be overwhelmed by sensations, thoughts, frightening beliefs, sounds (“voices”), or the environment.
- Be friendly, patient, accepting, and encouraging, but remain firm and professional.
- Be aware that a uniform, gun, and handcuffs may frighten the person with mental illness, and reassure the person that no harm is intended.
- Recognize and acknowledge that a person’s delusional or hallucinatory experience is real to him or her.
- Announce actions before initiating them.
- Gather information from family or bystanders.
- If the person is experiencing a psychiatric crisis, ask that a representative of a local mental health organization respond to the scene.

Officers should *not* do the following:

- Move suddenly, giving rapid orders or shouting.
- Force discussion.
- Maintain direct, continuous eye contact.
- Touch the person (unless essential to safety).
- Crowd the person or move into his or her zone of comfort.
- Express anger, impatience, or irritation.
- Assume that a person who does not respond cannot hear.
- Use inflammatory language, such as “crazy,” “psycho,” “mental,” or “mental subject.”
- Challenge delusional or hallucinatory statements.
- Mislead the person to believe that officers on the scene think or feel the way the person does.

illness who are agitated and possibly deluded or paranoid may act erratically, sometimes violently. If the person is acting erratically, but not directly threatening any other person or him-or herself, such an individual should be given time to calm down. Violent outbursts are usually of short duration. It is better that the officer spend 15 or 20 minutes waiting and talking than to spend five minutes struggling to subdue the person.

“I try to be as calm as I can around police, but I can’t always. Just the sight of a police officer scares me to this day.”

CAROL TRAXLER
consumer

Source: *Serious Mental Illnesses and the People Who Are Affected By Them: An Educational Videotape for Law Enforcement Officers*, 1992, Alliance for the Mentally Ill of Rhode Island

b**Recognize signs or symptoms that may indicate that mental illness is a factor in the incident.**

The officer responding to the scene is not expected to diagnose any specific mental illness but is expected to recognize symptoms that may indicate that mental illness is a factor in the incident. Symptoms of different mental illnesses include, but are not limited to, those listed in Table 2. Many of these symptoms represent internal, emotional states that are not readily observable from outward appearances, though they may become noticeable in conversation with the individual.

In addition to the symptoms outlined in Table 2, some specific types of behavior may also be signs of mental illness. These behaviors can include severe changes in behavior, unusual or bizarre mannerisms, hostility or distrust, one-sided conversations, confused or nonsensical verbal communication. Officers may also notice inappropriate behavior, such as wearing layers of clothing in the summer. It should be noted that these behaviors can also be associated with cultural and personality differences, other medical conditions, drug or alcohol abuse, or reactions to very stressful situations. *As such, the presence of these behaviors should not be treated as conclusive proof of mental illness. They are provided only as a framework to aid those police officers who must under-*

Table 2. Signs and Symptoms of Mental Illness

- **Loss of memory/disorientation.** Temporary or permanent memory losses may be symptoms of a disturbance. This is not the common forgetting of everyday things, but rather the failure to remember the day, year, where one is, or other obvious personal information.
- **Delusions.** These are false beliefs that are not based in reality. They can cause a person to view the world from a unique or peculiar perspective. The individual will often focus on persecution (e.g., believes others are trying to harm him or her) or grandeur (person believes he or she is God, very wealthy, a famous person, or possesses a special talent or beauty).
- **Depression.** Depression involves deep feelings of sadness, hopelessness, or uselessness.
- **Hallucinations.** It is not unusual for some people with mental illness to hear voices, or to see, smell, taste, or feel imaginary things. The person experiences events that have no objective source, but that are nonetheless real to him or her. The most common hallucinations involve seeing or hearing things but can involve any of the senses (e.g., a person may *feel* bugs crawling on his or her body; *smell* gas that is being used to kill him or her; *taste* poison in his or her food; *hear* voices telling him or her to do something; or *see* visions of God, the dead, or horrible things).
- **Manic behavior.** Mania involves accelerated thinking and speaking or hyperactivity with no apparent need for sleep and sometimes accompanied by delusions of grandeur.
- **Anxiety.** Feelings of anxiety are intense and seemingly unfounded. The person is in a state of panic or fright; may have trembling hands, dry mouth, or sweaty palms; or may be “frozen” with fear.
- **Incoherence.** A person may have difficulty expressing him- or herself clearly and exhibit disconnected ideas or thought patterns.
- **Response.** People with mental illness may process information more slowly than expected.

stand what questions to ask and to decide what services, resources, or support are needed to resolve the cause of the incident. Officers should obtain additional information at the scene from family, friends, or health professionals who are familiar with the individual's behavior.

Officers should be aware that substance abuse disorders can *mimic* many mental disorders; substance use can *mask* many mental disorders; and some somatic disorders, such as diabetes or Parkinson's, may seem to be mental and/or substance abuse disorders. To complicate matters, the co-occurrence of mental illness and substance abuse is also quite common (see Policy Statement 37: Co-occurring disorders). Due to the complexity of this diagnostic task, it will often be impossible for law enforcement officers to distinguish mental illness from substance abuse disorders. The officer who has observed unusual or erratic behavior should bring the individual to an assessment site that is capable of making an accurate determination of its cause.

Studies have shown that the potential for violence increases considerably when people with mental illnesses use alcohol or drugs.² For this reason, officers should be observant and note any signs (e.g., bottles, drug paraphernalia) of substance or alcohol use. At the same time, maintenance of a calm demeanor and use of de-escalation techniques can help to prevent violent behavior.

Officers will need to attend to the medication needs of some individuals with mental illness. If the encounter lasts for some time, or a person is being detained, people with mental illnesses may need access to their medication. Officers *must* follow departmental rules for verifying that any pills or capsules the person is carrying are prescribed, or to obtain the needed medication, so that they may authorize the individual to continue the prescribed treatment.

Police officers should be aware that some medications that treat mental illnesses have side effects that may also require attention. For example, medications may cause tremors, nausea, extreme lethargy, confusion, dry mouth, constipation, or diarrhea. Police officers should attend to needs for water, food, and access to toilet facilities. It is important not to mistake these side effects as evidence of alcohol or drug use.

C Determine whether a serious crime has been committed.

No individual should be arrested for behavioral manifestations of mental illness that are not criminal in nature. Arrest is generally appropriate when a felony has been committed or when the person has outstanding warrants. Arrest is also appropriate in cases in which the officer would normally make an arrest if the person did not have a mental illness, and if the current signs of mental illness are minor or not related to the violation.

In cases where the person with a mental illness has come to the attention of the police because of behaviors that result from the mental illness or nui-

2. H. Steadman et al., "Violence by People Discharged from Acute Psychiatric Inpatient Facilities," pp. 393-401.

sance violations, officers should engage referral mechanisms to mental health services and supports to address the mental illness in lieu of arresting the individual and engaging the criminal justice system. (See Policy Statement 4: On-Scene Response, for more on referral mechanisms.)

d

Consult personnel with expertise in mental illness to enhance successful incident management.

On-scene expertise in mental illnesses and their manifestations is critical to effective incident management. This expertise can be provided by primary or secondary on-scene responders who are specially trained police officers or mental health professionals.

The following examples highlight the ways that departments around the country have chosen to include this type of expertise. As described previously, these include Crisis Intervention Teams (CITs), the comprehensive advanced approach, mental health professionals who corespond, and Mobile Crisis Teams (MCTs). The basic difference in these models is whether expertise is provided by police officers who are trained extensively in mental health issues, or by mental health professionals who either co-respond with law enforcement or respond after the scene has been secured. While mental health professionals are likely more knowledgeable than patrol officers about involuntary commitment laws and bring additional, perhaps confidential, data to the scene, they are not always available. (See Policy Statement 25: Sharing Information for more on agreements between mental health and criminal justice agencies.)

Examples of approaches that use specially trained police officers to supply on-scene expertise—either as a special team or as the whole department—follow:

Crisis Intervention Team

Example: Memphis (TN) Police Department

In a Crisis Intervention Team (CIT) approach found in the Memphis Police Department, uniformed officers, specially trained in mental health issues, act as primary or secondary responders to every call involving people with mental illnesses. CIT officers are available on every shift and are also available to mental health clients (consumers) and their families. The Albuquerque, New Mexico, Police Department, The Roanoke, Virginia, Police Department and the Houston, Texas, Police Department are among numerous agencies across the country that have also adopted the CIT approach.

Comprehensive Advanced Response

Example: Athens-Clarke County (GA) Police Department

In a comprehensive response, the Athens-Clarke County Police Department decided that its small size precluded the formation of a specialized team to respond to calls for service involving people with mental illness. Accordingly, the department decided that every officer would attend the advanced 40-hour crisis intervention training and thus be able to respond appropriately to these calls.

"Each time a person with mental illness is killed by police it has tragic consequences for everyone involved—the person with mental illness, their loved ones, and the police officer. Improving law enforcement's knowledge and skills in responding to individuals with mental illness can prevent many of these deaths."

CHIEF ROBERT OLSON
Minneapolis, MN

Mental health professionals who co-respond

Example: Birmingham (AL) Police Department

The Birmingham Police Department uses a Community Service Officer (CSO) Unit, which is attached to the Patrol Division. The unit is composed of social workers who respond directly to an incident location when requested by an officer. They serve a variety of populations, including people with mental illness. The CSOs are also certified law enforcement academy trainers and work closely with community groups and other components of the criminal justice system.

Example: Long Beach (CA) Mental Evaluation Team

In this program, a patrol officer from Long Beach Police Department is accompanied by a clinician to respond ten hours a day, seven days a week, to calls for service involving people with mental illness. The clinician provides on-scene assessment of the individual's mental health needs and ensures admission into a mental health facility, if necessary. This approach prevents unnecessary incarceration of people with mental illnesses.

Example: San Diego County (CA) Sheriff's Office

The Psychiatric Emergency Response Team (PERT) approach used by the San Diego County Sheriff's Office pairs a licensed mental health clinician with an officer or deputy in a marked car to respond to situations determined by the dispatcher or another officer to involve a person suspected of having a mental illness that is a factor in the incident. These teams conduct mental health assessments and process referrals to county providers if appropriate.

Mobile Crisis Team

Example: Anne Arundel County (MD) Police Department

The Anne Arundel County Police Department has arranged for access to a team of crisis workers from a local mental health center that works seven days a week. The responding officer must determine if a Mobile Crisis Team is warranted at the scene and will call accordingly.

There are several important differences between the approaches that involve mental health professionals. One main difference is how the mental health professional is paid and supervised, usually either through the police department or through the county mental health agency. For example, in Birmingham the social worker is located in the police department and is under the direct supervision of the chief, while in Anne Arundel County, Maryland, the mobile crisis team members are paid by a mental health organization. Another difference is whether the mental health agent works in a team with the officer, or responds as a separate unit. An additional distinction is whether the civilian workers respond to a variety of calls for service beyond those involving people with mental illnesses, such as domestic violence. Yet, in all models, the mental health professional is responsible for understanding community resources and finding services within the community.

Successful incident management is often dependent on information about the person's current and past behavior. If it is not possible to obtain this information from the person with mental illness or a responding professional, sometimes it can be obtained at the scene from those who are close to the person, and who are familiar with the situation and with the person's history.

In those rare events when a person's life or the life of a bystander is in jeopardy, in addition to following standard crisis procedures, law enforcement should also formally call on specially trained mental health professionals for assistance in resolving the critical incident. (See Policy Statement 4: On-Scene Response, for more information on handling critical incidents.) Law enforcement personnel should protect the confidentiality of medical or mental health information to avoid disclosures (see Policy Statement 25: Sharing Information) and should follow protocols for written documentation provided in Policy Statement 5: Incident Documentation.

e

Determine, when warranted, whether the person may meet the state criteria for emergency evaluation.

The criteria for emergency evaluation are similar from state to state, although there is some variation in how they are interpreted. It is *not* the role of the police officer to make the sole determination that a person should be committed. However, being familiar with the criteria will help officers decide whether to detain the person and transport him or her for an emergency mental evaluation. This is not an arrest. Officers should be alert to the *behaviors, actions, and speech* of the person so that they can determine whether specific indicators of the criteria apply. Officers should also familiarize themselves with state law concerning emergency evaluation.

Most patients who receive inpatient or outpatient services for mental illness do so voluntarily. That is, when presented with their options—including the possibility of involuntary commitment—they choose to enter a hospital or to follow a course of outpatient treatment suggested by treatment professionals. In fact, in some states you cannot commit someone who is willing to admit him- or herself voluntarily. For a significant minority, however, there are times when involuntary commitment becomes the only available avenue to services and the surest way to ensure the safety of the person involved. Involuntary commitment involves deprivation of personal freedom and can be an indignity to the person being committed. In addition, it requires the participation of numerous professionals (including the certifying doctor, attorneys representing both the accepting facility and the patient, and a judge). For these reasons and the simple reality that commitment takes considerable time, in the majority of cases most clinicians will seek to offer voluntary admission to services before considering involuntary commitment.

Every state has a law that provides a clear path for those cases in which a person must be involuntarily committed to treatment. While the laws vary to some degree, they all attempt to define circumstances under which a person's unsupervised presence in the community poses a risk by reason of his or her mental illness. In almost all cases, it is the likelihood of a person's dangerousness to self or to others that is the primary trigger for involuntary commitment. In several states, the mental health law also includes language defining what is broadly known as the "gravely disabled" criterion, which is meant to cover instances in which a person's well-being is threatened by inattention to personal safety, failure to eat, exposure to extreme or dangerous conditions, or other evidence that he or she is in imminent danger if left untreated. Some state statutes also note a "need for treatment" or likelihood that a person will benefit from treatment as one of many criteria for commitment. Additionally, the laws covering involuntary commitment are subject to interpretation and, it should be noted, continued debate within the mental health community.

Traditionally, the treatment to which a person is involuntarily committed is provided in a secure inpatient facility. State law generally charges the department of mental health or its equivalent with regulating facilities to which involuntary commitment is possible. Not all hospitals are licensed to receive involuntary patients (although this does not always restrict their ability to conduct emergency evaluations). In addition, reimbursement issues may limit admission to some hospitals. It is important for law enforcement officers and others who might become involved in involuntary commitment proceedings to know which facilities are able to admit involuntary patients.

In some states, involuntary commitment to outpatient services is also possible under the law. As with involuntary inpatient commitment, there is considerable controversy within the mental health community with regard to the acceptable purposes and uses of this option. There is also considerable variability in the manner in which outpatient commitment is utilized. Not only do states have different standards in the law, but judges and doctors can and do differ widely in their understanding and use of discretion regarding the appropriateness of invoking outpatient commitment provisions.

To avoid the adversarial dynamics of involuntary commitment, in some instances crisis teams may consider the use of alternative dispute resolution (ADR). Crisis teams should consider including personnel trained in ADR techniques who can attempt to resolve conflicts short of involuntary intervention.

Many people with mental illness today have some broad understanding of involuntary commitment laws and of the rights they have under those laws. More broadly, many who have been in treatment have learned to understand their illness, to monitor their symptoms, and, ideally, to manage their condition. Patient education is a significant component of treatment in some mental health agencies. Some consumers have arranged to provide information to emergency responders (e.g., through wallet cards) on whom to contact in the event of a crisis. Officers should be aware that someone with a mental illness who is expressing a preference for particular actions, medications, or modes of treat-

ment may be speaking from experience. The person's requests should be relayed to any treatment professional called to the scene or consulted in follow-up to an incident.

"Advance directives" are legal mechanisms by which a patient's preference for particular medications or treatment alternatives can be expressed prior to a crisis, much as many in the general population execute "living wills" or other legal documents outlining their wishes should medical crises leave them unable to express themselves in this way. Officers should be familiar with this mechanism and should be aware of the possibility that a person with mental illness may wish to follow the steps outlined in his or her advance directive. In cases where the advance directive is followed, the person with mental illness may more readily agree to become engaged in services, thereby eliminating the need for involuntary commitment.

4

On-Scene Response

POLICY STATEMENT #4

Establish written protocols that enable officers to implement an appropriate response based on the nature of the incident, the behavior of the person with mental illness, and available resources.

This section discusses the appropriate disposition options chosen by the officer based on the nature of the situation as determined in the assessment phase—including the behavior of the person with mental illness, established protocols, and the availability of community resources.

The availability of community resources is dependent on a complex set of circumstances. For example, the advent of managed care and other changes in the broader health care system, as well as in the delivery of mental health services, have resulted in hospital consolidation, the shift to ambulatory care, and changes in emergency room procedures in almost every community in the country. In many places, practices in place just a few years ago no longer apply today. Due to factors well beyond the control of mental health services, it can be difficult to admit patients to a hospital or other medical facility. For this reason, law enforcement officers and others should stay abreast of how mental health services are delivered in their community.

Spurred by the new health care realities, mental health service providers in many communities have developed protocols intended to ensure that appropriate professionals see emergency psychiatric patients in a timely manner. Models differ among

communities due to numerous factors, but the most effective approaches seem to share certain characteristics, such as having staff who can respond quickly and make an assessment of the needs of each person who comes to them.

In rural settings, where hospitals or treatment centers may be located far from some communities, officers face challenges related to time and travel, in addition to the obstacle of identifying appropriate resources for someone they believe needs treatment. Increasingly, communities are using technology—“telemedicine”—for initial assessments. Alternatively, communities rely on general health care practitioners or lesser credentialed professionals to provide these assessments, which, while not ideal, may be the only means available with current system and resource constraints. Still, there are many instances in which long distances need to be traveled in order to connect a person in need of treatment with appropriate services. Generally, law enforcement agencies are called on for transportation in these cases. (See Policy Statement 18: Development of Treatment Plans, Assignment to Programs, and Classification / Housing Decisions, for more on telemedicine.)

The range of response options should always include the option of disengagement when the person is not a danger to him or herself or to others and has not committed a serious crime. Disengagement from police contact should not be interpreted to mean that no assistance is offered. What it can be interpreted to mean is that officers can and should provide referrals to appropriate mental health services and supports in such instances.

Departments should be aware that the simple presence of a law enforcement officer implies a certain amount of power—many people interpret whatever an officer says as something they *must* do. Officers should make clear that it is *voluntary* for people with mental illnesses—those who are not a danger or have not committed a serious crime—to

follow their suggestions for referral and treatment. True problem solvers will help the person with mental illness overcome such barriers to initial treatment as transportation problems or fear of traveling alone.

The following recommendations suggest ways to facilitate the appropriate disposition for the full range of people with mental illness who may encounter the police. The sections recommend procedures that enhance emergency evaluations, promote referral to support services, provide information to victims and families, and facilitate transportation and detention when necessary. Detailed policy recommendations on report writing and other incident documentation procedures are included in Policy Statement 5: Incident Documentation.

RECOMMENDATIONS FOR IMPLEMENTATION

a

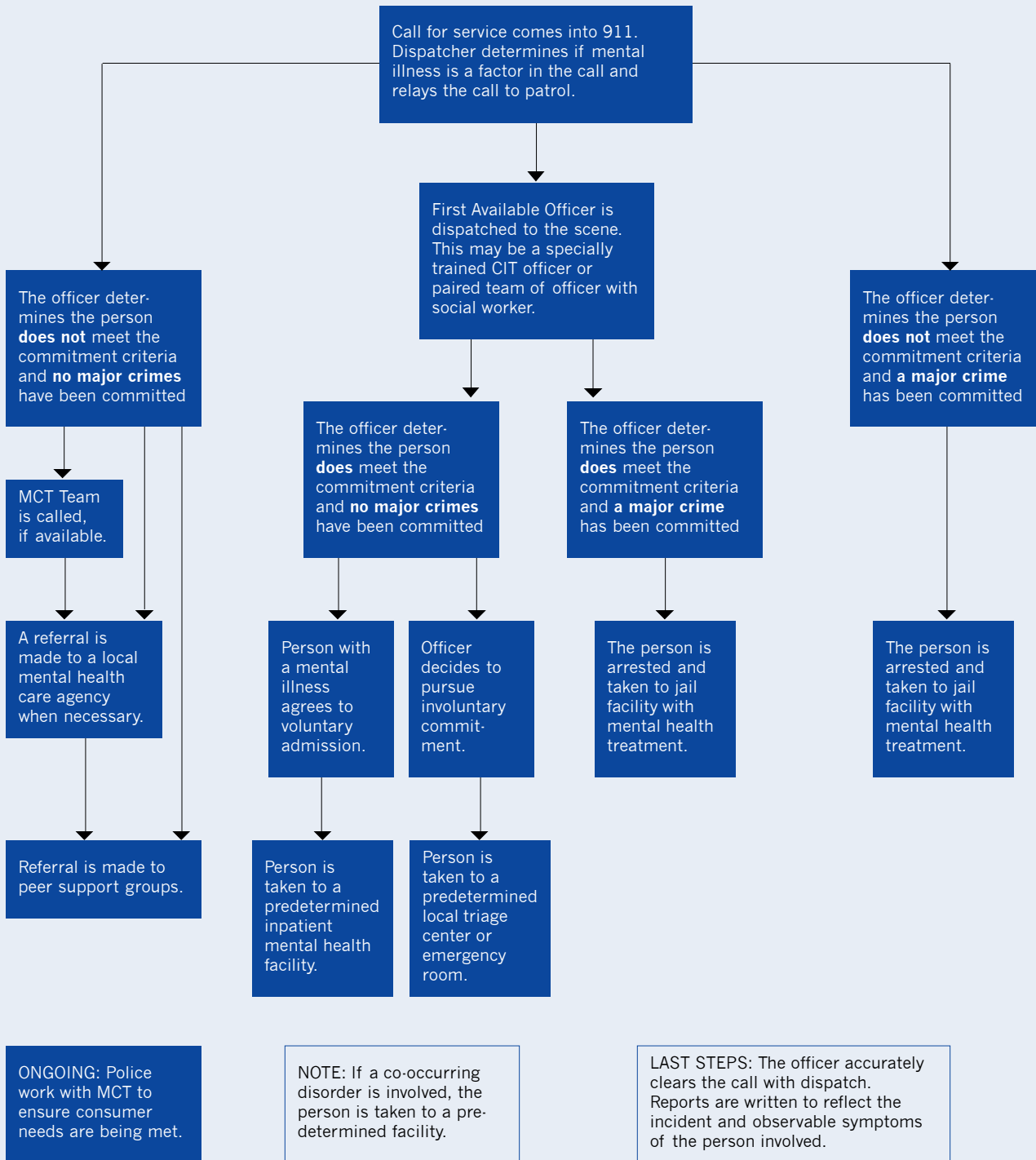
Institute a flowchart that matches hypothetical situations with disposition options.

Because calls involving people with mental illness can be influenced by a wide array of variables, a clearly articulated flowchart is a good way to enhance officer response to people with mental illness. A flowchart such as the one in Figure 1 helps officers decide what options are best suited to each situation they encounter. In order to develop such a tool, people involved in each point of the system should identify the different response options available for each type of scenario typically encountered by responding officers.

Figure 1 shows a sample flowchart that might be used by a Crisis Intervention Team combined with a Mobile Crisis Team, an admittedly rare but effective response approach. The chart depicts multiple situations and next steps recommended for each.

A flowchart helps clarify when diversion from the criminal justice system is appropriate and when it is not. For example, in the rare event that the threat of violence exists, a flowchart developed by the individual department can reinforce the decision as to when treatment providers and police can address the problem or when other special response teams should be called in. This reference can assist in determining appropriate levels of response (which do not include SWAT teams unless absolutely necessary) that are based on the likely success of de-escalation techniques and accurate assessments of threat.

Figure 1: Sample Flowchart for Responding to People with Mental Illnesses*



*This chart reflects responses of a Crisis Intervention Team (CIT) combined with a Mobile Crisis Team (MCT) and concerns situations involving people with mental illness who are the subject of the call for service. It does not encompass situations where the person with a mental illness is a crime victim or witness.

b**Designate area hospitals or mental health facilities as disposition centers that facilitate intake for people with mental illnesses who require emergency psychiatric evaluation.**

It is critical for a successful diversion program to have a place where responders can take people with mental illness who require emergency evaluations. The most common difficulty encountered by police is the lack of available facility space or long waiting times for intake procedures. Consumers with co-occurring disorders or additional special needs may not seem to fit any access requirements. Agreements between law enforcement and mental health facilities can result in designated centers for drop off, procedures at the center that shorten the wait for police referrals, and coordinated efforts to identify available beds and hard-to-access services (such as for co-occurring disorders) from a wide range of options. Given the difficulties in sorting out whether a person's symptoms are due only to mental illness or to substance abuse, these facilities must have the capacity to work with both disorders.

Example: Memphis (TN) Police Department

A key element to success for the Memphis Police Department has been the relationships developed with the mental health community. For example, the local psychiatric emergency room agreed to provide emergency evaluations to all people with mental illness brought in by the police. The hospital also assumes immediate responsibility for assessment and referral—to either community-based or inpatient treatment at the local state hospital—while officers return to police service in as little as 15 minutes.

Example: Florence (AL) Police Department

The Florence Police department liaison, with the help and support of the chief, negotiated an agreement with the director of the local emergency room to “fast track” medical assessments conducted on people with mental illnesses who were brought in by police. These assessments now take less than 30 minutes.

Example: Anne Arundel County (MD) Mental Health Facility

In Anne Arundel County, Maryland, the county mental health facility maintains a countywide bed registry to assist law enforcement in easily locating an available bed.

Example: Seattle (WA) Crisis Intervention Team

Crisis Intervention Team officers from the Seattle Police Department may transport individuals who appear to have a mental illness to a Crisis Triage Unit at a Seattle-area hospital. King County health care providers developed the unit, which is open 24 hours a day, 7 days a week to respond to people in crisis.

Long drives to mental health facilities may remain the rule in rural areas, but it is possible for officers to be assured that the effort will be worthwhile. For instance, telemedicine gives officers and psychiatrists or other mental health professionals an opportunity to ensure that preliminary assessments are per-

formed in a timely manner. These preliminary assessments help to guard against transportation that is ultimately unnecessary, and they ensure that proper arrangements are made to receive the individual.

"If you don't have appropriate access to treatment and services, the only option that most law enforcement officers have in most situations is the county jail"

C Ensure that comprehensive emergency psychiatric services are available to law enforcement agencies for around-the-clock intake, 24 hours a day, 7 days a week.

In most communities today, there are a limited number of clearly designated emergency intake centers—perhaps just one. Each intake center should have staff on hand or on call that can respond quickly and make an assessment of the needs of each person who comes to them. It is less important where the intake center is—in a hospital or in a community mental health center, for example—than that the staff at the center be informed of what resources are currently available and have the authority to place the individual in the appropriate services. Investing staff with these “gatekeeper” functions is very important both for ensuring a smooth and rapid “hand-off,” and for coordinated follow-up—whatever form it may take. Most important for police, of course, is that mental health staff be able to rapidly assume responsibility for an individual brought to them so that the officer can resume his or her duties.

Additionally, the community mental health center in some communities may operate an on-site emergency intake service only during business hours. Police and others would use the center at those times. After hours, the emergency intake service may shift to a local hospital, providing mental health workers with medical backup and laboratory services. In many settings, the mental health workers at the hospital also answer the overnight emergency telephone calls coming into the mental health center and thus have a sense of the demand for services. If services are lacking, mental health, police, and other criminal justice system professionals should lobby with consumer advocates for proper appropriations for such facilities.

In any setting, it is important that mental health workers be dedicated to emergency services, instead of being called away to treat accident victims or others coming to the emergency room for nonpsychiatric reasons. In many settings, it should be noted, the staff on hand may not include a psychiatrist. In all cases, however, a psychiatrist must be on call and available on short notice.

Example: The Providence Center (RI)

In Providence, Rhode Island, the Providence Center, a community-based, non-profit mental health provider, maintains an emergency services center at its main treatment site that operates during extended business hours, Monday through Friday. During other hours, emergency services are provided at a nearby hospital, where a Providence Center employee answers the emergency telephone line and makes on-site assessments of individuals who come to the hospital or are transported by police or others.

MAJOR SAM COCHRAN
Coordinator, Memphis
Crisis Intervention
Team, TN

Source: "Memphis Police Look to Help, Not Lock Up, Mentally Ill." June 8, 1999, available at: www.cnn.com/health/9906/08/mental.health

Erratic behavior can be caused by drugs or alcohol and other medical conditions as well as by a mental illness. While police may suspect the cause of erratic behavior, the actual factors may not be known for days or weeks. It is therefore important for the receiving mental health staff to be knowledgeable about the distinctions between mental illness, other medical conditions, and drug or alcohol involvement. The intake staff must have access to laboratory services and other diagnostic technology to accurately assess detainees' needs for treatment. Easy access to emergency medical care is similarly important. Staff must also be able to connect with needed drug and alcohol services and/or professionals with the ability to treat substance abuse and mental illness simultaneously if such services are called for (see Policy Statement 1: Involvement With Mental Health System).

Staff at the intake center must also be able to determine whether the individual meets criteria for involuntary commitment and, more important, be authorized to take appropriate steps in the event that commitment is warranted.

When the person with mental illness does not meet the criteria for involuntary commitment, it is especially important that law enforcement and staff at the intake center identify some short-term housing options for those who are homeless. Without a linkage to some type of housing, the police are likely to encounter the person on the streets not long after dropping him off at the intake center. Programs that make short-term housing available for individuals who do not meet the criteria for involuntary commitment should also work to connect clients with long-term housing opportunities.

Example: Baltimore Crisis Response, Inc. (BCRI), Baltimore City (MD)

Baltimore Crisis Response, Inc. (BCRI) manages mental health crisis beds within Baltimore City that are available on a voluntary basis to individuals who do not meet criteria for involuntary admission to a hospital and have not been charged with a crime that requires detainment. BCRI staff work closely with emergency rooms, the Baltimore Police Department, and mental health agencies to afford access to these beds as a form of pre-booking diversion. BCRI case managers work with individuals admitted to the mental health crisis facility to connect them to long-term housing and other services.

The type of insurance coverage an individual has can affect efforts to gain access to emergency psychiatric services. Private insurance, especially, may be governed by “medical necessity” criteria that can be interpreted to exclude someone with mental illness from emergency admission to some hospitals. Publicly funded mental health centers may be excluded from preferred provider lists developed by private insurers, which in some instances can complicate or even eliminate the possibility of admission. If an individual is an active Medicaid or Medicare patient, admission is still likely to be governed by some level of managed care admission criteria. While many hospitals and mental health centers receive funds allowing them to accept uninsured individuals, the absence of

any coverage complicates admission and, at a minimum, can cause further delays. None of these insurance issues are unique to mental health service delivery, but when they arise in instances involving someone who is psychotic or deeply suspicious they can stand between that person and the services he or she needs.

d Formalize agreements between law enforcement and mental health partners participating in protocols.

Chapter V: Improving Collaboration, discusses the importance of formal agreements between the criminal justice system and mental health system components on the roles and responsibilities of each partner. The following checklist outlines particular areas of such agreements that are specific to the concerns of law enforcement and mental health professionals when developing agreements. (See Policy Statement 26: Institutionalizing the Partnership, for more on elements of successful agreements.)

- What emergency detention authority do officers have and how will custodial transfer occur? It must include protections for taking the person into custody and provide liability protection as long as they are in custody. Partners will need to know what existing authority (local laws, indemnity clauses, and state statutes) may impact rights and obligations.
- What information can be shared under what circumstances? Confidentiality provisions for verbal or document exchange should address what will happen when information is included in either police or mental health reports that relates to an ongoing criminal investigation or to a mental health treatment plan. (See Policy Statement 25: Sharing Information.)
- How do law enforcement officers make the determination whether or not to place a person with mental illnesses in custody for transport to a mental health facility? It is important to specify rules based on how the person gets to the facility—in custody or voluntarily.
- When does responsibility actually shift from the on-scene responder to a mental health professional? (This could be at the scene, by phone, in a waiting room, etc.) There must be clarification of the point at which the responsibility to provide services transfers from one entity to the other.
- What intervention (such as an advocacy service) is available when a person suspected of having a mental illness is being held in a holding cell and is in need of services but who does not qualify for emergency evaluation?
- What liability protection is in place? Liability suits are related to practice, custom, policy, or accepted standards of care. The premise under liability law is that an officer cannot be sued for general duty to protect someone from being victimized, injured, or killed. However, if through a partnership a law enforcement agency creates a new special duty that

it is later unable to fulfill, departments and/or officers can be held liable. Law enforcement counsel should consider whether any agreement creates a new special duty to the individual that would create liability if breached. Each party should be held liable for its own agents' actions. If the memorandum of understanding (MOU) is carefully structured, a breach resulting in litigation would not focus on it being a joint venture with shared liability.

- What are the budgetary considerations? Cost or funding responsibilities must be addressed.

e**Ensure that mental health services and supports are available for every person in need.**

Ideally, any person brought to a mental health provider by police officers will be someone already known to the system or will be able to easily fit into existing services. Unfortunately, such cases appear to be more the exception than the rule. Perhaps because people who are not already engaged in the system come into contact with the police more frequently than others who are successfully engaged in treatment, they face a number of obstacles in entering the system. Because contact with police may, in fact, turn out to be a person's introduction to the mental health system, it is important that the system's door be open at this critical juncture and engagement not be made more difficult by bureaucratic concerns. Establishing protocols that allow a case to be opened or reopened smoothly can help with this process.

An important test of the partnership between police and mental health providers is the ability of officers and providers to agree on who needs mental health services. If police officers bring an individual they perceive to be in need to a provider, they expect the provider to offer appropriate services to that individual. Mental health providers must respect the observations and judgments of police officers charged with making quick decisions in the field. By the same token, police officers must respect the assessment of mental health providers about which cases they are able to address and which cases are beyond their capacities. If the law enforcement and provider agencies have not worked together before, it may take a period of trial and error for a balance to be struck. The important thing is for police and providers to ensure that they will learn as they go along and that every effort will be made to meet each individual's needs in the process. There must also be an understanding that if an individual's needs cannot be met, there is a shared plan for getting those resources established.

Even with appropriate training, police officers will occasionally seek services for someone who cannot be helped by the local mental health provider. It is important in such instances, however, that providers *not* simply turn the individual away or leave him or her under the responsibility of the police. Protocols should be developed that delineate how police and providers should work together to find some assistance for the individual, even if it is not in the mental health system.

One source of assistance for people with mental illness is peer support programs. Several types of peer groups exist to help consumers, including Drop-In Centers, Warmlines, and Clubhouses. “Drop-in centers” are informal social and recreational programs that serve as information clearinghouses and meeting locations for other peer support groups, including 12-step groups. Traditionally, people with mental illness fill staff positions. “Warmlines” are telephone support systems staffed by consumers trained to listen empathetically, provide information about appropriate resources, and act as a link to needed or desired supports and services. Warmline staff does not provide suicide intervention or crisis intervention, but they are trained to recognize the need to engage the more critical support offered by a suicide hotline. The staff also makes outgoing calls, contacting consumers who have asked to be called regularly to stay connected to a support system. “Clubhouses” are collaborative efforts between professionally trained staff and consumers who provide vocational support and prepare consumers to enter into or return to the workforce.

In many instances, law enforcement officers may deliver a person with a mental illness to a mental health provider only to discover that any of a number of complicating factors may make it difficult to connect that person with appropriate services. For example, the provider will want to determine whether the person has insurance or qualifies for Medicaid or other benefits or entitlements. Similarly, the person may have more than one diagnosis or display no interest in receiving services. In these instances, too, protocols must be in place to ensure the delivery of appropriate services or responses.

In some communities, ACT programs have been put in place or adapted to provide or arrange for comprehensive treatment and supports for people with mental illness whose behavior has brought them to the attention of law enforcement. The concentrated individual attention that characterizes the ACT model can provide assurance that a person in need will receive appropriate services. In other instances, it may be that clinical services aren’t needed, and the most effective connection can be made with peer services, either at a drop-in center or through individual contact with a peer counselor who is trusted because of the shared experience of mental illness.

Regardless of the model used, mental health providers should take steps to ensure thorough follow-up for any individual who is brought to them under mutually agreed conditions by law enforcement authorities. Follow up may help stop the cycle of repeated involvement with the criminal justice system, while offering mental health providers a ready barometer of conditions and situations that receive police attention. “Follow-up” in this case means, at a minimum, a thorough examination, which may result in a referral to a more appropriate provider. The protocols developed to ensure services must also include a component that allows providers and police to regularly assess the appropriateness of referrals. In addition, each participating agency should designate a liaison to work with counterparts to resolve problems.

Example: Anne Arundel County (MD) Mobile Crisis Team

The Mobile Crisis Team (MCT) approach is successful in Anne Arundel County because the MCT is connected to a local clinic, emergency shelter beds, and an In-Home Intervention Team. The MCT has the resources to ensure that people with mental illnesses get the intervention necessary. The Broken Arrow, Oklahoma, Police Department is among other agencies using a similar approach.

f

Ensure that specially trained mental health professionals are available to respond to scenes involving barricaded or suicidal suspects.

To respond as appropriately as possible in the incidences of barricaded subjects or violent situations, effective communication must exist between police, special responders and department negotiators. While agencies are often under pressure to resolve situations quickly, it is often the best approach to allow time for communication to work in these crisis situations. Hostage negotiators will likely be called to a scene when initial efforts by responding officers to resolve a critical incident have failed.

The effective resolution of these encounters is also dependent on the involvement of specially selected and trained mental health professionals who have expertise in crisis negotiation and familiarity with police operations. State-level mental health agencies will likely know of individuals suited to this role. These mental health professionals will be able to assist law enforcement in understanding the motivation for the incident, which is critical to defusing the situation.

g

Provide information to victims with mental illness and their families to help prevent revictimization and increase understanding of criminal justice procedures.

Research has shown that people with mental illness, like many people with disabilities, are at a greater risk for victimization.³ People with mental illnesses have been shown to be vulnerable to sexual assault as well as other violent crimes.⁴ These crimes are also disproportionately unreported, probably because these victims fear reprisals or retribution from their abusers for coming forward or fear the police won't believe them.

People with mental illness who have been victimized repeatedly may confuse events in their reports to law enforcement. This confusion does not negate their victimization and the importance of investigating the crime. In fact, people with mental illness may experience the trauma of victimization more acutely than other victims, partly because it triggers memories of past abuse. This history of abuse is relevant to case investigation and should be explored.

3. Virginia Hiday et al., "Criminal Victimization of Persons with Severe Mental Illness," pp. 62-68; also J.A. Marley and S. Buila, "When violence happens to people with mental illness: Disclosing victimization," *American Journal of Orthopsychiatry* 69:3, 1999, pp. 398-402.

4. D.D. Sorensen, "The Invisible Victims," available at: www.ncvc.org/newsltr/disabled.htm.

Unfortunately, when victims with mental illness do report their crimes, they are frequently viewed as unreliable witnesses and their cases are often dropped. Law enforcement must become more aware of the complexities of working with victims who have mental illness and should collaborate with their mental health partners to increase the reliability of evidence. These professionals can help law enforcement sort out these complex issues and improve case outcomes. Resources for responding to crime victims who have disabilities can be obtained through the Department of Justice's Office for Victims of Crime.⁵

Law enforcement agencies should provide information to these victims about available services that can help reduce their vulnerability and promote positive contacts with the criminal justice system agents who can inform them of case progress. Law enforcement can also work with consumers and their advocates to conduct crime prevention outreach.

h Inform affected third parties, including victims, minors and the elderly, about what to expect and what community resources are available.

Affected third parties can include victims, family members, employers, or others who share a home or part of their lives with people with mental illness. As in other similar situations, these individuals need a variety of supports and may look to law enforcement for help in accessing resources. In particular, victims (who may also be family members) should be apprised of the course of action to be taken by law enforcement and mental health agencies, and what they can expect the outcomes of the actions to be. They should also be made aware of national resources for victim assistance, including the National Organization for Victim Assistance, the National Center for Victims of Crime, and the Office for Victims of Crime.

In many instances, families try to maintain normalcy when dealing with one of their own who has a mental illness. It may be that the incident resulting in police involvement is the first public acknowledgment of mental illness in the home. Or it may be that the incident is the first manifestation that has clarified mental illness as a problem. In any case, the incident may represent the first time the family has reached out for help and thus the first opportunity for necessary supports to be made available to them. It is important, therefore, for police officers and mental health workers to be knowledgeable about the full range of resources that are available for families and others close to the affected person.

For example, police departments and their mental health partners can provide information on peer supports, such as consumer-managed neighborhood projects, drop-in centers, and warmlines, which offer nonemergency support to consumers by telephone. Regional NAMI affiliate organizations, com-

5. C.G. Tyiska, "Working with victims of crime with disabilities," available at: www.ojp.usdoj.gov/ovc/publications/factshts/disable.htm.

munity chapters of the Depressive and Manic Depressive Association, and local United Way organizations are all good resources for peer support and services. Families may also contact statewide consumer-managed organizations, an example of which is the Tennessee Mental Health Consumer Network.

If police have been called to a home as a result of a threat or threatening action, they should be able to inform family members in the home on ways to protect themselves. Even in instances where the individual is placed in treatment, voluntarily or involuntarily, it can usually be expected that he or she will be at liberty in the community within perhaps a matter of days. Families should be made aware of the process for obtaining a protective order, the associated risks and benefits, as well as what to expect should the order be obtained and violated by the ill family member.

In many instances, of course, members of the family may represent classes given special status or protection under the law. Children of a person with mental illness, for example, may be subject to actions taken by the child protection authorities intended to remove them from the risk of harm. If elderly individuals or spouses have been threatened or harmed, police may be required by law to arrest the individual family member or to notify other authorities. (It should be noted that mental health workers who uncover evidence of elderly, spousal, or child abuse may also be obligated under the law to notify certain authorities.)

Families that report and deal with incidents have great need for support. They may feel isolated and not know where they can turn for information that will help them provide the best care for their relative and for themselves. It is helpful for police to be aware of the resources available to assist families in these situations, such as NAMI. However, it is essential that mental health providers be prepared to provide complete information on support and education resources to families.

In some places, mental health agencies provide classes or resource centers stocked with information for families. More generally, community mental health providers rely on separate nonprofit organizations to provide information and support. Most commonly, these local organizations are affiliated with such previously cited national organizations as NAMI, the National Mental Health Association, or the National Depressive and Manic Depressive Association and are able to offer information and programs developed by these organizations. By meeting and communicating with others who have been through similar situations, families are able to learn skills that will help them to be effective advocates for themselves and for their relatives.

Law enforcement agencies should work with their mental health partners to prepare packets of information on available community-based resources for people with mental illnesses and substance abuse disorders and for their families. These packets should accommodate the full range of cultures and languages present in the community.

Example: Community Mental Health Centers

Community mental health centers in many communities have prepared packets of information for families of clients receiving emergency services. These packets include information about the services the center provides, the rights of patients, payment options, and materials from the local NAMI affiliate and the statewide Mental Health Association. In addition, counselors who meet the families in these initial encounters encourage the families to make contact with one of the organizations, taking time to allay their concerns about privacy, shame, and cost. The organizations, in turn, provide useful information, including Web addresses, book lists, schedules of classes or events, local contact information, as well as descriptions and contact information for area provider agencies.

i**Disengage or transport the person to the appropriate facility with the least restrictive restraint possible.**

Depending on the nature of the response chosen, officers will either leave the person at the scene, transport the person to a mental health facility, transport the person to their home or to the home of a friend or family member, or transport the person to a detention facility.

If police are requested to transport the person to the mental health facility for a *voluntary* admission, this is *service*, not a custodial transport. In general, police can take a person with mental illness into custody, only (1) when the individual has committed a crime; (2) the individual is at significant risk of causing harm to self or others and meets the state's criteria for involuntary emergency evaluation; or (3) in response to a court order or directive of a mental health or medical practitioner who has legal authority to commit a person to a mental health facility.

Before agencies revise policies on custodial and noncustodial transfer of people with mental illness, pertinent laws and liability issues should be explored. However, it is possible to decrease stigma and enhance the dignity of people with mental illness during the transport process.

Example: Washington, D.C., Police Department

A Washington, D.C., policy states that if the responding officer is asked to transport someone for voluntary admission and the officer deems the person to be nonviolent, the officer can provide transport to the facility without handcuffs.

If a person's behavior poses an imminent risk of serious harm to self or others, officers may need to take reasonable steps to physically restrain the person. If time permits, guidance from a mental health professional should be sought about the best restraint methods for the person and situation. Unless there is immediate danger to the individual, others, or officers, responding officers should move slowly and allow the person time to calm down in an effort to gain voluntary cooperation before resorting to physical restraints.

In some communities, police are able to call mental health staff to handle transport. Often known as mobile crisis teams, these mental health units are able to assume responsibility for the individual in question on the scene, allowing officers to return to patrol.

Example: Montgomery County (MD) Police Department

In Montgomery County, Maryland, the Police Department's Crisis Intervention Team works closely with the county mental health agency's Crisis Response Team. In many instances, the Crisis Response Team is called to the scene by the CIT, allowing police officers to transfer responsibility for an individual without accompanying that person to a mental health intake center or hospital emergency room.

j

Conduct suicide screening for all people with mental illness who are detained for a short time in a police lock-up or jail.

Depending upon the jurisdiction, a person taken into custody for a criminal offense is brought either to a police holding facility or to the local jail pending the initial appearance in court. While this stay in custody awaiting the court appearance is usually brief—in most instances less than 24 hours—it can be a vital time for a person with mental illness. Research has shown that most suicides that occur in custody take place within the first 24 hours.⁶ In addition, the behavior that led to the arrest may be the manifestation of an individual experiencing a mental health crisis.

As a result, intake procedures into these facilities should screen for a risk of suicide and assess the need for emergency psychiatric evaluation. Staff should also be trained in suicide prevention and crisis management procedures. These screening procedures are for the purpose of providing appropriate treatment, not for gathering evidence for a criminal proceeding. Agency staff should also note that people with mental illness may need access to their medication. Officers must follow departmental rules for verifying that any pills or capsules the person is carrying are prescribed, or to obtain the needed medication, so that they may authorize the individual to continue the prescribed treatment should they be detained.

As mentioned earlier, police officers should be aware that some medications that treat mental illness have side effects that may require attention. For example, medications may cause tremors, nausea, extreme lethargy, confusion, dry mouth, constipation, or diarrhea. Police officers should attend to needs for water, food, and access to toilet facilities. It is important not to mistake these side effects as evidence of alcohol or drug abuse. (See Policy Statement 13: Intake at County / Municipal Detention Facility, for more information on intake procedures.)

6. L.M. Hayes, *Prison Suicide: An Overview and Guide to Prevention*, National Institute of Corrections, 1995, available at: www.nicic.org/pubs/1995/012475.pdf

5

Incident Documentation

POLICY STATEMENT #5

Document accurately police contacts with people whose mental illness was a factor in an incident to promote accountability and to enhance service delivery.

While not *all* contacts with the public result in documentation, law enforcement agencies do collect information about most of their encounters with the public at several points: when the call comes in to the agency; when the officer clears the call and returns to service; when an official report is filed; and when supplemental reports are submitted. Many agencies maintain sophisticated computerized systems, while others rely on more traditional paper-based systems. Regardless of the level of sophistication, however, it is critical that data be reliable, accurate, and consistently entered.

When the call comes in to the agency dispatch, some agencies use a Computer Aided Dispatch (CAD) system that maintains important data elements on all calls for service. These systems keep track of calls based on their geographic location, and can show numbers and types of calls over time. When the officer has completed the call, he or she contacts the dispatcher to clear the call and can update the nature of the call at that time. Although not all departments have a CAD system, all do maintain some system for tracking calls for service.

Many agencies also maintain additional computerized data systems, often called Records Management Systems, or RMS, which capture information submitted on incident or arrest reports. These data may be used by police to manage a great deal

of information about contacts with the police, up to and including arrest. These data are analyzed to detect crime patterns and evaluate the police response. Supplemental reports for particular types of incidents may also be maintained in computerized formats, or in file cabinets, depending on the quantity of the information and its intended use.

Law enforcement agencies must consistently and accurately document their contacts with people who have mental illness, just as they should for all encounters—for consumers' protection and to provide better law enforcement service. Just as information has certain benefits, however, it also has risks to the consumer and his or her family. For this reason, privacy laws protect personal medical information, including information about a person's mental health, and limit the occasions when a medical professional can share that information without consent. A full discussion of protected information and its disclosure is provided in Policy Statement 25: Sharing Information.

The recommendations in this section address how law enforcement should capture data and under what circumstances. Ultimately, departments that develop effective internal information-management systems will depend less on mental health system information protected by privacy laws and be better prepared to address the needs of people with mental illness in the long term.

RECOMMENDATIONS FOR IMPLEMENTATION

a

Capture information related to mental illness consistently in calls-for-service data.

Regardless of agency size, law enforcement agencies should use special numerical codes when storing data to indicate when mental illness was a factor in the call for service.⁷ Smaller departments may document incidences using index cards while some larger departments may use computer equipment. In smaller jurisdictions without advanced Computer Aided Dispatch (CAD) systems, dispatchers must be specially trained to collect detailed information that can be stored in location files or similar data sources.

Officers should also be required to update this numerical code when clearing the call to change the nature of the call if they determine that mental illness is an issue. For example, if an officer is called for a noise complaint and finds a man having a psychotic episode who is a danger to himself, the call should be cleared to reflect this new information. If the officer determines that mental illness is *not* a factor in a call that was dispatched as such, he or she should also denote that change for dispatch.

Many CAD systems have only one field that captures the type of call and officers are asked to pick the most relevant code. Agencies will need to provide guidance to officers as to how and when to prioritize the mental illness as the critical feature of the call. By using appropriate clearance codes in the CAD system, law enforcement agencies can track information (such as repeat calls involving a person with mental illness) and assess agency responses.

Some departments also choose to place “flags” on certain locations in the CAD system (see Policy Statement 2: Request for Police Service). These flags appear when repeated calls for service are made to that location. The dispatcher then reads the text of the flag when dispatching the call to provide additional information to the responding officers. These flags are placed *only* on those call locations that pose a particular concern, such as potential for violence or as a repeat location. Personnel are designated to review these flags periodically to make sure the flags continue to reflect current issues or problems.

Example: Baltimore County (MD) Police Department

In the Baltimore County Police Department, supervisors make written requests to the communications center to place a flag on certain locations where police have made repeated calls or where there has been a history of weapons use or violence. These flags are used for a wide variety of calls, not just those related to mental health problems.

7. Law enforcement agencies should only document information about mental illness when it is relevant to the encounter. Agencies should not develop databases that con-

b Collect information related to mental illness accurately in police reports and supplemental forms, focusing on observable behavior.

Although information about a person's mental illness on written police reports is important for accuracy and to clarify officers' response choices, it has the potential to influence criminal case outcomes negatively. For that reason, care must be taken in the way that information pertaining to mental illness is documented.

Most important, officers should be trained to concentrate on documenting *observable* behavior, not pseudo-diagnoses or damaging slang. For example, reports should never include a box stating that a person is mentally ill, but could instead list indicators of mental illness involved (see Policy Statement 3: On-Scene Assessment, for examples of indicators of mental illness).

Report forms should also allow room for officers to include their own observations. However, officers should not draw conclusions in their observations about what they believe has caused the behavior, such as that the person is "off his meds," without supporting information. Whenever possible, local mental health professionals should participate in training officers about the type of information to be included in a report based on federal, state, and local laws. Confidential information shared by mental health professionals should not be documented in police reports.

Departments may also want to consider using supplemental forms that capture additional information about police contacts with people with mental illnesses. These forms should not become part of the charging documents and should be kept confidential. This documentation can provide information about the nature of the problem, mental health resources that were accessed, and the way police responded. This information will be helpful to internal decision-making processes, such as the allocation of resources, but will not be part of the individual's arrest record.

Example: Memphis (TN) Crisis Intervention Team

The CIT approaches used around the country employ a report form that is completed by the responding CIT officer and maintained by the coordinator for review and tracking. Memphis, Tennessee, and Montgomery County, Maryland, Police Departments use such a form to document incident specifics such as the living arrangement of the person, the use of restraints, and the disposition chosen.

Police observations related to a person's mental illness are also collected on commitment forms, which in many jurisdictions give only two lines to report observations. Commitment forms must be useful for police, which means short and fast, but they should have sufficient space to record observations that would be useful to mental health providers. These forms are used to indicate probable cause for emergency holds of individuals thought likely to meet criteria for involuntary commitment and will be presented to judges during civil commit-

"In terms of information, law enforcement needs to know enough to resolve the situation and keep people safe, but some of the detail and nuance are better kept confidential. If law enforcement has certain information, it can stigmatize the person with mental illness, and that can stay with the person for a long time."

**CHIEF CHARLES
MOOSE**
Montgomery County
Police Department, MD

ment proceedings. Often, police officers have had the best opportunity to observe behaviors that may indicate need for involuntary treatment, so an accurate and professional description in such instances is important.

C

Document information relating to a person’s mental illness only when that information is relevant to the incident.

Officers should document information about mental illness only when that illness is relevant to the police contact. For example, a suspect may have depression that is not relevant to the crime he or she is accused of. Similarly, for some victims of crime who have a mental illness, that illness is not relevant to the situation and thus should not be recorded.

6

Police Response Evaluation

POLICY STATEMENT #6

Collaborate with mental health partners to reduce the need for subsequent contacts between people with mental illness and law enforcement.

An important goal of any police response is to ensure that people with mental illness are well served by the services that are brought to bear and that approaches being implemented have the effect of reducing contacts with the criminal justice system. The way to assess how well services are working involves doing two things: consulting with ser-

vice providers to evaluate referral mechanisms and identifying individuals who continue to come into contact with the police. It is important when conducting any kind of assessment for the participants to have clearly articulated the program goals. Chapter V: Improving Collaboration and Chapter VIII: Evaluating Outcomes also address these topics.

RECOMMENDATIONS FOR IMPLEMENTATION

a Consult with service providers to evaluate rates of success in engaging people referred by the police.

Law enforcement agencies should consult with service providers (including those who focus on minors and victims) to gather information on the outcome of the police referrals. It is important, as always, that private information about the individuals seeking treatment be kept confidential. Consulting with providers serves as an evaluation tool to assess whether services were made available and accessed following encounters with law enforcement. Agencies should examine in-house protocols to ensure that referrals were made and to identify other resource issues.

This consultation can be conducted during routine partnership meetings where police and mental health practitioners review data they have collected. It is very important that these data be presented in the aggregate rather than

for each individual.⁸ For example, the law enforcement representative can provide the number of people who were referred for services, which can be compared to the mental health representatives' notes on how many people contacted the service. In this way, confidentiality is maintained, yet problems with the protocol can be examined.

b **Analyze police data to identify individuals who have repeat contacts with law enforcement and collaborate with mental health partners to develop long-term solutions.**

A proactive approach is fundamental to the philosophy of community policing. This involves identifying problem situations and working with community partners to craft long-term solutions. “Problem” situations involving people with mental illness are those that result in repeat calls to the police. These situations may not be resolved by existing protocols, may escalate in seriousness, and require a more in-depth look into the underlying causes of the problem.

To identify these cases, agencies must review internal databases designed to capture information on situations involving people with mental illness. As mentioned previously, some departments review CAD system data to reveal locations that previously have involved violence or that result in frequent calls for service. Other agencies review supplemental data forms collected by crisis intervention teams.

Once the case has been identified, law enforcement personnel should work closely with their mental health partners to identify the precise nature of the problem and the possible causes.⁹ Together police and mental health providers can then determine a course of action to help the person avoid further contacts with the police. It is always preferable for mental health personnel to conduct follow-up visits, should they be required, although some departments have paired a mental health professional with an officer who is not in uniform.

Example: Anne Arundel County (MD) Mobile Crisis Team

Mental health professionals from the Mobile Crisis Team in Anne Arundel County provide follow up for people with mental illness who have come in contact with local law enforcement.

8. This does not preclude police involvement in problem-solving teams, when requested to do so by mental health partners.

9. Many law enforcement agencies around the country use the Scanning Analysis Response and Assessment (SARA) model of problem solving. For more information about the

SARA model, see Goldstein, Herman, *Problem-Oriented Policing*, McGraw Hill, Inc., New York, 1990; also M. Reuland, C.S. Brito, and L. Carroll (Eds.), *Solving Crime and Disorder Problems: Current Issues, Police Strategies and Organizational Tactics*, Police Executive Research Forum, Washington, DC, 2001.

CONCLUSION

Those in law enforcement are continually bombarded with demands from constituents who want their concerns to be given top priority, mandated training, new resources, or revised protocols. Officers and other police personnel are frustrated with repeat calls for service that have no satisfactory resolution for anyone involved. They want to address problems before they escalate into confrontations that can have deadly consequences. They want to use their resources effectively and efficiently. At the end of the day, they want to improve the lives of people who struggle with mental illness as well as all those touched by the consequences of unmet mental health needs. It is for them that this section has been written.

Police are frequently the only 24-hour service providers citizens in a community know to contact for help. Many police departments lack the resources or mental health networks to reduce the costs—in human lives, quality of life, and dollars. It is hoped that this report will assist them in finding more immediate help to divert those who are better served by the mental health system, without threat to public safety. For those individuals whose needs continue to go unmet, there is still hope that the reforms suggested in the following sections on courts and corrections will prevent them from cycling back to the streets, no better off than when they started.

These subsequent chapters, in addition to the chapters in Part Two: Overarching Themes, will help police professionals and others fully understand how the actions of one component of the criminal justice system can so significantly affect others. The report presents creative strategies for collaboration and propose the kind of mutual support that can convince policymakers to make the reforms that each of them has unsuccessfully pressed for individually.

Pretrial Issues, Adjudication, and Sentencing

In jurisdictions where the law enforcement recommendations presented in the previous chapter are implemented, a great many people with mental illness who are currently brought to the court system for possible criminal prosecution will instead be diverted to an appropriate placement in the mental health system. For those who are referred for prosecution, the following policy statements and recommendations describe improvements courts can make that will assure that justice is served while meeting the needs of people with mental illness.

The extent to which these improvements can be made depends upon the level of services currently available in a jurisdiction. These policy statements and recommendations are written with two assumptions. The first is that the policy statements and recommendations contained elsewhere in this document pertaining to enhancements to mental health services are implemented (see Chapter I: Involvement with the Mental Health system and Chapter VII: Elements of an Effective Mental Health System). It would be counterproductive for

the court to enhance its referral capacities with no enhancements to existing mental health services. The second assumption is that the jurisdiction provides such services as early appointment of defense counsel; a victim assistance office; pretrial diversion through the prosecutor's office; and a pretrial services program that provides information and options to the court at the initial bail-setting hearing. Many jurisdictions do have all these services, and should be well positioned to take immediate advantage of the recommendations outlined here. Many other jurisdictions lack one or all of these services. Even in such jurisdictions, it would be possible to implement incremental change that could still have a dramatic impact on how the criminal justice system responds to people with mental illness.

The text includes many examples of initiatives jurisdictions have taken to improve the processing of people with mental illness through the courts. The inclusion of these examples is not meant to imply that jurisdictions need expensive new initiatives to make improvements. In many instances, simple adjustments to existing procedures can be very effective.

Several of the events discussed in this chapter—appointment of counsel, consultation with victims, prosecutorial review of charges, and pretrial release/detention hearing—all occur early in the life of a criminal court case. There is, however, no single process employed in all jurisdictions for when a criminal case is filed in court. In some, the defendant is appointed an attorney even before the prosecutor has reviewed the charges, or the two occur simultaneously. In others, the appointment of counsel does not occur until much later in the process. In some, the pretrial release/detention hearing occurs well before either appointment of counsel or prosecutorial review of charges. In yet others, contact with victims occurs even before any of these steps. The appointment of counsel is presented here first since so much of what is being recommended in this document depends on consent of the individual for the release of mental health information, and because consent should not be sought without first offering the person access to an attorney.

7

Appointment of Counsel

POLICY STATEMENT #7

Make defense attorneys aware of the following: (a) the mental health condition, history and needs of their clients as early as possible in the court process; (b) the current availability of quality mental health resources in the community; and (c) current legislation and case law that might affect the use of mental health information in the resolution of their client's case.

When a case is filed in court an inquiry is typically made regarding the defendant's financial ability to retain an attorney. If the defendant is found to be indigent, an attorney is provided. If the defendant is found to have sufficient financial resources, he or she is responsible for hiring his or her own attorney. Not surprisingly, most defendants in criminal cases are appointed counsel because they are found to be indigent.

The unique role that defense counsel plays for his or her client—spokesperson, translator, and court champion—becomes even more important when the client suffers from a mental illness. There are three key issues—all defense related—addressed in this policy statement. First, it is important that defense

counsel have speedy access to existing mental health information about the defendant. Information collected by law enforcement, pretrial services and other justice agencies, or from family members should be made available to the defense as soon as they are assigned or agree to represent a client. Second, attorneys have a responsibility to know about the mental health resources in the community—both their quality and their availability—that might be appropriate for clients with mental health issues, both pre- and post-adjudication. Third, the policy statement underscores the affirmative obligation of attorneys to be current as to laws that could affect their clients who have mental illness.

"Defense attorneys are often ill-equipped to represent people with mental illness. Training about mental illness and mental health resources in the community is a key means of ensuring that defendants with mental illness receive the best possible representation."

JO-ANN WALLACE
Vice President & Chief Counsel for Defender Operations, National Legal Aid & Defender Association

Source: Personal correspondence

RECOMMENDATIONS FOR IMPLEMENTATION

a **Ensure that defense counsel can identify the mental health status of their clients as soon as possible after appointment.**

The American Bar Association Standards Relating to Providing Defense Services state, "Counsel should be provided to the accused as soon as feasible

and, in any event, after custody begins, at appearance before a committing magistrate, or when charges are filed, whichever occurs earliest.”¹ One of the first actions of defense counsel after appointment should be to identify those clients with severe mental illness. This can be done by interviewing the defendant, and reviewing the police report and the information obtained by the pretrial services program. At least one state, Georgia, has a statute that allows defense attorneys access to state mental health records with the consent of the client.

It can also be done by listening to family members or others who may be in a position to provide useful information about the mental health status of the client. Attorneys should be careful, however, not to divulge information about a client’s mental health status to any of these parties without first obtaining the consent of the client.

Example: Public Defender’s Office, Hamilton County (OH)

In Hamilton County, a defense attorney is assigned to the case as soon as it is determined that the defendant may have a mental illness and the case is continued to a special afternoon calendar. The defense counsel consults with the defendant before a clinical assessment is conducted by a mental health clinician.

The mental health system should work with the defense counsel to assure that counsel has all the information needed to effectively represent a client.

b

Ensure that defense counsel can identify alternatives to incarceration in appropriate cases for their clients with mental illness.

In some jurisdictions it falls to a pretrial services program to identify and track programs in the community that could be used for referrals of defendants, and to probation departments to do the same for post-conviction alternatives. This recommendation calls for the defense to be equally familiar with mental health resources in the local community. Defense counsel should know program admission criteria and requirements; required lengths of stay; confidentiality rules imposed by the program; clinical capabilities; availability; and costs. Finally, defense counsel should be aware of the qualitative performance of such programs.

Obtaining this knowledge may require access by defenders to expert services. In many jurisdictions, the public defender’s office has staff who assist attorneys in finding appropriate alternatives.

Example: Public Defender’s Office, King County (WA)

In King County, social workers are assigned to the public defender’s office to help defense attorneys identify and develop mental health treatment alternatives to incarceration for defendants with mental illness.

“Defense attorneys aren’t thinking about me as an individual who has a mental illness. ...They are thinking about the short-term of this case. If they knew more about mental illness, they would do things differently.”

CONSUMER

Source: Derek Denckla and Greg Berman, *Rethinking the Revolving Door: A Look at Mental Illness in the Courts*, New York, Center for Court Innovation. 2001.

1. American Bar Association, *Standards for Criminal Justice: Providing Defense Services*, 3rd Edition, Washington, D.C., 1992, Standard 5-6.1, Initial Provision of Counsel.

In other jurisdictions—particularly small jurisdictions—defenders may have very limited resources. Yet even then, at least one state has taken on the responsibility of providing expert services to defenders in all parts of the state.

Example: Georgia Indigent Defense Counsel

In Georgia, much of the information regarding alternatives to incarceration for people with mental illness is catalogued by the Georgia Indigent Defense Counsel (GIDC), which serves as an information resource center for defense attorneys throughout the state. The GIDC provides defense attorneys with seminars and publications addressing the special needs of clients with mental illness. The GIDC is also available to defense counsel for telephone consultation on individual cases.

Determining What Is in the Client's Best Interests

A defense attorney representing a defendant with a mental illness can face difficult decisions in trying to determine what advice to the defendant would be in the defendant's best interests. On the one hand, the attorney has an obligation to reduce the defendant's possible exposure to sanctioning by the criminal justice system by removing him or her as quickly as possible from its jurisdiction. To that end, the attorney may believe that the best resolution of a case where the evidence is strong is a quick plea of guilty and acceptance of a short jail term, perhaps even credit for any time served, and may make that recommendation to the court. On the other hand, the attorney may recognize that the defendant will continue to be rearrested if his or her mental health needs are not addressed and that having a criminal record may make it more difficult for the defendant to obtain a job and to receive such services as public housing. In that sense, the attorney may advise that the best course of action is to try to get the defendant accepted into a pretrial diversion program where he or she would be under the supervision of the criminal justice system while in mental health treatment, and where charges would be dropped upon successful completion.

There are no right or wrong answers to this issue. Defense attorneys should present all possible consequences to their clients when discussing options for the resolution of the case.

c Develop materials and training programs that cover recent legal holdings that might affect the client with a mental illness.

Defense counsel representing persons with mental illness must carefully consider how mental health information may potentially be used—not just in the instant circumstance but in future hearings involving the client as well. Counsel must also be aware of the potential ramifications of actions being considered. For example, advising a defendant to plead not guilty by reason of insanity to a relatively minor offense could expose the defendant to more extensive loss of liberty than in simply pleading guilty. (See Policy Statement 29: Training for Court Personnel.)

d Make resources available to the family members and friends of people with mental illness to help them navigate the criminal justice system.

When a person with mental illness becomes involved in the criminal justice system, his or her family, friends, mental health service providers, and other advocates may want to help in a variety of ways. Family members may want to inform the defense attorney about the defendant's mental health history, to advocate for the defendant's placement in a particular treatment program, or generally to help their loved one navigate the criminal justice system. Advocates in some communities have developed resources for such situations.

Example: When a Person with Mental Illness is Arrested: How to Help, Urban Justice Center, New York City (NY)

Staff at the Urban Justice Center's Mental Health Project have developed a practical handbook for supporters of people with mental illness who have become involved in the criminal justice system. The handbook provides general information about the criminal justice process (arrest, arraignment, meeting with counsel), relevant statutes, and advice for advocates on working with defense attorneys, as well as information specific to the New York City criminal justice system.

8

Consultation with Victim

POLICY STATEMENT #8

Educate individuals who have been victimized by a defendant with a mental illness, or their survivors, about mental illness and how the criminal justice system deals with defendants with mental illness.

Victims in most jurisdictions have constitutional or statutorily defined rights. Generally, these involve the right to be informed of key events in the processing of the case, including charging decisions, plea agreements, and release decisions.²

Prosecutors or their agents have traditionally played a key role in the provision of victim support services, including explaining the often complex court processes to the victims of crime. This provision of support—explanations and education—begins as the charges are reviewed and filed, and goes on throughout the court process. It is important to stress that the victim of a crime committed by a person with a mental illness has no more rights than

any other victim in a similar situation, but may have more needs. When the mental health status of the accused is relevant to the processing of the criminal case, the pain of the victim can be exacerbated by the even more confusing jargon, procedures, decisions, and even dispositions that might arise in the prosecution of that person.

It must be kept in mind that most crimes committed by people with mental illness are minor, and may involve no victim. Victims' issues, in general, are most relevant where the crime is a serious one, involving harm or risk of harm to the victim. The recommendation that follows is meant to address these types of crimes.

RECOMMENDATIONS FOR IMPLEMENTATION

a

Assure that victim assistance offices have the expertise to meet the special needs of people who have been victimized by someone with a severe mental illness.

In recent years, great strides have been made in recognizing that victims of crime need assistance understanding both the legal process involved in the

2. See www.ncvc.org for more on statutes concerning victims rights.

prosecution of their case and their rights as victims. Many jurisdictions have established victim assistance offices that provide services to victims of crime, usually violent crimes.³ Staff from these offices typically act as a link between the prosecutor and victims, keep victims apprised of the status of the case, explain the court process to victims, and escort victims to court hearings.⁴ This recommendation addresses how offices that provide victim assistance can better address the needs of persons who have been victimized by someone with a mental illness.

Information

In cases where the accused person suffers from a mental illness the victim needs to be aware of the ways in which the criminal justice and mental health systems converge. Defendants with a mental illness may be subject to different legal procedures, such as a competency screening to determine their ability to understand the charges and their fitness to stand trial. In addition, victims may know little about mental illness—its causes, its impact on behavior, and how best to treat it. Providing such information should be viewed not as minimizing the victimization experienced, but as help for victims in understanding why they were victimized—an important part of the healing process.

Confidentiality versus the Right to Know

The rights of victims to be informed about what is going on with their case must be balanced, however, against the medical privacy rights of the person with mental illness. It may be difficult for victims to understand that the privacy rights of the person who victimized them outweigh their rights to information. There are actions that should be taken, though, to assure that victims receive all the information to which they are entitled. Victims should be informed immediately and as a matter of routine of any actions taken that become part of the public record. These would include when the defendant is being released, whether on pretrial diversion, pretrial release, or as part of a sentence, with the condition to participate in mental health treatment; when a competency screening has been ordered; or when the defendant enters a plea of not guilty by reason of insanity.

In the overwhelming majority of victimizations caused by people with mental illness, however, releasing mental health information to the victim will not

"When someone is victimized by an individual with mental illness they have a huge learning curve. Explaining to victims how the criminal justice system works and what their rights are is one of our jobs. It gets really complicated for us to explain the role of the mental health system. We as advocates often don't understand how the two relate."

ELLEN HALBERT
*Director, Victim Witness
Division, District
Attorney's Office,
Travis County, TX*

Source: Personal
correspondence

3. There are a number of different ways that victims can gain access to these services. The law enforcement agency investigating the crime should have referral information to victims' services. Listings for such services may appear in the telephone directory under either the local prosecutor's or the sheriff's office. These offices may also have web sites with information on how to access these services. The federal government also has taken steps to expand the availability of victims' services with the establishment of

the Office for Victims of Crime (OVC) within the Office of Justice Programs of the U.S. Department of Justice. OVC provides funding to state and local victim assistance programs. Information about OVC is available at: www.ojp.usdoj.gov/ovc/

4. While many of these offices are administratively located in the prosecutor's office, they can also be found in the local department of corrections, sheriff's department, police department, or probation office.

be an issue because the victim is already aware of the situation. It is estimated that 85 percent of those victimized by a person with a mental illness are either family or friends of the perpetrator.⁵ These victims need assistance at yet another level. A typical reaction of a loved one who has been victimized by a person with mental illness is to try to obtain help for that person. After perhaps experiencing numerous victimizations without pressing criminal charges, these victims ultimately may turn to the criminal justice system out of fear or frustration. When doing so, they may feel torn by being the complaining witness against a loved one. When they wish to do so, they should be advised on such issues as how to contact the defendant's attorney, how to assist in getting a signed consent to the release of the defendant's mental health information, and who to contact in the jail to make sure that the defendant is receiving his or her medications. They may also require additional supportive services to help resolve issues of guilt in reporting their loved one.

In short, in addition to the general role of victim assistance to explain how the criminal justice system works and what victims' legal rights are, when the alleged perpetrator has a mental illness victim assistance should also be prepared to do the following:

- explain the causes of mental illness and the impact it can have on a person's behavior;
- explain how the mental health system works, including confidentiality requirements;
- define terminology that the victim may encounter, such as "competency," "mental health court," and "Not Guilty by Reason of Insanity;" and
- help family members or others who have been victimized by a loved one with mental illness deal with issues of guilt.

Victims with Mental Illness

It is important to note that, contrary to the public perception that people with mental illness are more likely to commit violent crimes, studies show that individuals with mental illness are actually more likely to be the victims of violent crimes than people without mental illness. Though this issue is, in large part, beyond the scope of this report, victims' assistance offices should consider developing the expertise to meet the special needs of victims who have mental illness. These crime victims often face a variety of challenges, including low employment, lack of affordable housing, and substance abuse.⁶

5. *Victims of Mentally Ill Offenders: Helping Family Caregivers and Strangers At Risk of Assault*, New York University, Ehrenkranz School of Social Work's Institute Against Violence, December 2000.

6. Hiday et al., "Criminal Victimization of Persons with Severe Mental Illness."

9

Prosecutorial Review of Charges

POLICY STATEMENT #9

Maximize the use of alternatives to prosecution through pretrial diversion in appropriate cases involving people with a mental illness.

As the representative of the state, the prosecutor is responsible for ensuring that criminal cases are resolved in the best interests of justice.⁷ The best interests of justice can sometimes be served by extending to the individual the opportunity to address issues that may have led to the commission of the alleged offense without prosecuting the individual. When the case involves a minor offense or first-time offender, the prosecutor has the authority in many jurisdictions to provide that opportunity through pretrial diversion.

Authorizing which defendants will be offered pretrial diversion rests with the prosecutor and is addressed on a case-by-case basis in accordance with the laws of the jurisdiction authorizing diversion. Unlike the pretrial release/detention decision discussed in Policy Statement 11, the decision of whether to offer the defendant the opportunity to

participate in a pretrial diversion program is at the discretion of the prosecutor. Prosecutors typically rely on a number of criteria, including the potential danger to the community, the nature of the offense, the defendant's prior criminal record, and the wishes of the victim, in reaching a diversion decision. When faced with a defendant with a mental illness, prosecutors should also look at the relationship between the defendant's mental condition, whether the defendant was receiving adequate community treatment, and the behavior that led to the arrest.

Highlighting diversion programs designed especially for people with mental illness by no means suggests that these individuals should not have the same access to any diversion programs that are available in a jurisdiction to a person without mental illness.

7. "The prosecutor must seek justice. In doing so there is a need to balance the interests of *all* members of society, but when the balance cannot be struck in an individual case, the interest of society is *paramount* for the prosecutor," (emphasis in the original). National District Attorneys Association, *National Prosecution Standards*, Commentary to Standard 1, p. 11.

RECOMMENDATIONS FOR IMPLEMENTATION

a Provide sufficient dispositional opportunities for people with mental illness for prosecutors to employ early in the court process.

The crux of this recommendation is the need for more dispositional diversion programs for individuals with mental illness who come in contact with the criminal justice system. Pretrial diversion programs have been in existence in many jurisdictions for decades, serving mostly first-time offenders or those charged with minor offenses. The earliest diversion programs were based on the recognition that the justice process itself could be harmful—in some instances, criminogenic—and that for certain types of defendants, “diverting” them from the traditional process into a rehabilitative program and holding their charge in abeyance would reduce the likelihood of recidivism.⁹ This same recognition surfaces when considering the person with a mental illness who is charged with a crime.

There are jurisdictions that provide pretrial diversion opportunities specifically for defendants with mental illness.

Example: Mental Health Diversion Program, Jefferson County (KY)

In Jefferson County, the Mental Health Diversion Program serves nonviolent defendants charged with either misdemeanors or felonies who suffer from chronic mental illness and have a history of treatment for mental illness. Defendants who are placed in pretrial diversion undergo intensive treatment for a period of six months to one year. Upon successful completion, the charges are dismissed.

Several jurisdictions have been developing models for community prosecution, in which prosecutors reach out to the community to seek input and assistance in both preventing and responding to crime. Community prosecution may be an effective vehicle for expanding the opportunities for diverting from prosecution people with mental illness.

b Ensure that the defense and the mental health community work together to provide, in appropriate cases, mental health information to the prosecutor for use in pretrial diversion decisions.

When an arresting officer brings a case to the prosecutor’s office, a prosecutor screens the case to determine whether to file criminal charges, and, if so, which charges.¹⁰ The police report, which describes the circumstances that led

The use of the term “diversion” here employs the definition spelled out in the Diversion Standards of the National Association of Pretrial Services Agencies. “[A] dispositional practice is considered diversion if: (1) it offers persons charged with criminal offenses alternatives to traditional criminal justice or juvenile justice proceedings; and (2) it permits participation by the accused only on a voluntary basis; and (3) it occurs no sooner than the filing of formal charges and no later than a final adjudication of guilt; and (4) it results in a dismissal of charges, or its equivalent, if the diveree successfully completes the diversion process.”

8. National Association of Pretrial Services Agencies, *Performance Standards and Goals for Pretrial Release and Diversion*, August 1995, p. 1.

9. For an excellent review of the early years of diversion programming, see John P. Bellassai, “Pretrial Diversion: The First Decade in Retrospect,” *The Pretrial Services Annual Journal* 1, 1978, pp. 14-41.

10. According to the standards of the National District Attorneys Association, prosecutors should exercise that discretion using several criteria, including the strength of the evidence against the accused and the agreement of the victim to cooperate. Two other criteria are undue hardship caused to the accused and the availability of suitable diversion and rehabilitative programs. National District Attorneys Association, *National Prosecution Standards*, 1990.

to the arrest of the individual, might note any overt behaviors that are indicators of mental illness. (See Policy Statement 5: Incident Documentation.) That report usually is made available to prosecutors very early in the life of the case—sometimes within hours of arrest. Often, however, prosecutors may have no indication of possible mental health issues when reviewing the arrest information. The arrestee may not have exhibited symptoms of mental illness at the time of the incident, or the officer may have believed that the person was under the influence of drugs or alcohol. Without such information, the prosecutor cannot consider special accommodations that the defendant might need to be successful in pretrial diversion or any specialized mental health diversion program that might be appropriate. Procedures have been implemented in some jurisdictions to gather mental health information for the pretrial diversion decision.

Example: Pretrial Services Program, Pima County (AZ)

In Pima County, the prosecutor uses information collected by the pretrial services program for the pretrial release hearing to identify misdemeanor defendants who have a mental illness and who might be candidates for pretrial diversion. Those placed in the diversion program undergo a 180-day treatment program. Charges are dismissed upon successful completion of the program; prosecution resumes if the program is not completed.

In this example and others like it, the defendant has given prior written consent for the release of mental health information for the purpose of determining possible placement in a pretrial diversion program. The consent should be provided only after the defendant has consulted with his or her attorney. (See Policy Statement 7: Appointment of Counsel, for more on consent issues.) The consent provided should be in writing and explicitly specify what information the defendant is consenting to have released, who is being authorized to make the release, the parties to whom the information will be released, and the purposes for which the information is to be used. Finally, the release of mental health information should be consistent with all applicable confidentiality and ethical requirements, as well as conforming to the principle that the information released is the minimum necessary to make an informed pretrial diversion decision. All information collected through this process should also be made available to the defense attorney.

Identifying the Sources of Mental Health Information for Court Officials

A key issue in the release of mental health information to criminal justice officials, regardless of the decision point, is identifying all the sources of this information in individual cases. This can be problematic, especially in larger jurisdictions where the individual may have received services at a number of different locations, or where the individual is transient, moving from one jurisdiction to another. Ideally, the individual's most recent clinician should have as up-to-date a history as exists.

Identifying the correct source of information requires that the individual cooperate, supplying the name of the attending clinician and providing consent to contact the clinician.

In cases where the individual has no prior history of receiving mental health services it may be necessary to have an assessment conducted by a mental health clinician before a decision — pretrial diversion, pretrial release, adjudication, or sentencing — is made. In such instances, the incident that led to the arrest may have been the individual's first indication that he or she may have a serious mental illness.

C Expand the options available in rural areas to provide mental health services for people with mental illness who might be candidates for pretrial diversion.

The opportunities for identifying or establishing the resources that would provide the range of options discussed here are much greater in urban and suburban areas than they are in rural areas. In fact, in many rural areas there may be no options at all. The chief problem that rural areas encounter as it relates to viable options for those with mental illness who are in the criminal justice system is the lack of mental health professionals. For example, more than half of the 3,075 counties in the United States—all of them rural—have no practicing psychiatrists, psychologists, or psychiatric social workers.¹¹

The mobile units that law enforcement and mental health officials have teamed up in recent years to institute in many urban jurisdictions may hold clues for developing a model for options that can be used by courts to develop release alternatives in rural jurisdictions. These units are designed to respond rapidly to a person in a mental health crisis so that an arrest is avoided and the person is taken to an appropriate mental health facility. In rural areas, such mobile units may provide the courts with alternatives by bringing mental health treatment resources to those who need it. It may also be useful to make greater use of telemedicine, in which mental health professionals are available to conduct private telephone consultations with mental health patients from a remote location.

The federal government has been attempting to address the shortage of health care workers in rural areas since 1987, when the National Advisory Committee on Rural Health (NACRH) was established within the Department of Health and Human Services (HHS) to seek solutions to health care problems in rural areas. The committee has made several recommendations, such as: increase the awareness of health care opportunities in rural areas and ensure that students are academically prepared to take advantage of these opportunities; and create incentives for health care practitioners to practice there. Such incentives include financial support for students who will commit to service in rural areas, enhancement of Medicare reimbursements for rural providers, and granting tax credits to providers who serve rural areas. Many of these recommendations have been followed and have brought some relief to the health care shortages in rural areas.¹²

The U.S. Department of Justice, currently through its Bureau of Justice Assistance, also provides block grant funding to the states. In the past, block grant funds could be used for a number of different purposes, including to address alternatives to detention for those who pose no danger to the community.¹³

HHS has sought to address the mental health needs of rural residents through the Mental Health Block Grant program, which provides funding to states to improve access to mental health services.¹⁴ More than \$350 million is allocated to this program annually. In order to receive their block grant funds, states must submit plans to address the mental health needs of various state subpopulations, including those who live in rural areas.¹⁵

State and local officials should work together to ensure a coordinated use of block grant funds from the Departments of Justice and HHS to address the mental health treatment needs of people who have been charged with criminal offenses in rural areas.

11. Georgine M. Pion and Harriet McCombs, *Mental Health Providers in Rural and Isolated Areas: Final Report of the Ad Hoc Rural Mental Health Provider Work Group*, Rockville, MD: The Center for Mental Health Services, 1997.

12. *National Rural Health Policy: Recommendations from the First Eight Years of the National Advisory Committee on Rural Health*, Rockville, MD: Of-

fice of Rural Health Policy, U.S. Department of Health and Human Services, 1997.

13. See the Web site of the Bureau of Justice Assistance at: www.ojp.usdoj.gov/BJA for the latest guidelines on the use of block grant funds.

14. *Ibid.*

15. *Ibid.*

10

Modification of Pretrial Diversion Conditions

POLICY STATEMENT #10

Assist defendants with mental illness in complying with conditions of pretrial diversion.

Once the prosecutor agrees to offer the defendant the opportunity to participate in pretrial diversion, the defendant is interviewed by a representative of the pretrial diversion program to determine the most appropriate conditions of diversion. These pretrial diversion programs, which also monitor compliance with diversion conditions, fall administratively either within the office of the prosecutor or report to the prosecutor.

A defendant should be informed of the specific program requirements, length of program duration, and sanctions for noncompliance. Because people with mental illnesses, in many instances, will have difficulty understanding this information and fol-

lowing through on their requirements, extra care is required to ensure that these defendants report for initial intake into the appropriate service and continue their participation.

Pretrial diversion programs that serve people with mental illness should recognize that this population often presents a range of problems that should be addressed in an integrated fashion. They may need assistance in locating affordable housing, in handling their finances, in traveling back and forth to diversion program appointments, or in obtaining employment or job training. All pretrial diversion programs that serve people with mental illness should be designed to address these problems.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Ensure that interview protocols used by pretrial diversion staff on defendants with mental illness include questions to identify those with co-occurring substance abuse disorders.**

One way to assist defendants with mental illness in complying with conditions of pretrial diversion is to recognize that the majority also suffer from co-occurring substance abuse problems. According to several studies, rates of both mental health and substance abuse disorders are significantly higher in crimi-

nal justice populations than in the general population.¹⁶ Individuals with co-occurring disorders present unique challenges that must be addressed by the mental health and substance abuse treatment communities. Individuals with co-occurring disorders, when compared to individuals with a single disorder, have heightened psychosocial difficulty, including an increased likelihood of problems with finances, social roles, education, housing, transportation, and marital stability.¹⁷ In addition, people with co-occurring disorders experience more psychotic symptoms, have more severe depression and suicidality, have higher rates of incarceration, have more difficulty with daily living skills, are more noncompliant with treatment regimens, and are high service utilizers.¹⁸

b Design pretrial diversion conditions to address individual issues presented by each defendant.

Conditions of pretrial diversion should be the least restrictive necessary and reasonably calculated to accomplish the goal of pretrial diversion, which is to reduce the likelihood that the person will recidivate. When a defendant is currently in mental health treatment and the treatment is helpful, it should be a requirement that he or she continue treatment as a condition of diversion. If the defendant expresses significant concern regarding the usefulness of that treatment, a mental health consultation may be needed to determine whether there are better alternatives available. When the defendant is not currently in treatment, an assessment should be conducted by a qualified mental health professional to determine the most appropriate treatment for the defendant, and then a referral should be made to begin that treatment. This assessment should be conducted on an outpatient basis.

Those with co-occurring substance abuse and mental health disorders should receive integrated treatment. Barriers to specialized treatment for this population include differing mental health and substance abuse treatment philosophies and practices, policies that exclude active substance abusers from mental health treatment, policies that exclude persons with active psychosis or other symptoms of mental illness from receiving substance abuse treatment, and separate local, state, and federal funding streams for mental health and substance abuse treatment.

16. S. Keith, D. Regier, D. Rae, and S. Matthews, "The prevalence of schizophrenia: Analysis of demographic features, symptom patterns, and course," *International Annals of Adolescent Psychiatry* 2, 1992, pp. 260-84; M. Weissman, M. Bruce, P. Leaf, L. Floria, and C. Holzer, "Affective Disorders" in *Psychiatric Disorders in America* edited by L. Robins and D. Reiger, New York, Macmillan, 1992; and L. Robins and D. Regier, *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study*, New York, Free Press, 1991.

17. L. Pollack, G. Stuebben, K. Kouzekanani, and K. Krajewski, "Aftercare Compliance: Perceptions of People with Dual Diagnosis," *Substance Abuse* 19, 1998, pp. 33-44; A. Laudet, S. Magura, H. Vogel and E. Knight, "Recovery Challenges Among Dually Diagnosed Individuals," *Journal of Substance Abuse Treatment* 18, 2000, pp. 321-29.

18. F. Osher and R. Drake, "Reversing a History of Unmet Needs: Approaches to Care for Persons with Co-Occurring, Addictive and Mental Disorders," *American Journal of Orthopsychiatry* 66:1, 1996.

Treatment providers and the criminal justice community should be aware of the complexity involved in diagnosing co-occurring disorders and adapt professional practices accordingly. Identification of those with co-occurring disorders should occur in the early stages of criminal justice processing.

Research indicates that an integrated model of treatment is most effective for people with co-occurring mental and substance abuse disorders.¹⁹ That is, both the mental disorder and substance abuse disorder are treated in the same service setting, using cross-trained staff proficient in both mental health and substance abuse disorder therapy. Too often, co-occurring disorders are treated sequentially — individuals receive treatment in one system first (either mental health or substance abuse) followed by treatment in the other—or concurrently—that is, individuals receive both mental health and substance abuse treatment at the same time, but with different therapists or at different agencies. In both of these models, the burden of coordinating or integrating treatment lies with the client. (See Policy Statement 37: Co-occurring Disorders.)

Boundary spanners—people who act as liaisons to bridge mental health, substance abuse and criminal justice systems—should be knowledgeable about both mental health and substance abuse disorders and provide such information to the courts. (See Policy Statement 26: Institutionalizing the Partnership, for more on boundary spanners.)

Example: Drug Court, Lane County (OR)

In Lane County, a mental health specialist trained to deal with co-occurring disorders is assigned to the jurisdiction's drug court in the dual role of case manager and court liaison to assist with people with co-occurring disorders who are placed in the drug court.

C

Develop guidelines on compliance and termination policies regarding defendants with pretrial diversion conditions that recognize the needs and capabilities of people with mental illness.

The National Association of Pretrial Services Agencies (NAPSA) has standards for pretrial diversion that should prove useful in developing compliance and termination policies for defendants with mental illness who are placed in diversion programs.²⁰ Those standards state that diversion conditions should be clearly written in a service plan signed by the defendant and the diversion program representative. “Knowing exactly what is expected will decrease the likelihood of a participant’s being unsuccessful in treatment.”²¹ The service plan should also detail what actions could be taken in response to the participant’s failure to comply with the conditions. The diversion program rep-

19. The National GAINS Center, *Treatment of people with co-occurring disorders in the justice system*, Delmar, New York, The National GAINS Center, 2000.

20. National Association of Pretrial Services Agencies, *Performance Standards and Goals for Pretrial Diversion*, August 1995.

21. *Ibid.*, Commentary to Standard 4.1, p. 20.

representative should explore any noncompliance with diversion conditions to determine whether the violation was willful, was a symptom of the mental illness, or was an indication of the need to change the treatment plan. It must be recognized that decompensation and other setbacks are common occurrences for people under treatment for mental illness as the attending mental health clinician seeks the most appropriate treatment.

Defendants who are terminated for unsuccessfully completing the program should have their cases returned, without prejudice, to the regular court calendar. Defendants should also be allowed to withdraw from diversion and have the prosecution of their cases resumed without prejudice.

11

Pretrial Release/Detention Hearing

POLICY STATEMENT #11

Maximize the use of pretrial release options in appropriate cases of defendants with mental illness so that no person is detained pretrial solely for the lack of information or options to address the person's mental illness.

Usually within a day of arrest, a defendant will appear in court where a judge or magistrate will determine whether or not the defendant should be released pending adjudication of the case, and if so under what conditions. In making that decision, the judicial officer weighs the risks posed by the defendant to fail to appear in court and the potential threat to the community's safety if the defendant is released.

Judges, like any decision maker, seek to make informed decisions and to have a range of options at their disposal. Armed with the kind of information outlined below and improved options, the courts

should be in a position to minimize the unnecessary pretrial detention of people with mental illness.

This is not to suggest that people with mental illness should never be detained. It is particularly important, though, that mental illness itself not be used as a reason to detain a defendant in a case where a defendant with no mental illness facing similar charges and with a similar criminal record would likely be released. In such cases where the criminal charges do not warrant detention and the judge's primary concern is the defendant's mental illness, facilitating access to services should be considered instead of resorting to criminal detention.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Facilitate the release of mental health information where appropriate for use at the pretrial release hearing.**

Both mental health and criminal justice officials are bound by professional codes of ethics that define the doctor-patient, lawyer-client relationship. Communications between mental health providers and their clients, or attorneys and their clients, are protected from disclosure unless the client specifically

provides written consent for the release of information.²² As in cases where pretrial diversion is being considered, the written consent should explicitly state what information the defendant is consenting to release, who is being authorized to make the release, the parties to whom the information will be released, and the purpose to which the information is to be used. Recognizing that the privacy rights of the individual with a mental illness must be balanced against the needs of the court to have all the information that might be relevant to assessing the defendant's risks to public safety and of failure to appear in court, the information released should be the minimum necessary to make an informed pretrial release decision. (See Policy Statement 25: Sharing Information, for more in-depth recommendations on information sharing.)

For the pretrial release decision, the defendant is under no obligation to provide the court with any private information, including mental health status. In many instances, though, it is in the defendant's best interests to do so since it might facilitate his or her release and allow for the continuation of existing treatment. Seeking consent for the release of information from an individual who may have a mental illness, however, must be done with extreme caution because the mental illness may impair the person's ability to give informed consent.

If the individual has provided consent to the release of the information, the next step is to gain access to that information. Jurisdictions have taken different approaches to obtaining mental health information for the pretrial release hearing.

Example: Connecticut Mental Health Center

Mental health staff from the Connecticut Mental Health Center receive each day a list from the court of all individuals just arrested that they cross-reference with their database to see who is currently in their system. Staff then interview the defendant and, in coordination with the public defender's and the pretrial services offices, develop a plan for release. This plan is then submitted to the court.

Two other issues that must be addressed in a discussion of obtaining mental health information are the ethical guidelines of mental health professionals and the timeliness of receiving that information. Mental health clinicians are prohibited from conducting a mental health assessment before the defendant has had an attorney assigned and has consulted with the attorney. Jurisdictions have addressed these ethical guidelines in a way that allows for a timely assessment of a defendant's mental health status.

22. Every state has either statutory or regulatory provisions that specify the confidentiality guidelines for the protection of mental health information, although the states vary greatly in the protections that are provided. Given the variance in state protections and concern about the growing ease of electronically exchanging private health information, in 1996 Congress passed the Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191), which,

among other things, directed the U.S. Department of Health and Human Services to establish regulations for the protection of all medical, including mental health, information. Those regulations, which supercede state laws that provide less protections, became effective on April 14, 2001. The regulations permit access to and dissemination of mental health information as outlined here.

Example: Public Defender's Office, Broward County (FL)

In Broward County, where mental health clinicians conduct an assessment before the pretrial release hearing, the clinicians are on the staff of the public defender's office. This expedites the process of conducting a mental health assessment while ensuring that the client has received appropriate consultation with an attorney.

It is also important to respect established boundaries when court and mental health professionals work together in these ways. Mental health clinicians should not make recommendations regarding whether the defendant should be released pretrial; they should limit their presentation to the court to the defendant's mental health condition, history, and needs and how those needs can be addressed.

b Ensure that a neutral entity is available to provide the pretrial release decision making officer with all the information relevant to that decision, including mental health status, and with viable options to address any identified mental health issues.

According to American Bar Association Standards, every jurisdiction should establish a neutral entity that gathers all the historical information that is relevant for the pretrial release decision.²³ In many jurisdictions, there is no designated agency that conducts these functions, particularly in nonmetropolitan areas. In those jurisdictions, the judicial officer presiding at the pretrial release hearing typically receives information directly from the defendant, from the arresting law enforcement agency, and, if present, from prosecution and defense.

In many other jurisdictions, pretrial services programs or their functional equivalent provide this information. When these programs interview a defendant, it is standard practice to inform the defendant of the purpose of the interview, how the information will be used, and of the defendant's right to refuse to answer any or all of the questions. The scope of services provided by these agencies, including the populations that they target, the information that they gather, and the options that they provide to the court, vary greatly across jurisdictions.

Since jurisdictions vary so widely in the mechanisms used to obtain and disseminate information relevant to pretrial release decision making, it is not possible to recommend a single approach to providing the court with the defendant's mental health information. However, several principles should be followed. First, jurisdictions should have some neutral entity that provides the pretrial release decision-making officer with all the information relevant to that decision. Second, defendants should be advised that they have the right to

23. American Bar Association, *Standards for Criminal Justice*, Chapter 10: Pretrial Release Standards, American Bar Association, 1989.

speak with an attorney before answering any questions, and that they have the right to refuse to answer any questions. Third, the neutral entity should provide the judicial officer with viable options to address identified mental health issues.

In its interview with the defendant, the neutral entity should ask whether the defendant has any mental health problems and whether he or she has ever been treated, either inpatient or outpatient, for a mental health problem. The entity should recognize, however, that a history of mental health treatment is not necessarily an indicator of higher risk of failure to appear or rearrest. For example, if a defendant reported having received mental health counseling after a traumatic event in the past, this information may not be relevant to the pretrial release decision and the interviewer should use discretion in recording that information. The interviewer should note behavior, such as the defendant seeing things or hearing voices that are not apparent to the interviewer.

In some instances, the pretrial interviewer will be unable to conduct an interview with the defendant because the defendant's mental condition precludes communication. This situation often can be resolved quickly once the defendant is reconnected with his or her mental health caseworker.

Example: Data Link Project, Maricopa County (AZ)

As part of the Maricopa County Data Link Project, the local behavioral health authority receives an automated list of every person booked into the local jail. The computer at the health authority seeks matches from the jail list with the list of more than 12,000 clients who receive mental health services in the area. When a match is found, the person's caseworker is notified and can intervene quickly to see that the person is receiving proper medications while in jail and to assist in discharge planning.

The discussion thus far makes an assumption about people who have been referred to the courts by law enforcement and who have been identified—by observations of third parties, from the results of a mental health screen, or by the person's own statements—as possibly suffering from mental illness. The assumption is that the person has a history with the mental health system and will direct court officials to the source of information about that history. In many cases, however, the incident that led to the instant arrest may have been the first manifestation of a mental illness. In other cases, the person may have had a history with the mental health system, but either out of mental impairment, deliberate deception, or a simple refusal to respond did not divulge that history when asked about it.

A particular problem arises for the pretrial release decision maker when a person is arrested on a charge that involves violence—even if just a simple assault—and there are clear indications that the person may be suffering from a mental illness, but the person denies any current or past mental health treatment. The person might also have no prior record of arrests or convictions that

could guide the pretrial release decision maker, who is required to weigh risk of future violence in making a release decision. The best course of action may be to have the court order a mental health assessment by a qualified mental health professional. That assessment should confirm whether there are mental health issues, including past police contacts with the defendant, that resulted in referrals to mental health facilities in lieu of arrest.

Example: Pretrial Program, Hamilton County (OH)

In Hamilton County, pretrial program staff team up with mental health professionals to have an assessment completed by a mental health clinician prior to the initial pretrial release hearing. All defendants who are identified by the pretrial services program during its early morning interviews as having possible mental health issues are then placed on an afternoon calendar for their pretrial release hearing. The program alerts the court's Psychiatric Clinic, and a clinician from that office conducts the assessment before the afternoon hearing. This approach provides an assessment by a trained mental health clinician with the results reported to the pretrial release decision maker without having to continue the case to another day.

c **Ensure that interview protocols used by pretrial services staff also include questions to identify those with co-occurring substance abuse disorders.**

This issue was described in the discussion earlier of pretrial diversion, and that discussion applies here. It is of even more importance, though, that screening by pretrial services staff for co-occurring disorders be conducted for the pretrial release/detention decision. While pretrial diversion may be offered to only a small percentage of persons with mental illness who have been arrested, all of them must have a pretrial release/detention hearing. (See Policy Statement 10: Modification of Pretrial Diversion Conditions and Policy Statement 37: Co-occurring Disorders.)

d **Ensure that at the initial hearing defense counsel are prepared to offer, in appropriate cases, an alternative to pretrial detention for defendants with mental illness.**

Inherent in this recommendation is the support for the American Bar Association's call for defense to be present at the initial appearance of all defendants. The initial appearance is a critical juncture in all cases for all defendants. As stated by the American Bar Association, "[D]eterminations made in the course of first-appearance proceedings are the most important in the criminal process for many defendants." But the circumstances are hardly ideal: "Regrettably, these vital decisions often are reached under circumstances that would not be tolerated at trial. Courtrooms often are noisy and overcrowded,

cases are...treated hurriedly, and the entire process is motivated by the single aim of ‘moving the calendar.’ And as for the defendants, ‘...they are likely to be confused, exhausted, and frightened, particularly if they have had no earlier experience with the criminal justice system.’²⁴ Some defense attorneys have taken steps to be prepared.

Example: Public Defender’s Office, Honolulu (HI)

In Honolulu, by the time a defendant with mental illness appears in court at the initial hearing, usually the morning after arrest, the public defender will have discussed a release plan with the defendant and the mental health staff who work out of the jail.

One important issue that should be addressed in the context of the pretrial release decision is the release status of defendants who have been ordered to undergo a competency examination. The American Bar Association recommends that a defendant “otherwise entitled to pretrial release” should not be detained solely for the purpose of conducting the competency examination. According to the ABA, confinement for competency evaluation and pretrial release are two separate issues that courts should consider and rule on separately.²⁵

e

Ensure that mental health information presented to the presiding judicial officer at the pretrial release/detention hearing is limited to an indication of whether the defendant has a mental illness, and, if so, options for addressing it in the pretrial release decision.

Mental health information is relevant to the pretrial release decision.²⁶ Therefore, a defendant’s mental health status should be reported to the judicial officer making a pretrial release decision—with the consent of the defendant. It is sufficient in most cases to report the information that there are mental health issues.

Example: Jail Diversion Project, Connecticut Department of Mental Health and Addiction Services

Under a program run by the Connecticut Department of Mental Health and Addiction Services, mental health clinicians conduct assessments of defendants with mental illness prior to the initial appearance in court. These clinicians are employed by the Department of Mental Health, and not the courts. The only information that they provide to the court is a treatment plan. The nature of the illness and any diagnoses are kept confidential. If the client agrees to allow the clinician to share more information with the court, it is sometimes easier to prepare a treatment plan.

24. American Bar Association, *Pretrial Release Standards*, Commentary to Standard 10-4.2(a), 1988.

25. American Bar Association, *Criminal Justice Mental Health Standards*, Standard 7-4.3 and accompanying commentary.

26. In 34 states and the District of Columbia, and in the federal system, the judicial officer is required to assess two types of risks: that the defendant will fail to appear in court and that the defendant will pose a risk to the safety of the community. In the remaining jurisdictions, only the risk of flight is examined. John Clark and D. Alan Henry,

“The Pretrial Release Decision,” *Judicature* 81:2, September/October 1997. Most state statutes require the judicial officer to consider a number of factors in assessing these risks, including: the nature of the current charge; strength of the evidence; prior criminal history; prior record of appearance in court; current probation, parole, or pretrial release status at the time of arrest; ties to the community; and the defendant’s character, reputation, and mental condition. John Goldkamp, “Danger and Detention: A Second Generation of Bail Reform,” *Journal of Criminal Law and Criminology*, Northwestern University School of Law, 76:1, 1985.

f

Establish programs that provide judges, prosecutors, and defense attorneys with options to address the mental health needs of people with mental illness.

Providing judicial officers with a defendant's mental health information at the pretrial release/detention hearing without presenting options to address the mental health needs of defendants would likely lead to more unnecessary pretrial detention of those with mental illness. Information and options must go hand-in-hand. Options that might be used include assertive community treatment or intensive case management; a rehabilitation program that offers assistance in finding, getting, and keeping housing, employment, and benefits; crisis residential services; and inpatient treatment. For the reasons noted earlier in the pretrial diversion discussion, it is also important that pretrial release options include a range of integrated services, including housing, financial assistance, transportation assistance, and employment counseling, and address the needs of defendants with co-occurring substance abuse and mental health disorders.

A specialized mental health program that is designed to meet the needs of people with serious mental illness who have come in contact with the criminal justice system can address this broad array of options.

Example: Community Support Program, Milwaukee (WI)

In Milwaukee, the Community Support Program (CSP) of the Wisconsin Correctional Service screens defendants identified at the pretrial release hearing as having possible mental health problems. If released with conditions, CSP develops an individualized treatment plan and assigns a caseworker to monitor the day-to-day implementation of the plan. Within CSP there are housing specialists available to assist those with housing needs, and medical and pharmacy services to prescribe and administer medications. The program also has the capability to offer financial services to help clients obtain and maintain both private and public health benefits.

It is also important to ensure that the treatment resources are available in the jurisdiction whenever needed.

Example: Pretrial Services, Tulsa County (OK)

In Tulsa County, the Tulsa Pretrial Services works closely with the local mental hospital, which is next door to the jail, to ensure that both inpatient and outpatient treatment is available.

"The ability to monitor people on release status is limited, especially for low level crimes. Many of these people need close supervision, which is just not available. Appropriate housing oftentimes is impossible. Without medication and proper supervision, few housing programs are willing to accept individuals with criminal charges and mental health problems. The result is that the defendant stays in jail."

HON. MICHAEL D. SCHRUNK

*District Attorney,
Multnomah County, OR*

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*, September 21 2001

g**Design pretrial release conditions to address individual risks and needs posed by each defendant.**

An important principle that should be followed in imposing conditions of pretrial release, particularly on the population of those suffering from mental illness, is that the conditions be the least restrictive necessary to ensure the safety of the public and appearance in court. Overburdening defendants with mental illness with extraneous conditions of release raises the possibility that they will be unable to handle them and will fail to meet their requirements.

h**Expand the options available in rural areas to provide mental health services for people with mental illness who are charged with a criminal offense.**

Many pretrial services practitioners in rural jurisdictions admit that the typical action taken at a pretrial release hearing involving a defendant with mental illness is that a money bond is set. Few, if any, options exist for those requiring attention to their mental illness, and judges believe that they have no alternatives but to set a money bond. Most often that bond is unattainable for the defendant, who then spends the next several weeks or months in jail while the case is adjudicated. This is an outcome that satisfies no one—judge, prosecution, defense, or defendant. In fact, the person with mental illness in all likelihood will decompensate quickly. As noted in the discussion of expanding pretrial diversion options in rural areas, a possible approach to expanding mental health resources may be with the use of mobile units and telemedicine. (See Policy Statement 18: Development of Treatment Plans, Assignment to Programs, and Classification / Housing Decisions, for more on telemedicine.)

12

Modification of Pretrial Release Conditions

POLICY STATEMENT #12

Assist defendants with mental illness who are released pretrial in complying with conditions of pretrial release.

Once conditions of pretrial release are set by the court they are monitored by a pretrial services program. If the defendant fails to comply with the conditions, the program notifies the court, after which the court can revoke the release, modify the conditions, or issue a warning to the defendant.

Conditions of pretrial release are set for the purpose of minimizing risks that the defendant will present a danger to the community or fail to appear in court. Defendants with a mental illness may have particular difficulty in understanding and fulfilling those conditions. In addition, an individual with mental illness who has been detained in jail—even for a very brief period following an arrest—can face tremendous obstacles upon his or her release. In many instances, the greatest challenge is to find a suitable, affordable place to live, or to identify a family member or friend with whom to reside. Other

challenges may include reestablishing eligibility for disability benefits under the federal Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Medicaid programs, getting back to work or other meaningful daytime activity, and establishing a connection with a provider of mental health services to ensure that appropriate treatment and support are provided in the community. Another challenge upon release may be that jail time has interrupted treatment or has altered the medication regimen, which may cause some post-release difficulties and adjustments. Thus, it is in the interests of both the defendant and the court that assistance be given to defendants in meeting the conditions of release. In addition, under the Americans with Disabilities Act, it may be required that people with mental illness be given the assistance they need to comply with pretrial release conditions.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** Streamline administrative procedures to ensure that federal and state benefits are reinstated immediately after a person with mental illness is released from jail.

People with mental illness who are unable to afford private insurance to help pay for treatment costs may be eligible for Medicaid. (See Policy Statement 13: Intake at County / Municipal Detention Facility, for more on detainees' Medicaid and Social Security eligibility.)

- b** Develop guidelines on compliance and termination policies regarding defendants with pretrial release conditions.

Placing court-ordered mental health conditions of pretrial release on those with mental illness must be accompanied by the ability to monitor compliance with those conditions. The judge and the defense attorney should make clear to the defendant the consequences for violating release conditions. The responses to condition violations should reflect the nature of the violation and should, unless the violations are severe, gradually escalate before imposition of the ultimate response—revocation of release.

It is important to have a written understanding regarding compliance and termination policies. When a court orders a defendant to enroll in or maintain treatment, whether it be for a mental illness, or for drug or alcohol abuse, deference must be paid to the treating clinician regarding the status of the person in treatment. Decomensation itself should not be considered a violation and the first response to noncompliance should be an attempt to adjust the treatment. Thus, the clinician or treatment program must assess the client's compliance with the order to participate in treatment on a case-by-case basis. However, the treatment program should provide the court and the referring agency with written guidelines outlining its general policy for determining whether a client is in compliance and when it is time to both successfully and unsuccessfully terminate a client from treatment.

When a violation of a pretrial release condition has been alleged, the court should hold a hearing looking into the circumstances of the alleged violation before taking action on the violation. Such circumstances should include attempts by the defendant to comply; reasons cited for noncompliance; and the nature of the violation. The court should consider that people with mental illness commonly experience relapses while in treatment, and that finding the most appropriate treatment is often a matter of trial and error for the treating

clinician. Before imposing punitive sanctions for noncompliance, the court should conclude that the defendant was capable of complying but chose not to.

Given the difficulties that defendants with mental illness may have in complying with conditions of pretrial release, it may be beneficial to have specially trained staff from pretrial release and diversion programs be responsible for supervising defendants with mental illness.

Example: Pretrial Services Program, Bernalillo County (NM)

In Bernalillo County, New Mexico, a team of three specialists from the pretrial services program supervises defendants with a mental health condition of release. These specialists work closely with a Forensic Case Manager who facilitates client treatment and acts as liaison between treatment services and the criminal justice system.

To protect the therapeutic/treatment relationship, mental health treatment programs should not report compliance and terminations directly to the court, but through the referring court entity—the pretrial services program or the pretrial diversion program. In most cases, it would be sufficient to provide compliance information in summary form. An exception would be if staff of the treatment program became aware of a specific threat that the client may pose. In that instance, the professional guidelines of the clinician should dictate the most appropriate method of response.

13

Intake at County / Municipal Detention Facility

POLICY STATEMENT #13

Ensure that the mechanisms are in place to provide for screening and identification of mental illness, crisis intervention and short-term treatment, and discharge planning for defendants with mental illness who are held in jail pending the adjudication of their cases.

Defendants not released at the pretrial release/detention hearing are booked into jail pending the posting of bail or the adjudication of the charges. Being jailed after arrest is a particularly critical period of time for a person with mental illness because the stress of incarceration can significantly raise the risk of decompensation. There are several important services that should be provided while the defendant is in custody, including identifying those detainees with mental health problems; addressing any immediate concerns about their men-

tal health; attending to their mental health needs while in custody; and planning for their transition back to the community.

Many of the recommendations below, while especially relevant to pretrial detainees, also apply to sentenced inmates, whether they are in jail or in prison. For a thorough review of the issues that should be addressed when a person with mental illness is incarcerated, see Chapter 4: Incarceration and Re-entry.

RECOMMENDATIONS FOR IMPLEMENTATION

a Screen all detainees for mental illness upon arrival at the facility.

This recommendation calls for screening to be conducted on all detainees, regardless of their known history of mental illness and their presenting appearance. (See Policy Statement 17: Intake at Correctional Facility for Sentenced Inmates, for a more thorough discussion of screening procedures.)

In the majority of jails, staff immediately screen new admissions for basic issues that might affect housing assignment and safety, but many of these screens fail to address mental health issues. The screening should occur at the point of intake, before placement in a housing area. The screening should be done using a standardized instrument developed under the direction of a quali-

fied mental health professional. Booking staff should receive training in how to use the instrument and interpret the results. Several states, including Colorado and Montana, have statutes that require administrators of detention facilities to mandate screening for mental illness at the time of intake. In Montana, the screening is intended to identify misdemeanants who could be diverted from the detention facility into mental health services.

When the screen shows possible indications of mental illness, the screening officer should arrange for a more thorough examination by a qualified mental health professional. Some jurisdictions have developed a multitiered approach to identifying people with mental illness.

Example: Screening, Summit County (OH) Jail

The Summit County jail has a three-tiered approach that includes the initial screening by the booking officer, a cognitive function examination by a mental health worker, followed by an evaluation by a clinical psychologist.

Jails should also ensure that the screening protocol includes identification of suicide risk. Given the high rates of suicide in jail when compared to those occurring in the general population, it is important that great care be taken in identifying those at risk of suicide.

Example: Suicide Screening Initiative, Montgomery County (MD) Detention Center

In Montgomery County, detained inmates are screened at three points of intake using the same set of seven questions: at central processing, upon institutional intake, and as part of medical screening. When an inmate is first processed through the Central Processing Unit, an officer completes the Suicide Screening Form, comprising seven items relating to current suicidal ideation and past history of suicidal/self-destructive behavior. There are specific questions regarding mental health history and current psychiatric treatment. When inmates are processed through intake, the same form is completed a second time. Inmates answer the questions a third time when nurses at medical intake use the same questionnaire. The document first used at Central Processing follows the inmate throughout this process. If an inmate answers affirmatively to any of the questions at any point along this three-part process, a referral is generated to mental health services, who then conduct an assessment.

Example: Suicide Prevention Screening Guidelines Tool (SPSG), New York State

New York State has developed a Suicide Prevention Screening Guidelines (SPSG) tool that is used in all local lockups, county jails, and state prisons throughout the state. SPSG was developed and approved by the New York Commission of Correction and the Office of Mental Health and has been validated through numerous research projects. It consists of a structured interview conducted during the booking process by booking officers, and examines risk factors from past behavior, the inmate's current situation, and mental status. If there are indications that the inmate may be suicidal, the booking officer contacts the shift commander for immediate intervention, who arranges for increased supervision of the individual.

"Building internal jail mental health programs at the expense of community based treatment just doesn't make sense. We need to help people with mental illness in their communities, not wait until they arrive in jail to provide adequate treatment."

ART WALLENSTEIN
Director, Montgomery County Department of Corrections, MD

Source: Personal correspondence

When resources do not allow for a timely, comprehensive, in-house follow-up assessment to a screen, such as may be the case in rural or remote settings and small facilities, creative alternatives should be found. These might include contracting for services with community mental health, or making provision for interns at local universities who might be available to conduct assessments on site on a part-time basis. Another option is telepsychiatry, where a qualified mental health professional is able to interview and examine the detainee through the use of telephone or closed-circuit television. (See Policy Statement 18: Development of Treatment Plans, Assignment to Programs, and Classification / Housing Decisions, for examples of telepsychiatry and electronic communication arrangements in use in Texas and Alaska.) When a delay in providing a follow-up assessment is unavoidable, jail personnel must provide adequate supervision to ensure the physical safety of an inmate at risk of suicide until professional mental health services can be provided.

Individuals admitted to jail facilities may be withdrawing from a psychoactive drug, including both illicit substances and psychotropic medication. It is important that an observation period extend through the first 72 hours of detention and that the screening protocol be repeated if the detainee's behavior indicates the possibility of post-acute withdrawal or mental decompensation. Jail medical staff should also keep in mind that many psychotropic medications, particularly ones that are used in injectible forms, can take several weeks to clear a patient's system. Intake screeners and anyone reviewing medical records should look for indications of such long-lasting drugs and take steps to ensure that suicide screening and prevention measures are extended over several weeks in appropriate circumstances. This is particularly important in jails that have a limited pharmacy and may change the type of drug or form of administration.

b **Work with mental health service providers, pretrial service providers, and other partners to identify individuals in jail who may be eligible for diversion from the criminal justice system.**

The admission of an individual with mental illness into a county or municipal detention facility presents an opportunity to determine whether continued involvement with the criminal justice system is the most appropriate strategy to address that individual's situation. Once a detainee has been identified as having a mental illness, corrections officials can work with pretrial service programs, mental health service providers, and other partners to determine whether the detainee may be eligible for programs that provide an alternative to further detention. Some states, such as Montana, have passed legislation

Steps in Suicide Prevention²⁷

Eight essential steps for an institution suicide prevention plan:

- (1) Training of correctional staff, who are the primary observers of behavior when mental health staff are unavailable;
- (2) Immediate screening at intake and ongoing assessment;
- (3) Communication between transport officer and corrections officer, facility staff and mental health staff, and facility staff and inmate;
- (4) Placement in housing appropriate to the situation, emphasizing use of general population settings instead of isolation;
- (5) Establishing appropriate levels of supervision, including close and constant observation;
- (6) Rapid and correct response to suicide attempts;
- (7) Reporting of suicide attempts throughout the chain of command; and
- (8) Follow-up and administrative review, including attending to the effects of critical incidents on staff stress.

27. L.M. Hayes, *Prison suicide: An overview and guide to prevention*, Washington, D.C., U.S. Department of Justice, 1995.

requiring jail administrators to divert certain detainees to mental health services, either in the community or to inpatient hospitals.

Many programs use detention facilities as the first point of contact to identify a person with mental illness who may be eligible for diversion. Jail administrators who work closely with such programs will help individuals who would be better served by diversion from the criminal justice system while at the same time freeing jail beds for more appropriate purposes. It is essential that programs providing alternatives to further involvement with the criminal justice system for individuals with mental illness consider the multiple needs of these individuals, especially the need for adequate housing (see Policy Statement 38: Housing).

Example: Thresholds Psychiatric Rehabilitation Centers Jail Program, Cook County (IL)

The Thresholds Psychiatric Rehabilitation Centers Jail Program in Cook County provides intensive case management for individuals with mental illness who have become involved in the criminal justice system. Thresholds case managers work with individuals while they are still in jail, even accompanying them to court and often helping secure their early release. Once released, the case manager helps the individuals access mental health services, find employment, and locate housing. Threshold Jail Program members, as the program's clients are called, are usually housed in single-occupancy rooms in local hotels. Thresholds has developed relationships with landlords, guarantees the rent payment, and provides 24-hour on-call case managers in case of a crisis situation. Though Thresholds owns some 30 group homes and ten apartment houses, community and local government opposition prevents them from using these resources to house most individuals with mental illness who have been released from jail.

"If I had gotten into this [jail treatment] program in the beginning, things could have been different... I always wanted to excel, to do something good...I don't like the way my life has turned out, but I have the option to be someone."

LEON
consumer

Source: William Branigan and Leef Smith, "Mentally Ill Need Care, Find Prison," *Washington Post*, Sunday, November 25, Section A, p. 1

C

Facilitate the release of information to assist in the identification of need.

While important in identifying people who might have a mental illness, a screen conducted at booking depends exclusively upon inmate self-reporting. Yet detainees, and particularly those with mental illness, are often unreliable reporters of factual information. It is important, therefore, to obtain information about a detainee that can shed light on his or her mental health history and help the facility to make appropriate decisions regarding classification and to ensure that those currently in treatment continue to receive it while in custody. In many instances the arresting officers may have input into classification decisions.

Several jails have also developed ways to alert the mental health community when a mental health client has been arrested so that mental health can respond immediately to the situation.

Example: Cook County (IL) Jail

Through an automated information system, the Cook County Jail electronically transfers its jail census on a daily basis to mental health clinics in the Chicago area. Clinic staff review the lists to see if they can identify any of their clients. The goal is to notify these clinics when one of their clients is in custody to aid in the continuation of treatment while in custody.

Example: Montgomery County (MD) Detention Center

The county detention center in Montgomery County each day posts the names of detainees who have entered the facility in the previous 24 hours, ensuring that a copy of the list is available to local mental health providers. Providers recognizing names of current or past clients on the detention center list may then, without breaching confidentiality, contact mental health staff at the detention center with information, including diagnosis and medication, that might help the detention center provide appropriate services or make decisions regarding placement or diversion. (See also Maricopa County Data Link Project, Policy Statement 11: Pretrial Release / Detention Hearing.)

Another way to facilitate the release of mental health information is to encourage individuals who are at risk of being arrested to provide their clinician with prior consent to discuss their mental health needs with jail officials if an arrest and detention occurs. (See Policy Statement 25: Sharing Information.)

Families can also provide more comprehensive information about the mental health history of a jail detainee. They should be encouraged to share any information that will result in delivery of appropriate mental health treatment in the jail setting.

d Ensure that the capability exists to provide immediate crisis intervention and short term treatment.

People arriving at a jail may be in an active psychotic state or may decompensate to such a condition during the period of confinement. Jail staff must have the resources that they need to intervene effectively with detainees experiencing a crisis. The American Psychiatric Association has offered the following recommendations regarding crisis intervention in jails:

- Training of jail staff to recognize crisis situations;
- Around-the-clock availability of mental health professionals to provide evaluations;
- A special housing area for those requiring medical supervision; and
- Around-the-clock availability of a psychiatrist to prescribe emergency medications.

28. In *Estelle v. Gamble*, 429 U.S. 97 (1976), the Supreme Court addressed the medical needs of prisoners in the context of the Eighth Amendment. The court held that deliberate indifference to serious medical needs is prohibited “whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once

prescribed. Regardless of how evidenced, deliberate indifference to a prisoner’s serious illness or injury states a [claim under the Constitution.] Id. at 104-105.” A prisoner must provide evidence of “acts or omissions sufficiently harmful” to show deliberate indifference in order to bring an Eighth Amendment claim.

Since *Estelle*, the Supreme Court has only refined the “deliberate indifference” standard once. In 1994 the Court

Example: Summit County (OH) Jail

At the jail in Summit County, one corrections officer is designated as the crisis intervention specialist and receives 40 hours of training each year from the jail's mental health coordinator.

The capability must also exist to meet the treatment needs of detainees. In larger jails, separate mental health units may be available. Often, however, there can be waiting periods to get into such a unit. In smaller jails, such units are typically not available, and the most severely ill inmates may need to be transferred to a state hospital or other secure facility. Regardless of where the individual is housed, there can be great benefit to ensuring that the clinician who was attending the individual before arrest continues to monitor the person's treatment while in custody.

e

Facilitate a detainee's continued use of a medication prescribed prior to his or her admission into the jail.

Inmates are usually prohibited from bringing their own medications into jail. Owing to formulary restrictions, prohibitive costs, limited inventories, or a combination of these factors, however, correctional health officials are often unable to fill a prescription prepared by a doctor outside the facility. Accordingly, the effect of the medications that detainees are taking at the time of their incarceration is likely to wear off soon after their arrival at the jail. The detainee's condition is thus likely to deteriorate, and he or she may commit disciplinary infractions that will lengthen his or her stay in jail.

Increasingly, offenders with mental illness are brought to jails with prescriptions for the newer, and considerably more expensive, psychotropic medications. In many cases, when facilities provide for the continuation of treatment, they substitute the medications the inmate has been taking with one on their formulary and readily available in their own pharmacy.

In some states, correctional health officials are required to adhere to the formulary, even if it is limited. Such policies can have negative consequences for inmates for whom medications on the formulary are either ineffective or cause harmful side effects. When a particular medication prescribed by a psychiatrist is not on an institution's formulary, corrections administrators should ensure that a mechanism is in place to enable access to the medication within 24 hours.²⁸

said that deliberate indifference "... [lies] somewhere between the poles of negligence at one end and purpose or knowledge at the other;" (Farmer v. Brennan, 511 U.S. 825, 1994). The Court affirmed an "adequacy" standard stating that "prison officials must ensure that inmates receive adequate food, clothing, shelter and medical care." (id. at 833), but went on to emphasize that "deliberate indifference" requires a culpable state of mind. Federal District Courts (the trial court in the federal system) may interpret

"adequate" with wide discretion. On appeal to the Federal Circuit Courts—the layer of the judiciary just below the U.S. Supreme Court—this has led to vastly varying law, especially in regards to the treatment of HIV. See *Psychiatric Services in Jails and Prisons: A Report of the American Psychiatric Association Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons*, second edition, p. 2.

"During a visit to South Carolina, I suffered the second manic episode of my life. When police were called, although I was exhibiting bizarre behavior and my wife desperately tried to advise them of my illness and show them the vial containing the medication that I should be taking, they took me to jail. At no time during my stay in the jail, even after the appearance before a magistrate, did I see any medical personnel or receive any medical treatment. If such experiences can happen to me, with a Ph.D. in criminology and my background and knowledge of the criminal justice system, they can happen to anyone."

RISDON SLATE

Associate Professor of Criminology, Florida Southern College

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*, September 21 2001

Jail officials should understand that although there are often several medications that can be prescribed for the same diagnosed illness, the effectiveness and medical risks of different medications often varies considerably. The practice of switching medications can be particularly ineffective because many psychiatric medications take weeks to build up to therapeutic levels. Common drug interactions between different medications prescribed for the same problem can exacerbate the delay before the new medication becomes effective and can create serious medical risks for patients, and potential problems for the jail staff, if both medications are present in a patient's system at the same time.

Community mental health programs and service providers should be involved in medication issues for recently arrested and detained defendants. They can serve as a resource for detention-based health care officials in determining detainee medication needs, possibly assisting facilities with limited formularies to obtain and share the costs for less commonly prescribed and more expensive medications, if they are required for the detainee's well-being.

f

Suspend (as opposed to terminate) Medicaid benefits upon the detainee's admission to the facility to ensure swift restoration of the health coverage upon the detainee's release.²⁹

Enrolling a person who is eligible for Medicaid in this federal benefit program is a time-consuming process. Reinstating someone in Medicaid after their benefits have been terminated can take anywhere from 14 to 45 days (and sometimes longer), depending on the state.³⁰ Accordingly, when a detainee with mental illness enters jail, and he or she is already enrolled in Medicaid, staff should do everything possible to maintain that person's enrollment in the program. Suspending, instead of terminating, the detainee's enrollment in Medicaid enables staff to effect the reinstatement of the benefits immediately upon release, guaranteeing the individual access to the treatment and medications likely to keep him or her from coming into contact with the criminal justice system again.

A myth in many corrections, mental health, and public health agencies is that federal regulations require states to terminate a person's enrollment in Medicaid once he or she is incarcerated. In fact, federal law does not require states to terminate inmates' eligibility, and inmates may remain on the Medicaid rolls even though the services provided in jail are not covered. According to the US Secretary of Health and Human Services, "Federal policy permits, but does not require states to use administrative measures that include temporary

Understanding Federal Benefits

Several federal benefit programs are particularly relevant for people with mental illness who will be released from a corrections facility: Supplemental Security Income (SSI) disability benefits; Social Security Disability Insurance (SSDI); Medicaid; Medicare; Temporary Assistance for Needy Families (TANF); Food Stamps; and Veterans Benefits. Understanding who is eligible to participate in these programs and how they qualify is extremely complex. Appendix C, a reprint of a policy brief that the Bazelon Center for Mental Health Law published, explains these program rules.

The recommendations in Policy Statement 13 addresses only those pretrial detainees who are enrolled in Medicaid immediately prior to their incarceration. Many detainees with mental illness are eligible for Medicaid but, for a variety of reasons, were not enrolled when they were admitted to jail. An essential component of planning the return of these inmates to the community is ensuring that they have some form of health coverage to continue their treatment plans after their release. Similarly, jail staff should facilitate inmates' access to other relevant federal and state benefit programs. The policies and procedures that should be in place to accomplish this for jail detainees are equally relevant to sentenced inmates, and they are therefore addressed in Policy Statement 21: Development of Transition Plan.

29. Much of this recommendation and the commentary below draws on an extremely useful and comprehensive review of jail detainees' Medicaid eligibility published by the Bazelon Center for Mental Health Law. Bazelon Center

for Mental Health Law, *Finding the Key to Successful Transition from Jail to the Community: An Explanation of Federal Medicaid and Disability Program Rules*, March 2001.

30. Ibid.

suspending an eligible individual.”³¹ Thus, determining when a detainee’s enrollment in Medicaid should be terminated is, in some important respects, at the discretion of the state.³²

Given these parameters, jail administrators should work with appropriate state and local social security administrators and state Medicaid administrators to develop policies and procedures to prevent the unnecessary termination of detainees who enter the facility on Medicaid. Ideally, for those detainees eligible for Medicaid by virtue of their enrollment in the Supplemental Security Income (SSI) program, authorities should terminate a detainee’s Medicaid coverage only when SSI eligibility is terminated. (This occurs after 12 consecutive months of SSI suspension.)

Example: Interim Incarceration Disenrollment Policy, Lane County (OR)

Officials in Lane County have confronted the barriers and disruption in continuity of care for people detained for a short time in jails. At the behest of the county, the state adopted the Interim Incarceration Disenrollment Policy. This policy specifies that individuals cannot be disenrolled from their health plan during their first 14 days of incarceration, during which the state makes the Medicaid payments. In addition, Lane County officials developed a relationship with the local application-processing agency for Medicaid and Social Security Insurance. Now, the application process for those individuals who did not have benefits prior to incarceration or whose incarceration period lasts longer than 14 days can begin while the detainee is still in custody.

When a detainee whose participation in Medicaid has been suspended, corrections administrators should work with health officials to authorize immediate coverage of the detainee upon his or her release. While the confirmation of a released detainee’s qualification of Medicaid is pending, federal rules permit the reinstatement of the benefits for six months. (This reinstatement may be terminated before six months have expired if state officials determine beforehand that the individual is no longer eligible for Medicaid). In those cases where a released detainee’s benefits are reinstated, and the person’s qualification for Medicaid is subsequently confirmed, officials should ensure that services already delivered are billed, retroactively, to the federal government.

g

Commence discharge planning at the time of booking and continue the process throughout the period of detention.

One reality for jail staff attempting to address the mental health needs of pretrial detainees is that a detainee may be released at any time with little or no warning to jail staff—the detainee may post the bail or plead guilty and be sentenced to time served, or the prosecutor may dismiss the charges. Given

31. See October 11, 2001 letter from Tommy Thompson, Secretary, US Department of Health and Human Services, to Congressman Charlie Rangel, confirming earlier written statements from DHHS Secretary Donna Shalala, April 6, 2000.

32. The Council of State Governments conducted a survey of state Medicaid agencies in 2001. All but one of the states responded. Each reported that they had a policy of terminating a person’s enrollment in Medicaid upon his or her incarceration. Collie Brown, “Jailing the Mentally Ill,” *State Government News*, April 2001, p. 28.

this situation, it is of little surprise that recidivism rates among people with mental illness released from jail are exceptionally high.³³ Thus, it is important that planning for the ultimate discharge of the individual be an ongoing process during the time the individual is detained. Such planning should include arranging for services immediately upon release; ensuring that there is no disruption in medications made available to the individual; and assisting with other needs, such as housing, food, clothing, and transportation.

Example: Discharge Planning, Fairfax County (VA) Jail

Discharge planning at the Fairfax County Jail is the responsibility of Offender Aid and Restoration (OAR), a nonprofit organization. OAR staff conduct weekly meetings with the jail's psychiatrist to set plans for release for all inmates with serious mental illness, and provide emergency services for those released before a plan is completed. Staff of OAR carry caseloads, and the same case manager works with an inmate with mental illness from the time of booking through discharge.

Example: Case Management Services for Pretrial and Sentenced Offenders, Hampshire County (MA) Jail

At the Hampshire County jail, all inmates, regardless of whether they have a mental illness, are assigned case managers, who have a typical caseload of approximately thirty detainees. Inmate treatment needs are assessed at intake, and the case manager then provides individual counseling, meets with the family, and makes referrals to appropriate resources both inside and outside the facility. Assignment of sentenced and pretrial inmates to a case manager facilitates the process from intake through discharge planning (and reentry, if applicable). A high level of contact between the client and the case manager ensures that inmates have access to services and that they do not slip through the cracks.³⁴

One of the most pressing problems facing individuals with mental illness who have become involved in the criminal justice system is the lack of affordable housing. Housing for people with mental illness should be directly linked to other services, including mental health and substance abuse treatment, life skills, and job training. This model of "supportive housing" has been shown to have significantly higher retention rates than housing alone or housing that is not directly linked to services.³⁵ Long-term housing is crucial for helping individuals with mental illness maintain stability and avoid involvement in the criminal justice system. (See Policy Statement 38: Housing.)

"When I was arrested, I was living in subway stations. When I am released from jail, I will need Medicaid insurance so that I can go to a clinic and get medication and counseling so that I do not get sick again. I will also need to get my disability benefits again so that I can afford to buy food and get a place to live. If I do not get my medication, I will end up getting sick and living in subway stations again. I am intelligent and I am not all that crazy... I could have been somebody if I didn't spend my whole life in hospitals and jails."

BRAD H.
consumer

Source: Affidavit of Brad H., exhibit to complaint in *Brad H. v. City of New York*, a class action lawsuit regarding discharge planning for people with mental illness being released from New York City jails

33. Lois A. Ventura, Charlene A. Cassel, Joseph E. Jacoby, Bu Huang, "Case Management and Recidivism of Mentally Ill Persons Released From Jail," *Psychiatric Services* 49:10, Oct. 1998, pp. 1330-37. This study examined the effect of community case management on recidivism for jail detainees who have mental illness. The study followed releasees for 36 months. Within the 36 months, 188 of 261 subjects (72 percent) were rearrested

34. As reported in H. Steadman and B. Veysey, "Providing Services for Jail Inmates with Mental Disorders," National Institute of Justice Research in Brief, National Institute of Justice, Office of Justice Programs, U.S. Department of Justice, January 1997, p.4.

35. Dennis P. Culhane, Stephen Metraux, and Trevor Hadley, "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems," *Housing Policy Debate* 12, 2001.

Example: Maryland Community Criminal Justice Treatment Program (MCCJTP)

Through the Maryland Community Criminal Justice Treatment Program, staff in jails throughout the state work to provide treatment and aftercare plans for inmates with mental illness, and then provide community follow-up after their release. The MCCJTP has been widely recognized for impressive cross-system collaboration, focus on co-occurring disorders, transitional case management services, and attention to long-term housing needs. A \$5.5 million grant from the U.S. Department of Housing and Urban Development, complemented by matching local funds, allows MCCJTP case managers to help offenders with mental illness who qualify as homeless to become eligible for Shelter Care Plus housing funds.³⁶ Local service providers participating in MCCJTP support Shelter Care Plus recipients with vocational training, substance abuse treatment, and life-skills training to ensure that these individuals have access to meaningful daytime activity.

Example: Conditional Community Release Program, Maricopa County (AZ) Adult Probation Department

The Maricopa County Adult Probation Department has instituted a program called the Conditional Community Release Program, which is geared toward early jail release of offenders with mental health issues and provides appropriate treatment in the community at a reduced cost. This program utilizes a contract psychiatrist, probation officer, surveillance officer, and intake specialist to identify, diagnose, and supervise offenders with mental illness. Once referred, the inmate is evaluated within 72 hours by an intake specialist. If appropriate, the inmate is admitted to the program and jail release planning is undertaken. The psychiatrist will see the person in jail in order to ensure continuity of care once released, and the probation officer will see the client to complete all necessary paperwork.

Once released, the probationer may be placed in a housing facility funded by Adult Probation, or released to their home if appropriate. While in the community, the client is supervised by the probation officer and surveillance officer, and seen by the psychiatrist for follow-up treatment if not enrolled in community treatment. Using contracts with a local medical services agency, medication is provided at a reduced cost and necessary psychological testing is performed.

The program is 45 days in length, at which time the client is transferred back to his or her original probation officer, or referred to a specialized mental health caseload. In the event the client is not stabilized psychiatrically, the county will continue to serve the client until this is accomplished.

36. The McKinney Act of 1987 is the major federal housing program to support people who are homeless. This act defines a homeless individual as (1) “an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is— a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); b) an institu-

tion that provides a temporary residence for individuals intended to be institutionalized; or c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.” Technically, individuals coming out of detention facilities are not considered homeless until they have spent one night in a shelter or similar location. See www.hud.gov/offices/cpd/homeless/rulesandregs/laws/index.cfm

14

Adjudication

POLICY STATEMENT #14

Maximize the availability and use of dispositional alternatives in appropriate cases of people with mental illness.

A criminal case can be adjudicated in several ways—the charges can be dismissed, the defendant can plead guilty or be found guilty in a trial, or the defendant can be found not guilty. The law provides several dispositional alternatives specifically for people with mental illness— i.e., incompetent to stand trial, not guilty by reason of insanity, guilty but insane.³⁷ This document does not make any recommendations regarding how these dispositions are used or the frequency of their use.³⁸

Rather, the document addresses other dispositional alternatives to conviction and sentencing that are available under the law. Although known by different names, these alternatives are generally referred to as “adjudication withheld” or “deferred adjudication.”

Earlier, the pretrial diversion decision of the prosecutor was addressed. Under the pretrial diversion alternative, the prosecutor decides to hold the charges in abeyance while the defendant undergoes a program intervention. If successful, the charges are dismissed. If not, the case is placed on a court calendar for prosecution. The distinction

between that alternative and those discussed here is that in this instance it is a judicial, rather than prosecutorial, exercise of discretion.

There are variations in how jurisdictions make these alternatives available. For example, under Florida law, the court can withhold adjudication “if it appears to the court...that the defendant is not likely again to engage in a criminal course of conduct and that the ends of justice and the welfare of society do not require that the defendant presently suffer the penalty imposed by law.” The court then orders the defendant to participate in what is called a “community control” program. If the defendant successfully completes the program there is no conviction. Texas law has a “deferred adjudication” provision. Under this provision, once the defendant enters a guilty plea, the judge may defer the proceedings without entering the adjudication of guilt and order the defendant to abide by certain conditions if the judge finds that doing so “is in the best interests of the victim.” If the defendant successfully completes supervision, the charges are dismissed.

37. Some jurisdictions have replaced the “Not Guilty by Reason of Insanity” disposition with “Guilty but Insane,” or some similar variation.

38. For a discussion of these dispositions, see: American Bar Association, *ABA Criminal Justice Mental Health Standards*, 1989. Cases in which defendants plead Not Guilty by Reason of Insanity often receive significant publicity, which encourages the public impression that these pleas are commonly used. In actuality, use of the Not Guilty By Reason of Insanity plea is extremely rare. One study in Baltimore City of

the circuit and district courts found that of 60,432 indictments filed during one year, only eight defendants (.013 percent) ultimately pleaded not criminally responsible. All eight pleas were uncontested by the state. Jeffery S. Janofsky, Mitchell H. Dunn, Erik J. Roskes, Jonathan K. Briskin, and Maj-Stina Lunstrum Rudolph, “Insanity Defense Pleas in Baltimore City: An Analysis of Outcome,” *American Journal of Psychiatry* 153:11, November 1996, pp. 1464-68.

RECOMMENDATIONS FOR IMPLEMENTATION

a Provide sufficient dispositional alternatives for defendants with mental illness for courts to employ at any stage of the court process.

At least one jurisdiction has established a dispositional alternative for people charged with serious offenses.

Example: The Nathaniel Project, Center for Alternative Sentencing and Employment Services (CASES), New York City (NY)

The Nathaniel Project in New York, NY, run by the Center for Alternative Sentencing and Employment Services, is a two-year intensive case management and community supervision alternative-to-incarceration program for prison-bound defendants with serious mental illness. The program targets defendants who have been indicted on a felony, including violent offenses, most of whom are homeless and suffer from co-occurring substance abuse disorders. Forensic Clinical Coordinators, who are masters level mental health professionals and have expertise in negotiating the criminal justice system, create a comprehensive plan for community treatment. Starting work with participants prior to release, the project creates a seamless transition to community care. Once released, program participants are closely monitored and engaged in appropriate supervised community-based housing and treatment. Participants are required to attend periodic court progress dates. Charges are dismissed upon successful completion of the program.

Key to the success of individuals with mental illness who are diverted from jail or prison under the Nathaniel Project is their linkage to both temporary and long-term housing. The Nathaniel Project has developed relationships with housing providers to ensure that their clients will have shelter upon their release. Housing stabilizes the individual's life and enables the case manager to strengthen his or her relationship with the person with mental illness. Housing for individuals with mental illness should be integrated with support services including mental health, substance abuse, employment, and others.

Intensive case management is crucial in helping clients locate and flourish in supportive housing. Even when housing and services are integrated in a supportive model, many clients may need assistance in availing themselves of those services. A dedicated case manager, with small enough caseloads to devote significant energy to each client, is integral to making supportive housing, and diversion in general, a success.

The mental health courts that have been initiated in some jurisdictions often use dispositional alternatives. These courts focus specifically on cases involving defendants with mental illness, usually targeting only those charged with minor offenses. In some, the charges are dismissed upon successful completion of the program. In others, the defendant is required to plead guilty as a condition of participation but receives consideration at sentencing if the program is successfully completed.

Mental health courts vary greatly in the procedures that they employ, making it difficult to define “mental health court” or to present a mental health court model. It has been noted that “[a]ny similarities among current mental health courts occur more or less by chance at the implementation level and stem mostly from mirror-imaging by new jurisdictions seeking to replicate recently visited mental health courts or to duplicate drug courts.”³⁹ Some have argued against several elements of specialized mental health courts, including requiring the defendant to plead guilty first as a condition of participation, and requiring the defendant to spend a significant period of time under court supervision for a charge that might otherwise bring a very short sentence.⁴⁰ Others have argued that mental health courts can be defined as “almost any effort by the courts to better address the needs of persons with serious mental illness who engage with the criminal justice system.”⁴¹

Using that definition, the policy statements and recommendations presented in this document represent a model that does not necessarily require a specialized court and does not limit the population of those allowed to participate. Rather, the model envisions an integration of efforts into existing court practices to balance the needs of people with mental illness who are charged with a criminal offense with the needs of the courts to process the criminal case. If jurisdictions choose, however, to implement specialized mental health courts, then all parties, including the judge, prosecution, and defense, should receive training on available treatment resources and on how to choose which program or service is appropriate for each defendant. Furthermore, it is important that courts work closely with the relevant mental health professionals to ensure that treatment plans developed in the court are successfully fulfilled (see Policy Statement 29: Training for Court Personnel.)

"No judge wants to be faced with a defendant with mental illness without the knowledge, tools, and resources to properly and fairly handle the case."

HON. TOMAR MASON
Superior Court Judge,
County of San Francisco,
CA

Source: Interview, January 11, 2002, Washington, DC.

b Facilitate the release of mental health information where appropriate for use in a dispositional alternative.

When a case reaches a point where a judge is considering a dispositional alternative, it is likely that some information about the defendant’s mental health status will be available in the case file. This might include observations of the arresting officer as recorded in the police report and the information provided for the pretrial release/detention hearing. If the defendant’s competency was called into question, there may be a report in the file from a mental health clinician on the defendant’s mental health status. Several states have statutes

39. Henry Steadman et al., “Mental Health Courts: Their Promise and Unanswered Questions,” *Psychiatric Services*, April 2001, p. 457.

40. For more on the design and operation of four of the earliest mental health courts established in the United States, see John S. Goldkamp and Cheryl Irons-Guynn.

Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage. Bureau of Justice Assistance. April 2000, available at: www.ncjrs.org/pdffiles1/bja/182504.pdf.

41. Henry Steadman et al., “Providing Services for Jail Inmates with Mental Disorders,” 1997.

that specifically allow for the disclosure of mental health records in court. In Georgia, records can be disclosed in response to a valid subpoena. In Illinois, a statute allows for the disclosure of mental health records once the recipient of mental health services introduces his or her mental condition as an element of the claim or defense.

Since a dispositional alternative will in many cases be a favorable outcome for the defendant, the defense attorney should carefully discuss with the defendant the advantages and disadvantages of the possible alternative before the defendant agrees to the release of any additional mental health information to the court. In some cases, the defense attorney may find it advantageous to request an assessment of the defendant and provide the full results to the court to facilitate a decision to offer a dispositional alternative. In these cases, release of the information would be with the consent of the defendant. (See Policy Statement 25: Sharing Information.)

Example: Mental Health Court, Broward County (FL)

For possible placement in the Broward County Mental Health Court, public defenders will often ask for an assessment that includes a listing of any medications that the defendant is taking, possible diagnosis, family support, social support, housing, and substance abuse issues. The assessment is done with the consent of the defendant.

15

Sentencing

POLICY STATEMENT #15

Maximize the use of sentencing options in appropriate cases for offenders with mental illness.

Several options are available to the court at sentencing. Generally, they can range from setting a fine, placing the offender on probation for a specified period, or imposing a period of incarceration in jail or prison. As the recommendations presented under the previous court events are implemented, by the time a case reaches the sentencing stage there may be information in the court file about the defendant's mental health status. The recommendations presented below describe how to build on

that information to ensure that the sentencing court has all the information it needs to make an informed sentencing decision. Consistent with earlier discussions, no offender with mental illness should be sentenced to incarceration in jail or prison due solely to the lack of information or options to address the mental illness. In addition, the court should never enhance a sentence solely because of the offender's mental illness. Rather, the sentence should be based on the behavior that brought the offender into court.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** Ensure that the capacity exists to complete presentence investigation reports in cases where there are indications that the offender may have a mental illness.

The presentence investigation (PSI) report, prepared by the probation office, provides the sentencing judge with information about the offender so that an informed, individualized sentencing decision can be made. According to ABA standards, the court should order a PSI when it "lacks sufficient information to perform its sentencing responsibilities," or upon the motion of either the prosecution or defense.⁴² In Washington, state law requires the court to order a

⁴². American Bar Association, *Standards for Criminal Justice: Sentencing*, 3rd Edition, 1994, Standard 18-5.2,

presentence report before imposing a sentence when the court determines that the defendant may have a mental illness.

A PSI can better inform the court of individual case nuances to be considered in ordering case-specific conditions of probation. The information presented in the PSI report should be neutral; that is, it should include both mitigating and aggravating factors. According to the American Probation and Parole Association (APPA), the PSI should cover the following items:

- a description of the offense and circumstances surrounding it;
- a description of the status of any victim, including the impact of the crime on the victim;
- the offender’s complete prior criminal record;
- the offender’s social history, including family status and residence history;
- the offender’s educational background and employment history; and
- the offender’s medical history.⁴³

The ABA standards state that PSIs should not become part of the public record. Distribution of the reports should be limited to the sentencing court, the prosecution and defense, and to the entity (i.e., probation, jail, or prison) that will be responsible for supervising the offender.⁴⁴ Many states have statutes or court rules that specify that the contents of presentence reports, including any mental health information, are confidential and may be disclosed only to the court, prosecution, and defense. Most states permit the disclosure of their reports to correctional institutions that will be housing the offenders for use in classification.⁴⁵

b Facilitate the release of mental health information for use at the sentencing hearing.

As noted earlier, communications between mental health providers and their clients are protected from disclosure without written consent from the client authorizing the release of information. Furthermore, the offender has the right to refuse to answer any or all of the questions asked by the probation officer during a PSI interview and offenders with a mental illness need to understand this right. Refusing to cooperate with a PSI interview, however, may be counterproductive, so the offender should obtain guidance from the defense attorney on how to proceed before the presentence investigation begins.

It is the obligation of the probation officer conducting the PSI to verify information contained in the report. As a result, if the offender indicates that

available at: www.appa-net.org.

43. Position Statement of the American Probation and Parole Association.

44. American Bar Association, *Standards for Criminal Justice: Sentencing*, Standard 18-5.6.

he or she is in mental health treatment, the probation officer must verify that with the treatment program. To do so, the offender must authorize the release of information to the probation officer. The probation officer and defense counsel should work together to assure that necessary written consents have been signed. The information the probation officer receives from a treatment program should include the offender's diagnosis, treatment recommendations of the attending clinician, and progress with treatment.

When an individual's mental illness is already known, these reports should include information about any diagnosis that has been made, current and past treatment, and the resources available in the community that can help the offender refrain from engaging in the same or similar conduct that led to the arrest. At least one jurisdiction assigns specially trained probation officers to these tasks.

Example: Probation Department, Orange County (CA)

In Orange County, probation officers specializing in mental health cases develop individualized integrated service plans and present them in the PSI that can include social services, housing, and medication as well as treatment for those with co-occurring mental health and substance abuse problems.

"The access to information will always be a provocative issue. We need to find common ground between the mental health community's need for confidentiality and the criminal justice system's need for information."

HON. WILLIAM DRESSEL
President, National Judicial College

Source: Interview, January 11, 2002, Washington, DC.

c **Have a complete assessment conducted by a mental health clinician before sentencing when the mental health information contained in the pre-sentence investigation report is insufficient to make an informed sentencing decision.**

The capacity to have that assessment done in a timely manner by a qualified professional should be available. The assessment should be conducted on an outpatient basis whenever possible. An inpatient assessment should be necessary only when the person poses too great a risk of injury to others or to him or herself, or of failure to report to court or to the assessment. In determining whether such risks exist, the judge should consult the prosecutor, defense attorney, probation officer, and any available mental health records.

d **Ensure that interview protocols used by probation staff with offenders with mental illness include questions that enable staff to identify those with co-occurring substance abuse disorders.**

Just as identifying those with co-occurring disorders is important for other decisions in the court process, it should also be done at sentencing. See the discussions on this topic under Policy Statement 10: Modification of Pretrial Diversion Conditions and Policy Statement 11: Pretrial Release/Detention Hearing (also Policy Statement 29: Training for Court Personnel).

e**Establish programs that provide judges, prosecutors, and defense attorneys with options to address the mental health needs of the offender.**

Those people with mental illness who have been in pretrial detention throughout the processing of the case, assuming that the recommendations included in Chapter 4: Incarceration and Reentry of this document have been implemented, would have received mental health services while in jail. It is common for misdemeanants who have not been released pretrial (either by judicial decision or for inability to meet bail) to be found guilty of a crime and to be sentenced to time served. At this point, they will be released from custody and need have no more involvement with the criminal justice system regarding that particular offense. It is important that some discharge planning have been undertaken for such offenders, to ensure that their release will lead to a successful reintegration in the community with appropriate treatment and services. Without such discharge planning, the likelihood of their returning to the criminal justice system in short order is greatly increased.

Some of those who have been on pretrial release while the case was being adjudicated, assuming the implementation of the recommendations in this section, would have mental health conditions attached to their release. As a start, the same options that exist for the pretrial release decision should also exist for the sentencing decision. Additionally, once the individual has been convicted, the court has more authority to order mental health treatment.

Example: Project Link, Monroe County (NY)

In Monroe County, Project Link has developed a close working relationship with the probation department to identify offenders most in need of mental health services. It has a mobile treatment team, consisting of a psychiatrist, nurse practitioner, and five culturally diverse case workers, that is available 24 hours a day to focus on 40 of the most serious cases.

Before ordering treatment as a condition of the sentence, the judge should, as specified in ABA sentencing standards, determine that the offender “will participate in and benefit from” the treatment program.⁴⁵ The judge should also determine whether the offender needs mental health services.

f**Expand the sentencing options available in rural areas to provide mental health services for people with mental illness.**

(See Policy Statement 10: Modification of Pretrial Diversion Conditions and Policy Statement 11: Pretrial Release/Detention Hearing, for more on this topic.)

45. See, for example, Pennsylvania Rules of Criminal Procedure, Rule 703.

16

Modification of Conditions of Probation/ Supervised Release

POLICY STATEMENT #16

Assist offenders with mental illness in complying with conditions of probation.

If the offender is placed on probation with conditions, those conditions are supervised by a probation officer. If the probationer fails to comply with the conditions, the probation officer notifies the court. The court can revoke the probation, modify the conditions, or issue a warning.

Many of the same issues that were discussed under the Modification of Pretrial Release Conditions pertain here as well, including assisting the offender in getting reconnected to treatment and to financial and housing support after a period of incarceration, and establishing accountability in complying with the terms of release. There is an impor-

tant distinction, though, that has implications for treatment planning. Once the person has been convicted and sentenced, the length of time that the offender will be under supervision is known at the outset—six months, one year, 18 months, etc. While in the pretrial status, however, the duration of supervision lasts only as long as the case lasts, which cannot be known when the release conditions are set. This distinction makes it easier for mental health staff to develop an appropriate treatment plan for individuals who are on probation as opposed to those on pretrial release.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Develop probation conditions that are realistic and address the relevant individual issues presented by the offender.**

Typically, when a judge sentences an offender to probation, the order may read that the offender is to participate in treatment, whether drug, alcohol, or mental health. It is up to the probation officer to identify the most appropriate treatment program for the offender, and then to monitor the offender's compliance. The key to successfully designing conditions of probation is to identify first the offender's individual needs and then identify the services in the com-

munity that can meet those needs. The information contained in the presentence investigation report, in addition to information taken at probation intake, should be very useful in identifying the needs of the individual offender.

b Streamline administrative procedures to ensure that federal and state benefits are reinstated immediately after a person with mental illness is released from jail.

In instances when the person was on pretrial release while the case was pending there should have been no disruption in the receipt of benefits. When the person was held in jail pretrial, however, or where there was a split sentence—i.e., 30 days in jail followed by two years probation—benefits would have to be reinstated very soon after release so that the offender can begin to comply with the probation conditions. Probation officers should identify benefits for which an offender is eligible and assist the offender with the application or reinstatement process. (See Policy Statement 13: Intake at County / Municipal Detention Facility, for more on federal and state benefits.)

c Assign offenders with mental health conditions on probation to probation officers with specialized training and small caseloads.

Most probation officers carry very high caseloads, making it very difficult to provide close supervision. Offenders with mental illness recidivate at a higher rate than those without mental illnesses, and they often do so within the first months of release. Close supervision by probation officers, including the time to attend to the individual needs of offenders with mental illness, will help to ensure compliance with conditions of release, and help to reduce recidivism. It is also important that these offenders be assigned to probation officers who have been specially trained to address the needs of offenders with mental illness. Such an approach has been used with success in at least one jurisdiction.

Example: Adult Probation Department, Cook County (IL)

The Mental Health Unit of the Cook County, Illinois, Adult Probation Department is comprised of probation officers with a background in mental health. These officers are qualified to perform the following functions:

- conduct clinical assessments
- make referrals
- develop supervision plans
- monitor compliance with probation conditions, medication requirements, and other treatment objectives

One important issue that should be addressed in any discussion of court referrals to mental health programs is the rejection of clients by programs that have restrictive admission criteria. A common frustration for courts is to identify a person with mental health needs, consult its inventory of programs, and be unable to find a program that, because of the person's charge, treatment history, or lack of insurance, is willing to accept the person. (See Policy Statement 1: Involvement with the Mental Health System.) One strategy to address this issue is the development of written agreements between the referring entity and mental health agencies.⁴⁷ (See Policy Statement 26: Institutionalizing the Partnership, for more on written agreements between criminal justice and mental health partners.)

46. American Bar Association, *Standards for Criminal Justice: Sentencing*, Standard 18-3.13.

47. "Repeated rejections of clients can be avoided if program administrators sign contractual agreements with local mental health agencies to ensure that clients will be

accepted for services," Arthur J. Lurigio and James A. Swartz, "Changing the Contours of the Criminal Justice System to Meet the Needs of Persons With Serious Mental Illness," in *Criminal Justice 2000, Volume 3: Policies, Processes, and Decisions of the Criminal Justice System*, edited by Julie Horney, Washington, D.C., National Institute of

- assist probationers in obtaining disability and other benefits
- serve as advocates for probationers in their efforts to obtain mental health treatment.

Mental health providers whose clients are on probation, while being careful not to become monitors of compliance, can also assist the individual to understand the consequences of their behavior in terms of sanctions and can build a collaborative relationship with the specialized probation officers that can benefit the individual. In this way, the probation officer can have more confidence when making decisions on how to respond to violations. For example, the officer and the provider can meet jointly with the individual to identify barriers to compliance and to make changes in the treatment plan or probation rules as necessary.

"You want [defendants] to think about the consequences—stay on track, you get a reward; mess up, you get punished. But what if they're confused and can't think straight because their medication is wrong? That's not their fault. It's not right to punish them then."

CONSUMER

Derek Denckla and Greg Berman,
*Rethinking the Revolving Door:
A Look at Mental Illness in
the Courts.*

d Develop guidelines on compliance and violation policies regarding offenders with mental illness.

It is important to establish incentives for probationers with mental illness to comply with conditions. Such incentives could include reducing the frequency of reporting after a period of compliance.

Example: Adult Probation Department, Cook County (IL)

The Mental Health Unit of the Cook County Adult Probation Department has three phases, each lasting a minimum of three months. The first phase is the most restrictive. Advancement to the next phases is contingent upon the probationer's compliance. Once advanced to a less restrictive phase, the probationer can be returned to the previous phase for noncompliance. Upon successful completion of all three phases, the probationer is placed in the standard probation supervision program for the remainder of his or her term.

Probation officers should be prepared to respond to offenders with mental illness who violate the conditions of probation in a way that recognizes that the violation may be a function of the offender's illness but that also holds the offender accountable. When a probationer commits a technical violation—for example, failure to report to treatment—probation officers should employ a graduated scheme of responses before employing the most serious response, that is, revocation of release. State law in Washington provides that, when an offender with a mental illness violates a condition of a release that involves failure to undergo mental status evaluation or treatment, the community corrections officer must consult with the treatment provider before taking action on the violation. Responding to minor technical violations early may obviate the need for revocation and may prevent more serious violations, such as reoffending. In developing intermediate responses, criminal justice officials should establish written agreements with mental health treatment programs

Rearrest on New Charges

as to actions that will be taken for failure to participate in treatment. When a probationer's mental condition decompensates while under probation supervision, a more appropriate response would be to modify the treatment plan rather than to seek the revocation of probation.

At least one jurisdiction has developed a program that seeks to prevent a probation revocation by offering intensive treatment rather than incarceration for those who violate probation conditions.

Example: The Nathaniel Project, Center for Alternative Sentencing and Employment Services (CASES), New York City (NY)

Among the groups targeted by the Nathaniel Project in New York, New York, (mentioned earlier) run by the Center for Alternative Sentencing and Employment Services, are offenders with mental illness who have violated conditions of probation. Case managers are clinically trained professionals with caseloads of only ten. Staff assist participants in obtaining medication, housing, and other services, i.e., day treatment, psychosocial clubhouse, vocational training, and job placement. (See Policy Statement 14: Adjudication, for more on The Nathaniel Project.)

It is not uncommon for people under supervision for a current charge—whether pretrial diversion, pretrial release, or probation—to be rearrested on a new charge. A person with mental illness who is released from custody may need time to stabilize and rearrests may result during periods of decompensation.. When rearrests occur, courts should treat them as they would other violations of the conditions of supervision, weighing the seriousness of the rearrest charge, and the person's compliance with other conditions of supervision. A rearrest on a new offense should not in and of itself be a reason for denying pretrial release in the new case or for revoking release in the first case.

CONCLUSION

Leaders in jurisdictions able to implement the changes proposed in this chapter (along with those offered in the two preceding chapters, *Involvement with the Mental Health System* and *Contact with Law Enforcement*) will have gone a long way toward ensuring that persons with mental illness that come in contact with the criminal justice system will be treated fairly and appropriately. Improved collaboration with mental health providers, access to appropriate information, and increased awareness about mental illness will better prepare the courts to determine the proper resolution of cases involving defendants with mental illness. Sometimes, justice will be best served through diversion programs that help individuals with mental illness obtain treatment and support services. Many defendants with mental illness, however, will eventually be incarcerated.

The next chapter, *Chapter IV: Incarceration and Reentry*, focuses on an area of the criminal justice system that is too often overlooked—corrections. Correctional institutions are the ultimate destination for many individuals with mental illness who become involved with the criminal justice system; in many ways, they have become the country's new mental health institutions.

It is important for officials who focus on pretrial issues, adjudication, and sentencing to become familiar with the policies and programs that need to be in place to identify, treat, and prepare for release people with mental illness who are incarcerated. These are the issues that the subsequent set of policy statements address.

Incarceration and Reentry

One of the most dramatic public policy shifts (some refer to it as a "social experiment") during the last three decades in the United States has been the unprecedented increase of the number of people who are incarcerated. The national prison population grew by nearly six-fold between 1970 and 2000 and the combined prison and jail population in 2000 was 1.9 million.¹ Approximately 10 million people are booked into U.S. jails each year.²

The extraordinary growth of prison and jail systems has presented enormous challenges to corrections administrators. Of these challenges, few, if any, are more formidable than operating a comprehensive mental health service delivery system for inmates. Increasing budgetary pressures on corrections systems make this challenge especially daunting. Estimates regarding the number of

people with mental illness in prison or jail vary. The US Department of Justice reported in 1999 that about 16 percent have a mental illness.³

Like the policy statements in the preceding chapters, the following policy statements do not suggest that people with mental illness should not be held accountable for their behavior. Indeed, given the crime they committed, it is appropriate and necessary for some people with mental illness to be incarcerated.

The policy statements in this chapter adhere to the principle that identifying inmates with mental illness, treating them, and preparing them for release is good corrections policy. And it is the right thing to do. It improves corrections administrators' ability to protect people with mental illness while they are incarcerated, to maintain calm environments in the facilities, and to promote staff safety. Perhaps most importantly, the vast major-

1. The Sentencing Project, *State Sentencing and Corrections Policy in an Era of Fiscal Restraint*, available at: www.sentencingproject.org.

2. *Correctional Populations in the United States*, U.S. Department of Justice Statistics, NCJ-163916, 1997.

3. Ditton, *Mental Health and Treatment*, p. 1

ity of people in prison or jail will ultimately re-enter the community. Screening inmates for mental illness, delivering effective services, providing appropriate housing, and developing a comprehensive treatment plan improve the likelihood that an inmate with mental illness will return to the community (and to his or her loved ones) healthy and safely.

The policy statements in this chapter go beyond what should happen when a person with mental illness is incarcerated. They also address the role of community corrections officials in monitoring and assisting people with mental illness who are released from prison or jail under some form of supervision. Furthermore, they review the pivotal role of the mental health system in maintaining the person on a path toward recovery once the person is released.

17

Receiving and Intake of Sentenced Inmates

POLICY STATEMENT #17

Develop a consistent approach to screen sentenced inmates for mental illness upon admission to state prison or jail facilities and make referrals, as appropriate, for follow-up assessment and/or evaluations.

Every correctional system has procedures in place to receive a sentenced inmate admitted to an institution. These intake procedures typically are used for inmates who arrive at the institution from a detention facility immediately following their sentencing or for inmates who have been transferred from a different institution.

Recommendations under this policy statement explain how corrections administrators can ensure that each sentenced offender entering the institution is screened for potential mental illness. These recommendations include the following: the key elements of a screening instrument and its administration; procedures to follow up on the results; and protocols for evaluating its effectiveness.

Typically, when institutional intake staff receive inmates, they fingerprint them, conduct a medical exam, and review a host of issues in order to make decisions about classification, housing, and other programmatic or special needs. Determining whether the inmate needs mental health services should be a critical component of the inmate booking and receiving process. Immediately upon the inmate's arrival at the facility, it is especially important for staff to determine whether the inmate has any suicidal tendencies or poses a danger to self or others, and whether he or she is taking psychotropic medication.

Not adequately screening inmates to determine the possible existence of a mental illness jeopardizes the safety of personnel and inmates alike. Identifying and addressing mental illness among inmates will minimize the likelihood of an offender's risk of hurting him- or herself or others. It may also minimize the incidence of hospitalization, assaults on officers or other inmates, or other incidents that may generate considerable harm and costs. Responding to mental illness at a late stage requires the most expensive and intensive level of mental health care as well as collateral costs such as lost personnel time, overtime, and compensatory time when officers are injured.

In addition, with a consistent, system-wide approach in place for identifying inmates with mental illness, correctional administrators are able to compile the data needed to understand the scope of mental illness within their institutions. This, in turn, enhances their ability to project the future mental health needs of their agencies and communicate to policymakers the changing needs of prisoners.

Some correctional administrators fear that a mental health screening process may overstate the mental health needs of the inmate population, and thus generate excessively expensive use of mental health services. Aside from identifying those indi-

viduals who are of immediate concern and who should receive urgent attention, however, a properly designed and implemented screening function during the receiving and intake process only suggests when there may be a potential mental health problem that should be further assessed. It serves as a form of triage, ensuring a cost-effective use of resources. Screening alone is not intended to provide a diagnosis or determine the need for services or medication.

Implementation recommendations contained here are consistent with the American Psychiatric Association's (APA) Task Force for Psychiatric Services in Jails and Prisons, which, since 1990, has developed guidelines for the delivery of mental health services in jails and prisons. Consistent with the APA, recommendations under this policy statement recognize the varying levels of services provided upon admissions:⁴

- **Receiving Mental Health Screening.** Mental health information and observations gathered for every new admitted inmate during the intake procedures as part of the normal reception and classification process

by using standard forms and following standard procedures.

- **Referral.** The process by which inmates who appear to be in need of mental health treatment receive targeted assessment or evaluation so that they can be assigned to appropriate services.
- **Intake Mental Health Screening.** A more comprehensive examination performed on each newly admitted inmate within 14 days of arrival at an institution. It usually includes a review of the medical screening, behavior observations, an inquiry into any mental health history, and an assessment of suicide potential.

As a result of the above, the APA advises, professional clinicians would then conduct the following:

- **Comprehensive Mental Health Evaluation.** A face-to-face interview of the patient and a review of all reasonably available health care records and collateral information. It includes a diagnostic formulation and, at least, an initial treatment plan.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** Incorporate screening for mental illness and referral to mental health services into the existing receiving/admission protocol by integrating into the process a screening instrument along with observations by those charged with booking newly received inmates into the receiving/admission process.

The purpose of a screening instrument is to identify inmates with mental illness immediately upon their arrival at the institution and to prompt referral for further assessment of those inmates' mental health needs.⁵ Screening instruments typically are paper-and-pencil forms that may be completed by the inmate or used as a structured interview protocol by any trained staff person. It should take no longer than 10 to 15 minutes to conduct a screening.

There are no validated instruments for mental health screening in adult populations. Most correctional settings use a series of questions that seek in-

4. American Psychiatric Association, *Psychiatric Services in Jails and Prisons: A Report of the American Psychiatric Association Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons*, second edition, pp. 31-46.

5. American Psychiatric Association *Guidelines on Psychiatric Services in Jails and Prisons* provide that mental health and suicide screening should be completed immediately upon the inmate's arrival in prison. *Ibid.*, p. 40.

formation on past psychiatric services or current medications. Systematic attention to current psychiatric symptomatology is often cursory. The New York State Office of Mental Health has developed Suicide Prevention Screening Guidelines that have face validity as a screening measure for suicide, and the state trains its correctional staff in the application of this tool.⁶

Recognizing the need for a reliable screening tool, the National Institute of Justice has recently funded research at the University of Maryland to develop and test a nine-item Brief Jail Mental Health Screen. Correctional settings in Maryland and New York are participating in this study. Until a validated instrument emerges, correctional administrators should work with their mental health staff to ensure questions are asked early on in the process that are sensitive to critical mental health issues. The discussion that follows addresses other issues essential in an effective screening instrument.

Self-assessment should never entirely replace critical observations by staff. Use of a self-administered intake screening instrument does not absolve correctional or clinical staff of the responsibility to query and observe for mental illness at the time of intake. Training staff for such responsibilities is essential. (See Policy Statement 30: Training for Corrections Personnel.)

In general, when an effective screening instrument is implemented properly, staff will more often incorrectly identify someone as exhibiting signs or symptoms of mental illness than overlook someone who truly has a mental illness. Erring on the side of caution at the outset increases the likelihood that high-risk cases are discovered; only a relatively small percentage of mental health assessments are conducted when they are not needed. A useful screen will send a significant percentage of inmates (perhaps as many as 25 percent) forward for a more comprehensive evaluation.

Example: Screening Instrument, Oregon Department of Corrections

In Oregon, staff administer a group-led pen-and-pencil instrument to all offenders admitted at the time of intake. This instrument generally identifies 30 percent of the population as having a mental illness. When this 30 percent are referred for professional assessment, the percentage assessed as having a significant mental illness is reduced to 17 percent.⁷

A screening instrument should use an objective scoring system. Many jurisdictions use a straightforward numeric scoring system, resulting in a “red flag” or “green flag” determination of the possible presence of a mental illness. Though effective screening instruments currently in use vary considerably, each tool must address the following: suicidality; depression; use of narcotic drugs and alcohol; anxiety; history of hospitalization for psychiatric problems; trauma history; and the use of any medications prescribed for a mental illness.

Substance abuse greatly influences symptoms of mental illness. For this reason, and because the majority of people with mental illness who are incar-

6. Fred Osher, Director, Center for Behavioral Health, Justice and Public Policy, private correspondence, April 18, 2002.

7. Gary Field, Administrator, Counseling and Treatment Services, Department of Corrections, private correspondence, February 2002.

cerated have a co-occurring substance abuse disorder, staff should screen for substance abuse in tandem with mental health. Subsequent assessments should allow clinicians to observe the individual in a drug-free state over time in order to separate the causes and effects of substance abuse on mental health.

Ideally, the intake process would be seamless, incorporating health screening, mental health screening, classification procedures, and other protocols. This process could be captured in a single, integrated instrument, such as the one being developed by the University of Maryland.

In some states, properly trained correctional officers—especially those with close and sustained contact with inmates during the first few days of incarceration—serve as initial, informal screeners. They may be in the best position to observe behavior and to identify signs and symptoms of mental illness, particularly when such symptoms emerge several days after intake. Although this measure may seem inefficient, given the screening that mental health staff will perform later, such redundancy is in fact cost-efficient; it effectively narrows the pool of inmates who receive a professional assessment to those who are most likely to have a mental illness.

b Ensure consistency of screening protocols within correctional system by using the same screening instrument at all facilities statewide and training facility staff in their use.

In many correctional systems, a different mental health screening instrument is employed at each prison in the system. Such variation among the prisons is complicated and compounded by the procedures in use at county jails, where staff at each facility typically employ a distinct instrument and process (if one is used at all) to screen inmates for mental illness. Although it may be a challenge, particularly in states with an elaborate network of independent county jails, state officials should require the use of the same screening and assessment instruments and protocols at all correctional facilities in the state. The American Psychiatric Association recommends standardizing mental health screening procedures and instruments so that the responses can be documented in a consistent fashion.⁹

Uniformity in screening procedures has numerous advantages. It can provide valuable information about the impact of transfers, the incidence of inmate decompensation, and identify trends occurring over time. It also enables state correctional systems to collect data needed to inform research and evaluations and to support legislative advocacy and public education. To achieve uniformity, directors of state departments of corrections may be able to issue an administrative order. In other states, however, leadership from mental health

In 2001, at the request of the Pennsylvania Office of Mental Health and Substance Abuse, the Pennsylvania Department of Corrections assembled data on the mental health and treatment status of its inmate population in all Pennsylvania state prisons over a four-year period. The data revealed that 90 percent of the inmate population had an issue with substance use, of which they estimated about 75 percent had a substance abuse problem serious enough to warrant treatment. Concurrently, about 15 percent of the total Pennsylvania inmate population had a mental disorder. Of the 15 percent of inmates with mental health disorders, 90 percent also had a substance use issue and an estimated 75 percent warranted drug and alcohol treatment. These data were consistent over four consecutive years.⁸ This prevalence of inmates with co-occurring disorders is certainly not unique to Pennsylvania.

Although this chapter of the report does not assume that an inmate with a mental illness has a co-occurring substance abuse disorder, it does recognize that the assessment, housing, program, treatment, case management, and habilitation needs of inmates with mental illness must address substance abuse issues as well if they are to be effective.

8. Information cited by Charles Curie, Administrator, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (SAMHSA), and former Deputy Secretary for Mental Health and Substance Abuse Services for the Department of Public Welfare of the State of Pennsylvania, in an address to

the Council of State Government Criminal Justice / Mental Health Consensus Project Advisory Board Meeting in January 2002, and reported by Teddy Fine, M.A., Director of Communications Policy and Strategy, Substance Abuse Mental Health Services Administration (SAMHSA).

9. APA, *Psychiatric Services in Jails and Prisons*, p. 41.

agencies or statewide legislative advocacy may be necessary, especially when county government officials are unwilling to assume the financial implications of implementing such an order.

Example: Screening Instrument, New York State Office of Mental Health

In an attempt to encourage uniformity of mental health screening, assessment, and referral procedures, the New York State Office of Mental Health (OMH) has been developing model policies and instruments for use in New York's county and municipal jails. First, in 1985, OMH developed and field-tested a suicide screening protocol for use in the jails. The New York State Commission of Correction, which accredits and oversees the development of new technology for jails and prisons in the state, adopted the suicide screening protocol and now requires all county jails and penitentiaries and state prisons to employ it.

More recently, OMH, in association with the New York State Office of Alcoholism and Substance Abuse Services (OASAS), has been involved in sponsoring jail validation studies of two receiving screening instruments developed by the Nathan Kline Institute for Psychiatric Research for use in community settings. One, the "MINI Screen," was designed to identify individuals with substance abuse problems who are receiving services in community mental health settings. The second, the "DALI Screen," was designed to identify individuals with mental health problems who are receiving treatment in substance abuse settings.¹⁰ At the time of publication of this report, the jail validation study involving 400 newly admitted detainees and offenders at New York State county jails had just gotten under way.

In states and localities where correctional institutions are located at considerable distance from one another, some jurisdictions have relied on information technology to ensure consistent screening and assessment methods.

Example: Suicide Screening Initiative, Alaska Department of Corrections

There are 13 correctional facilities and pretrial facilities in Alaska, a state where geography and low population density present particular challenges. To ensure consistent, comprehensive inmate mental health screening, the Alaska Department of Corrections has developed a screening tool that trained, nonmedical staff can download, administer, and return completed almost immediately to the department's central office using handheld personal desk assistants or Palm Pilots. Mental health professionals in the central office can then make assessments and recommend or initiate appropriate interventions, if needed.

The Palm Pilot serves not only as an electronic means of keeping medical records, but as a platform for the entire management information system. All clinicians perform the same, standardized exam on the Palm Pilot. The information is then uploaded to a statewide computer network and becomes available for printing of medical files. The system makes it possible to generate information in summary and/or aggregate form, thereby facilitating quality assurance and research.

As is the case in many correctional facilities, Alaska's Suicide Screening Initiative relies exclusively on inmate self-reported information. It is important, however, to use sources other than the inmate alone to supplement self-reported mental health information. Self-reports are not always reliable, and

10. M.J. Alexander, "Validating the MINI Screen for Mental Health Problems in Chemical Dependency Treatment Settings" and "Validating the DALI Screen for Substance

Abuse in Mental Health Treatment Settings," The Nathan Kline Institute of the Center for the Study of Issues in Public Mental Health, Orangeburg, NY.

they rarely provide a complete picture of an inmate's mental health treatment history; sometimes, they also fail to shed light on co-occurring disorders. It is essential to obtain this information during the assessment phase, and it helps to inform decisions regarding classification and treatment plans.

When the screening results in a "red flag," staff should seek additional information, such as an existing treatment plan or information about medications the inmate has been prescribed, from supplemental sources. For example, the mental health professional conducting the subsequent mental health assessment should review information and reports from other criminal justice staff, such as the pretrial investigator, the presentence investigator, and county/municipal detention staff, who have previously had contact with the inmate. Reports from other criminal justice system personnel such as law enforcement or jail officials will provide details of mental health and behavioral issues pertinent to the screening and evaluation process of the inmate. Additionally, state departments of correction may wish to consider gathering supplemental information from the local or county corrections authority. It might be advisable for states to require county jail officials to inform receiving state correctional authorities if a person has been receiving mental health services. Such information is not considered confidential, and may well prove to be critical for the health and well-being of inmates with mental illness.

Staff should also obtain assessment and treatment history information from community mental health treatment providers. In at least some corrections systems, staff encourage the inmate to sign a release of records form, which allows correctional staff including clinicians to obtain mental health records from previous treatment providers in the community. In other cases, staff at the corrections center request the assistance of community mental health officials in cross-referencing the names of their clientele with the jail population (see Policy Statement 13: Intake at County / Municipal Detention Facility).

The individual charged with conducting the screening is most often the booking or receiving officer, intake nurse, or intake clinician; in general, any properly trained individual can administer a straightforward screening instrument and gather necessary information. As state mental health agencies become more involved in assisting, overseeing, and/or providing mental health services within the criminal justice system, professional credentialing and licensing requirements are more likely to be consistently enforced when addressing the needs of people with mental illness in correctional settings. A low-cost, high-quality solution involves making arrangements with educational institutions that can place graduate-level clinical psychology or social work student interns at facilities to conduct screening and assessment of inmates.

The extent to which any of these staff implement the screening procedures effectively, however, depends in large part on whether they understand their responsibilities and execute them properly. In short, training on issues such as the screening protocol, the appropriate use of information gathered, confidentiality issues, and cultural and gender sensitivity is key. (See Policy Statement 30: Training for Corrections Personnel.)

c **Develop a system of triage to ensure that follow-up responses to the screening results reflect the immediacy of the inmate's needs.**

An effective screening tool should enable screeners to distinguish between inmates in need of immediate mental health attention and inmates currently on medication or in treatment who will require a complete assessment within 24 hours of their screening. When staff members conducting the screenings determine that inmates are in need of immediate attention, they should ensure that these inmates are transferred to a specialty facility for 24-hour observation and care or placed on suicide watch until more suitable arrangements can be made. They should also check whether there is any indication that the newly admitted inmate is currently taking psychotropic medication and ensure that he or she receives it when ready for the next dose.

Inmates who display significant mental health disorders should receive a professional mental health assessment as soon as possible after admission. The APA recommends that a brief mental health assessment for individuals who screen positive for mental illness should be conducted within 72 hours, with a provision for immediate evaluation in cases of increased urgency.¹¹

These brief assessments may be conducted by qualified health professionals (e.g., general practitioner nurses or physicians) where specialty mental health staff are not available daily. After this brief assessment, the inmate should be placed on a medication review protocol and scheduled for a full treatment plan review within 30 days.

d **Evaluate periodically the effectiveness of the screening instrument employed, as well as the mental health assessment and mental health evaluation protocols.**

Staff can implement various mechanisms at the facility level to ensure that the instrument and protocols are successfully identifying inmates who have significant mental health issues and following up appropriately:

- **Inter-rater reliability review.** Comparison of the outcomes of screenings conducted by different staff.
- **Feedback from assessment results.** Determination of the rates at which a positive screening successfully identified an inmate with mental health needs and the rates at which a positive screen incorrectly flagged a mental illness or mental health problem.
- **Interdisciplinary review.** Interdisciplinary communication (i.e., among health and custody staff) about mental health screening issues.

Another key element in evaluating the effectiveness of screening and referrals is to determine the extent to which the screening instrument is sensi-

11. APA, *Psychiatric Services in Jails and Prisons*, p. 41.

tive to cultural variations and that those who administer the process are sensitive to inherent cultural biases. Inmates with mental illness are disproportionately African American, Hispanic, and Native American. Given the reality, it is incumbent on those who oversee and carry out the care and supervision of defendants and offenders with mental illness to ensure that the procedures undertaken and the services provided are done so in a nondiscriminatory way, while at the same time are sensitive about and responsive to cultural and linguistic differences. Similarly, the growing number of women who have a mental illness and who come to the attention of the criminal justice system deserve gender-specific and gender-competent care and treatment.

No matter how culturally competent or how culturally neutral a screening instrument may be, it will not substitute or supercede personnel's abilities when it comes to asking questions and making observations. It is critical that, in addition to training around the signs and symptoms of mental illness, specifics about screening, and preliminary assessment protocols, staff need to be trained to move toward cultural competency.

e

Conduct a comprehensive mental health evaluation of every inmate flagged as having significant mental health issues during the professional mental health assessment process.

A comprehensive mental health evaluation should include, at a minimum, the following:

- mental health history
- prior treatment
- medication history
- relevant psychosocial history (i.e., family, social, legal, relationships)
- functional assessment
- current situational stressors
- mental status examination
- current diagnosis
- relevant medical diagnoses
- current medication
- substance abuse status

The evaluation should include a structured interview with inmates and a review of any available mental health records and collateral information, including behavioral observations by institutional staff. The evaluation should result in a diagnosis and a preliminary treatment plan.

Early models of cultural competency were developed in the mid-1980s at Georgetown University's Child Development Center.¹² Cultural competence is something that must develop concurrently at policymaking, administrative, practitioner, and consumer levels. "The culturally competent system values diversity, has the capacity for cultural self-assessment, is conscious of the dynamics inherent when cultures interact, has institutionalized cultural knowledge and has developed adaptations to diversity."¹³

The language of any good screening instrument should, at least, be presented at a language comprehension level that enables inmates to understand what is being asked of them. It should also be available in Spanish and/or other language(s) prevalent in the community. In addition, cultural competency should be a part of the training curriculum for screeners. (See Policy Statement 43: Cultural Competency.)

12. See: www.georgetown.edu/research/gucdc/nccc/index.html

13. T. Cross, B. Bazron, K. Dennis, M. Isaacs, "Towards a Culturally Competent System of Care: a Monograph on

Effective Services for Minority Children who are Severely Emotionally Disturbed," Child and Adolescent Service system Program Technical Assistance Center, Georgetown University Child Development Center, March 1989, p. 19.

18

Development of Treatment Plans, Assignment to Programs, and Classification/Housing Decisions

POLICY STATEMENT #18

Use the results of the mental health assessment and evaluation to develop an individualized treatment, housing, and programming plan, and ensure that this information follows the inmate whenever he or she is transferred to another facility.

Correctional administrators should ensure that the results of the initial receiving mental health screening—along with subsequent screenings, assessments, and evaluations—inform the decisions that follow regarding housing, programming, and treatment. Mental health screeners serve as gatekeepers who, in turn, must communicate effectively with correctional staff responsible for housing and program decisions.

Once mental health staff have determined the inmate has a mental illness, several decisions follow. Mental health staff must develop an individualized treatment plan that recognizes the specific needs of each inmate. They also must work with correctional staff to determine the housing unit and programs to which such persons should be assigned. Information about decisions made at one institution must be passed along to the staff at the institution that next receives the inmate.

The first series of recommendations under this policy statement addresses the use of medications in correctional settings. The development over the previous 15 years of new types of psychotropic medications, such as atypical antipsychotics and selective serotonin reuptake inhibitors (SSRIs), has increased dramatically the prospects of recovery for people with mental illness.

The prescription of medications, however, should be only one component—not the central focus—of a treatment or case management plan. Historically, staff at many correctional facilities have overrelied on the use of psychotropic medications and, in many cases, sedative-hypnotic medications, simply to pacify and to control inmates with mental illness and others believed to be disruptive. This reveals a common prejudice about inmates with mental illness: they are noncompliant, difficult to manage, violent, and otherwise undeserving of clinical attention or services. This is a view current clinical research and practice does not support.

14. In *Estelle v. Gamble*, 429 U.S. 97 (1976), the Supreme Court addressed the medical needs of prisoners in the context of the Eighth Amendment. The court held that deliberate indifference to serious medical needs is prohibited “whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced,

deliberate indifference to a prisoner’s serious illness or injury states a [claim under the Constitution.] *Id.* at 104-105.” A prisoner must provide evidence of “acts or omissions sufficiently harmful” to show deliberate indifference in order to bring an Eighth Amendment claim.

Since *Estelle*, the Supreme Court has refined the “deliberate indifference” standard only once. In 1994 the Court said that deliberate indifference “[lies] somewhere be-

RECOMMENDATIONS FOR IMPLEMENTATION

a Include the most appropriate psychotherapeutic medications in prison and county correctional institution formularies.

A growing body of clinical evidence shows the benefits of widespread access to the newer generation of medications (see Policy Statement 35: Evidence-Based Practices). Fewer people taking these medications require hospitalization or rehospitalization, yielding substantial cost savings. More people taking them are able to enter the workforce and reduce their dependency on a wide array of social services. As the benefits of the newer medications have become more widely recognized the demand has increased, allaying concerns about higher costs.

Newer medications, which are considerably more expensive than older medications, are not used as frequently in prisons and in jails as they are in the general community. Using these newer medications in many instances, however, is in fact cost-effective; their ability to increase the likelihood that the inmate will adhere to his treatment plan may offset, at least in the long term, the difference in cost between the two generations of medications.

Correctional officials usually require that licensed staff in the jail or prison pharmacy fill prescriptions, including those for psychotropic medications, in accordance with a departmentally prescribed formulary. Policies should define procedures that ensure a balance between the higher cost and the more desirable results, including the lesser side effects of many of these new medications. At a minimum, pharmacies should maintain adequate stocks of the most commonly prescribed psychotropic medications. These should not be limited to the least expensive and generic brands. Sufficient supplies of newer medications that have been prescribed by the psychiatrist for individual patients should also be kept on hand.

Furthermore, regardless of whether a particular medication is on the jail or prison formulary, there should be provision for obtaining any medication that a physician deems appropriate to prescribe. If the medication is not on the formulary, the physician should be able to order it as a special request and receive it in a timely manner.¹⁴

tween the poles of negligence at one end and purpose or knowledge at the other”(Farmer v. Brennan, 511 U.S. 825, 1994). The Court affirmed an “adequacy” standard stating that “prison officials must ensure that inmates receive adequate food, clothing, shelter and medical care . . .” (id. at 833), but went on to emphasize that “deliberate indifference” requires a culpable state of mind. Federal District

Courts (the trial court in the federal system) may interpret “adequate” with wide discretion. On appeal to the Federal Circuit Courts—the layer of the judiciary just below the U.S. Supreme Court—this has led to vastly varying law, especially in regards to the treatment of HIV. See APA, Psychiatric Services in Jails and Prisons, p. 2

b **Develop and adopt jointly standardized clinical decision protocols (i.e., algorithms) that are based upon research conducted on a national level.**

In order to ensure consistency in the application of psychotropic medications, and to manage pharmacy costs, state correctional agency officials should work with leaders in the mental health system to develop and adopt jointly standardized clinical decision protocols (i.e., algorithms) that are based upon research conducted on a national level.

Example: National Formulary, Federal Bureau of Prisons

In an effort to deliver consistent and cost-effective medical care, the Pharmacy and Therapeutics Committee of the Federal Bureau of Prisons (BOP) established the National Formulary for the Bureau of Prisons. The committee's objectives are to ensure that inmate medical care will be delivered consistently and cost-effectively as a result of the formulary's implementation.

Implementation of the formulary includes review of evidence-based scientific literature for new and existing drugs and to determine their appropriate role in the Bureau's pharmacotherapeutic armamentarium. It is the committee's role, through the formulary, to stay current with BOP clinical treatment guidelines for medical and mental health conditions, as well as reflect the generally accepted professional practices of the medical community at large.

The committee meets and conducts reviews annually and is composed of pharmacists and clinicians from the bureau and other institutions and includes the chief physician and chief psychiatrist; it is chaired by the chief pharmacist. Responsibilities include reviewing the formulary and updating it to be in line with evidence-based medicine; new drugs are reviewed by conducting literature searches and cost/benefit analyses to determine whether the side effect of a given drug is worth the benefit of administering it.

Example: University of Texas Medical Branch, Texas Department of Criminal Justice

Beginning in 1995, the Texas Department of Criminal Justice (TDCJ) developed policy and guidelines for facility-level providers to obtain nonformulary drugs for offenders in the custody of the Texas Department of Corrections. TDCJ has incorporated the procedure for obtaining nonformulary drugs for inmates as part of the Pharmacy Policy and Procedure Manual. The prescribing physician must provide documentation in the offender's health record about what role the desired drug will have in the offender's treatment plan (e.g., diagnosis, special considerations) and also provide documentation confirming that no acceptable substitute is available on the formulary.

Procedures and a flowchart have been developed to show the protocols for what happens when such a request is made. Requests for nonformulary medication are made to the clinical pharmacist assigned, who, in turn, evaluates the request by a review of information provided by the prescribing physician/psychiatrist and/or a review of other relevant information including the target disease, previous medications used for the indication, dosages, compliance allergies, diagnostic procedure, TDCJ Disease Management guidelines, national standards and guidelines, and applicable scientific literature.

The Texas Department of Criminal Justice has evaluated the program through continued monitoring of nonformulary requests and denials. The initiative is funded through a contract with the University of Texas Medical Branch/Correctional Managed Care to provide mental health services for offenders in the TDCJ through the Correctional Managed Care Advisory Committee.

Much progress has been made in the area of clinical informatics as a result of managed care initiatives that have moved into pharmacy services.

Example: The Texas Medication Algorithm Project, Texas Department of Mental Health and Mental Retardation

The Texas Medical Algorithm Project (TMAP) is a public and academic collaborative effort headed by the Texas Department of Mental Health and Mental Retardation. TMAP is designed to improve the quality of care and achieve the best possible patient outcome by establishing a treatment philosophy for medication management. TMAP developed and instituted a set of algorithms to illustrate the order and method in which to use various psychotropic medications. The TMAP algorithms have been adopted by the Texas Department of Criminal Justice for use in the state's prisons.

The ultimate goal of TMAP is to optimize patient outcomes with the underlying assumption that resources will be most optimally utilized. It is intended to develop and continuously update treatment algorithms and to train systems to apply these methods to minimize emotional, physical, and financial burdens of mental disorders for clients, families, and health care systems.

TMAP consists of four phases. During Phase 1, guidelines were developed through scientific evidence and expert clinical consensus, resulting in the development of algorithms for use of various psychotropic medications for three major psychiatric disorders: schizophrenia, major depressive disorder, and bipolar disorder. Phase 2 was the feasibility trial of the project and evaluated the suitability, applicability, and costs of the algorithms. The third phase was a comparison of the clinical outcomes and economic costs of using these medication guidelines vs. traditional treatment/medication methods. The fourth and final phase is the implementation of TMAP throughout clinics and hospitals of the Texas Department of Mental Health and Mental Retardation and is known as the Texas Implementation of Medication Algorithms (TIMA). Collaboration for this project included public sector and academic partners, parent and family representatives, and mental health advocacy groups.¹⁵

In order to ensure quality and objectivity, correctional agencies should enlist the services of a licensed pharmacist to review policies and procedures, and to assist in a review of the use of medications in the facilities. For example, there may be some instances when physicians prescribe the newer, more expensive medications even though the older medications may achieve the same desired clinical outcome. If replacement medications are considered, prescribing physicians should keep in mind the potential impact of side effects associated with switching medications. Checks and balances must be established and enforced to ensure that physicians are not overprescribing medications that yield little additional salutary effect.

15. Graphic presentations of algorithms and explanatory physicians' manuals are available on the TMAP Web site: www.mhmr.state.tx.us/centraloffice/medicaldirector/TMAPtoc.html.

C

Require, at a minimum, that (1) mental health-specific case management services and (2) effective, research-based behavioral and counseling interventions accompany the use of medication.

To ensure that mental health and correctional facilities staff members do not become overly dependent on medications alone to modify or to control inmate behavior, mental health services should include an array of interventions designed to meet the unique needs of inmates with mental illness. When interdisciplinary teams work together to develop a treatment plan, the services delivered are more likely to be balanced and tailored to the specific needs of the inmate

Interventions that have proven to be effective in a correctional setting include the following:

- cognitive-behavioral therapy, particularly those interventions that improve basic problem-solving skills and reduce maladaptive (criminal) thinking
- individual and group therapy that is skill acquisition oriented
- independent living-skills training
- medication self-management
- relapse prevention
- physical exercise programs

Example: Behavior Modification Treatment Level System, West Virginia Division of Corrections

The West Virginia Division of Corrections has implemented a Behavior Modification Treatment Level System at the Mount Olive Correctional Complex. Mental health staff at the facility put this system in place to facilitate effective inmate management and to provide an incentive for inmates placed in the Mental Health Unit (MHU) to achieve an appropriate functioning level.

Programming is offered at various levels for some inmates who used to be locked down in their cells for 23 hours a day. Since the program has started there has been only one four-point restraint utilization, no cell extractions, and inmates that used to be housed in single cells are now stabilized and socialized to be double bunked. To increase success, the warden was asked to forgo disciplinary infractions for inmates receiving mental health treatment on the unit. This approach has empowered mental health staff to implement programming without having punitive restrictions. Critical to this approach is the ability to select staff who are philosophically aligned with a habilitation model as opposed to a punitive model.

At most institutions, correctional staff members provide general case management services. When inmates have a mental illness, however, they should be assigned to case managers specially trained to understand the distinct service needs of this population.

"Effective treatment makes our prisons safer and easier to manage. Prison wardens are keenly aware that inmates exhibiting symptoms of mental illness can cause unrest and tension in the general population. It is obvious that a large proportion of those inmates have better control over their actions when they receive the appropriate treatment for their illness."

REGINALD A. WILKINSON

Director, Ohio Department of Rehabilitation and Correction

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*, September 21, 2001

d Develop and provide programs for inmates with co-occurring disorders.

All programs for inmates with mental illness should also address inmates with co-occurring substance abuse disorders. Over the past decade, virtually every state department of corrections has implemented residential substance abuse treatment programs within their prisons. Some of these programs specialize in treating the dually diagnosed—those with co-occurring substance abuse and mental health problems. These programs generally serve inmates whose primary problem is substance abuse, and whose mental health problems tend to be less severe but there are clearly examples of offenders with co-occurring disorders whose mental illness is the primary concern. Some of these residential programs are specifically designed for women—a large percentage of whom are dually diagnosed—with depression as the primary psychiatric diagnosis.¹⁶

Key program components for co-occurring disorders include the following: an extended assessment period; orientation/motivational activities; psychoeducational groups; cognitive-behavioral interventions, such as restructuring of “criminal thinking errors”; self-help groups; medication monitoring; relapse prevention; and transition into institution or community-based after-care facilities. Many programs use therapeutic community approaches that are modified to provide greater individual counseling and support, less confrontation, smaller staff caseloads, and cross-training of staff.¹⁷ (See Policy Statement 37: Co-Occurring Disorders.)

Example: Co-occurring Disorder Programs, Columbia River Correctional Institution (OR)

In 1998, the Oregon DOC combined state and federal grant resources to create a system of four co-occurring disorder programs at a single institution (the Columbia River Correctional Institution). Two of these programs are for men, and two for women. One program for each gender is targeted at inmates whose problems are more heavily weighted toward addiction and criminality, but who also have some mental health problems (the Turning Point programs). Another two programs (again, one for each gender) are designed to address the needs of offenders with serious and significant mental health problems who also have problems with addiction. Mental health and substance abuse treatment in all four programs is provided in an integrated manner, with much cross-pollination of ideas and information among supervisors and staff of all four.

At the Oregon Department of Corrections (DOC), substance abuse and mental health services are administratively and functionally integrated. This allows for fast and efficient communication between planners and policymakers at the agency level, as well as treatment supervisors and treatment providers at the facility level. Each year, the Oregon DOC brings together its substance abuse and mental health planners and providers for a two-day “integration seminar,” where matters of mutual concern are considered and discussed. Last year, the seminar focused on relapse prevention.

16. GAINS Center, Women’s Program Compendium, Delmar, NY, Policy Research Associates, Inc., 1997; L.A. Teplin, K. M. Abram, and G.M. McClelland, “Prevalence of Psychiatric Disorders Among Incarcerated Women,” *Archives of General Psychiatry* 53, 1996, pp. 505-12.

17. John F. Edens, Roger H. Peters, and Holly A. Hills, “Treating Prison Inmates with Co-occurring disorders: An Integrative Review of Existing Programs,” *Behavioral Sciences and the Law* 15, 1997, pp. 439-57.

e Facilitate access to professional psychiatric services by using telepsychiatry in systems where inmates are distributed across a large geographical area or in locations where there is a shortage of psychiatric service providers.

Qualified, licensed mental health staff can be hard to come by in jails and prisons located in remote, rural areas. As a result, some jurisdictions, including some in Texas, have resorted to electronic communications as a means of providing professional, clinical services to such institutions. (See Policy Statement Section 41: Workforce.)

Example: Telemedicine, Texas Department of Criminal Justice

Texas Tech University Health Sciences Center (TTUHSC) is responsible for providing medical care in the western portion of Texas to inmates in the Texas Department of Criminal Justice and to juveniles in five Texas Youth Commission facilities. In 1994, TTUHSC began delivering health services to inmates via telecommunications technology. As of 2002, TTUHSC conducts approximately 2,000 prison telemedicine consultations a year for the 33,000 inmates that are housed in the 26 prison units for which TTUHSC is under contract. Approximately one-third of all telemedicine consultations are in telepsychiatry and telepsychology. This expansion has significantly reduced the amount of time clinicians spend driving to distant prison sites.

Psychotropic medications should be prescribed by, or in consultation with, a psychiatrist or other licensed mental health professional having training in psychotropic medications and authority to prescribe them as determined by the state. Given the shortage of psychiatrists, doctors who provide general health care, but who are not credentialed in psychiatry, are allowed to prescribe psychotropic medications for inmates with serious mental illness. It is essential that physicians who specialize in psychiatric medicine oversee mental health treatment, in addition to psychotropic medication prescription, administration, and monitoring.

f Review mental health services provided to ensure that they are evidenced-based.

Like their counterparts in the community, mental health professionals working in correctional settings have access to a growing body of research documenting the effectiveness of certain interventions and the promise of others. Similarly, researchers have demonstrated that various service models have little or no impact on the behavior or health of a person with mental illness. To ensure provision of the most effective possible services to people with mental illnesses in prisons and jails, correctional mental health officials should stay abreast of the work of research efforts on evidence-based practices such as those conducted at the New Hampshire Dartmouth Psychiatric Research Center and at the National Association of State Mental Health Program Directors

(NASMHPD) Research Institute.¹⁸ Researchers affiliated with these organizations have identified services that have been shown in a variety of settings to provide treatments and supports that will enhance the ability of a person with mental illness to live successfully in the community. (See Policy Statement 35: Evidence-Based Practices.)

g

Ensure the cultural competency of all programs for inmates with mental illness.

As stated earlier in this chapter, the majority of people incarcerated in the United States are African American or Latino. In some states, people of color make up nearly 80 percent of the prison population. Cultural competency has generally been shown to improve client receptiveness to services and counselor effectiveness (see Policy Statement 40: Cultural Competency). Mental health services in correctional settings should recognize the effects of culture on all aspects of mental illness and, in order to treat inmates effectively, should organize and design their approaches accordingly. In particular, clinicians and other correctional staff who are in routine contact with inmates with mental illness should receive training to enhance their “cultural competency” and their ability to recognize and respond to the needs of people from different cultural backgrounds who come under their care or control.

h

Provide mental health treatment and services that are gender-specific.

Male and female inmates may have similar mental illnesses and custody levels, but their treatment plans, housing situations, and programming needs will be distinct. For example, the Bureau of Justice Statistics has found that histories of trauma and abuse are particularly high among females in prison and jail: more than 78 percent of female state prison inmates and more than 72 percent of the female population in jail reported such histories.¹⁹

In response, a growing number of jurisdictions have instituted programs intended to identify women who are victims of past abuse and to offer interventions that meet their specific needs. These programs provide training that helps correctional administrators and officers to understand the high prevalence of trauma history among their inmates as well as the relationship between abuse, substance abuse, mental illness, and criminal behavior. The programs also include interventions that help inmates with histories of abuse to better understand their own situations, often through group meetings.

18. Available at: www.dartmouth.edu/dms/psychrc;www.nasmhpd.org

19. Ditton, *Mental Health and Treatment*, p. 6. Although the prevalence of histories of abuse is much higher among females than males, male inmates with mental illness were also significantly more likely than inmates without mental

illness to report a history of abuse. More than 32 percent of male state prison inmates and more than 30 percent of male jail inmates reported such histories, as compared with 13 percent and 10 percent, respectively, of male inmates without mental illness.

20. Travis et al., *From Prison to Home*, p.14

Example: The TAMAR Project, Maryland Mental Hygiene Administration, Division of Special Populations

The TAMAR (Trauma, Addictions, Mental health, And Recovery) Project was initially piloted in one rural and two suburban counties in Maryland and has now spread to a number of counties in the state. Its goal is to provide integrated services for women who typically have interrelated trauma, substance abuse, and mental illness issues. Meeting in groups, the women are encouraged to share their stories with one another and to engage in therapeutic activities such as art therapy and journal writing. Once released from jail, women in TAMAR are able to continue to meet in groups in the community that provide continuing support.

i

Recognize the distinct programming needs of special populations with mental illness, such as the elderly, the developmentally disabled, those with chronic medical problems, substance abusers, and sex offenders.

Prisons have increasing numbers of inmates with mental illness who also are elderly, developmentally disabled, or sex offenders. The clinical needs, treatment approaches, strengths and deficits, and general goals of programs for inmates in these groups differ significantly. Correctional administrators should ensure that mental health programs and services provided to these special populations are distinct from programs and services provided to other inmates with mental illness

Some program approaches that serve sex offenders and those with developmental disabilities may provide useful guidance for approaches for offenders with co-occurring disorders.

Example: Program for Inmates with Developmental Disabilities, Texas Department of Criminal Justice

This program was established to minimize the negative effects of incarceration on offenders who have developmental disabilities and to maximize the likelihood of their successful reintegration into the community. An Interdisciplinary Team (IDT) includes a physician or registered nurse, licensed or certified psychologist, social caseworker, vocational supervisor, social work supervisor, and rehabilitation aide. Occupational therapists and speech pathologists are included as necessary. The IDT performs a needs assessment to determine what services are best suited to meet the needs of the individual. A vocational evaluation is completed, which takes into account the inmate's assets and limitations. Offenders with developmental disabilities are housed in the least restrictive environment appropriate to their habilitation, treatment, and safety and security needs. Available services include: medical care; psychiatric services; educational programming; occupational therapy; substance abuse treatment; treatment planning and monitoring; and continuity of care (transitional planning).

Example: ASEND Program, Utah Department of Correction

Since 1986, the Utah Department of Corrections has been operating the Advantage Program at the Utah State Prison to address the needs of offenders with an IQ below

70. In 1999, space was designated at the prison and new policies and procedures were implemented for an expanded program, called ASEND, operating in a segregated living unit.

The ASEND Program provides programming for those inmates lacking the skills and knowledge to meet the standards of self-sufficiency and acceptable social responsibilities, not only in society but also within this institutional environment. The goal of the ASEND Program is to assist inmates to live successfully in the prison population and to prepare for their eventual release to the community.

The program comprises the following components: 1) a written individual habilitative plan; 2) an education program component; 3) a cognitive programming component; 4) an employment job readiness component; 5) modified behavior privilege matrix; 6) additional services coordination for inmates who have a mental illness, or who have sexual or drug abuse histories; 7) recreation and physical activities; 8) aftercare services; and 9) appropriate training and habilitative specialist status for block officers.

Example: Sexual Offender Accountability and Responsibility (SOAR) Program, North Carolina Department of Corrections

SOAR is a voluntary day treatment program for incarcerated sexual offenders referred by psychological staff from state prisons. Two program sessions are held each year, with a total of 72 offenders participating. Inmates are housed in a segregated unit while participating. Group therapy conducted by a program staff psychologist is the primary mode of treatment. The program, which has been in existence since 1991, is relatively inexpensive to operate (\$7.16 per day per inmate) and has been demonstrated to be reasonably effective. The latest outcome study reported that by April 2000, 302 of a total of 501 participants who had completed the program had been released to the community. Of these 302 men, only 7, or 2.3 percent, had been returned to prison for a new sexual offense charge. This compares very favorably with the return rate of general population inmates in North Carolina. According to a 1996 study, 47 percent of all inmates leaving North Carolina prisons are reconvicted within three years. A youth SOAR program designed to serve offenders between the ages of 16 and 21 is planned.

Example: Sexual Offender Residential Treatment (SORT) Program, Virginia Department of Corrections

SORT provides comprehensive assessment and treatment services for inmates who are a moderate to high risk for reoffense. The program operates in five phases: orientation; assessment; treatment readiness; treatment; and release planning. The program begins with the development of an individualized treatment plan, then progresses through the participation by offenders in various psychoeducational groups, and, finally, in a program of treatment having the Trans-theoretical Model and Cognitive Behavioral Techniques as its basis. The release planning phase, which includes the participation of the offender's community supervision officer and family members, includes an evaluation of future needs and the identification of programs and providers to address such needs.

j **Develop graduated housing options for inmates with mental illness that ensure the safety of staff and inmates and prepare inmates, when appropriate, for transition from specialized housing to general population units.**

Beyond general population beds, correctional administrators usually have few housing options, especially in overcrowded facilities, for inmates with mental illness. In those units, staff members generally are not trained adequately to address these inmates' needs. Inmates suffering from severe mental illness who are housed in general population, especially when their illness is undiagnosed or untreated, often decompensate more quickly than they would in housing designed and operated for inmates with mental illness. When inmates with mental illness in general housing decompensate they are likely to incur disciplinary infractions, which in turn prompts their reassignment to segregation cells, where their mental health is likely to deteriorate still further and more rapidly.

Centralized and noncentralized approaches to housing inmates with mental illness each have benefits and drawbacks. Generally, it is more cost-efficient to hold people with significant problems in specialized units at a central facility. On the other hand, decentralizing services provides greater administrative flexibility. Furthermore, "mainstreaming" inmates who can safely be housed in the general population reduces the stigma associated with mental illness.

An ideal approach to this issue is to have both options available. Depending upon the size of the system and facilities, correctional administrators should provide separate residential services to inmates with serious mental illness, as well as a range of counseling activities in day and outpatient levels of care. Several states have developed multilevel housing systems for inmates with serious mental illness. These include maximum-security medical units, step-down, post-acute housing, and transitional housing units.

In order to make the most appropriate housing assignment for an inmate with mental illness, staff should first take into account the medical requirements of the inmate, including concurrent nonpsychiatric conditions (e.g., HIV, TB, etc.). For example, inmates whose medical needs are within reasonable limits, are medication compliant, and are responsive to supervision could likely be assigned appropriately to general population units. Cross-discipline participation on panels and committees that make decisions regarding the handling of inmates with mental illness should be a standard practice.

Correctional staff should reevaluate the housing assignments of inmates with mental illness routinely to ensure the assignment is properly serving their changing needs. Inmates assigned to a specific unit because of their mental illness should be evaluated regularly for changes in their mental health needs.

k**Provide disciplinary hearing officers with the proper orientation and training to make informed decisions about offenders with mental illness.**

Custody and program staff, whether they are assigned to special housing units or to general population, should receive training in basic mental health issues. In order to have an impact on problem inmates with mental illness receiving disciplinary actions due to their illness, it is recommended that hearing officers, and others involved in the work of disciplinary committees, also receive this training. These officers should have discretion to consider the presence of mental illness as a mitigating factor in imposing sanctions (see Policy Statement 30: Training for Corrections Personnel).

l**Ensure continuity of services when inmates are transferred to a different facility.**

When inmates are transferred to a new institution, it is critical that information regarding their mental illness and treatment history accompany them. When this information does not follow the transferred inmate, the receiving facility must undertake the inefficient and expensive step of conducting another evaluation.

Service delivery between the two institutions should also be seamless. Without continuity of care, an inmate's condition can worsen.

Employing one of three mechanisms will enable corrections administrators to ensure that an inmate's mental health information will be forwarded to a receiving institution whenever he or she is transferred:

- Establish a central, computerized tracking system, which alerts the mental health case manager at the receiving institution that an inmate with mental health needs will be arriving at the facility; or
- Send with the inmate a summary form that alerts the mental health case manager at the receiving institution. When mental health information is not maintained in a system-wide database, staff will need to include in this form a clinical summary of assessment results and a brief description of treatment and services received at the previous institution; or
- In jurisdictions that do not have a central computerized tracking system, the mental health record should accompany the inmates at the time of their transfer.

Example: Wisconsin's Health Transfer Summary

Wisconsin's Health Transfer Summary, a form and protocol used to ensure continuity of care when inmates are transferred from one correctional facility to another, pertains to transfers between county jails, between state prisons, and between county jails and state prisons. In particular, the summary provides necessary information to health care providers and custodial staff at correctional facilities to ensure their proper

care—such as current health and mental health status; medications in use; and treatments—while maintaining the confidentiality of inmate health care information in compliance with state law. At the time of a transfer, the Health Transfer Summary is prepared by a facility health care professional and delivered along with the inmate by the transportation officer assigned to transport the inmate to the receiving facility. If the transfer is completed at a time when the health care professional is not available, the form is prepared and dispatched with alternative means within 24 hours.

Once received, a health care professional at the receiving facility logs in the summary, notifies the sending facility that it has been received, and makes follow-up assessments, investigations, and requests for information concerning the inmate's health care status or condition as required. The summary is maintained in the inmate's medical files as a confidential record following guidelines set forth in Wisconsin law. According to the statute, inmate consent for the transfer of his or her health care information between correctional facilities is not required. The statute also authorizes the sharing of the inmate's complete health record, but specifically excludes the mental health information from being included when that complete record is shared. The exclusion can be waived only with the inmate's consent.

Confidentiality regulations designed to protect the privacy and rights of those receiving treatment for mental illness and substance abuse are often misinterpreted, and, in some cases, such regulations unnecessarily impede the flow of information needed to ensure the quality and continuity of care for offenders who are transferred between facilities. Mechanisms can be used that enable correctional agencies to share important and relevant information while maintaining an appropriate level of confidentiality for the inmate. Information sharing should be understood here as sharing between clinical treating providers at two different sites, and not as sharing with administrative or other correctional staff. Clinical files (whatever form they take) should be sealed and opened only by qualified personnel who have appropriate training in confidentiality issues. Inmates who receive services for their mental illness should be encouraged to provide written consent in order for agencies to release treatment records to another program. Even when a statute allows sharing without consent, it is still a good idea to obtain it. (See Policy Statement 25: Sharing Information.)

It is particularly important to facilitate the transfer of records from jails and other facilities that are not operated by the state correctional agency. Similarly, state corrections directors should also consider developing memoranda of agreement between state agencies, such as the agency for mental health services, to ensure the transfer of patient records when an individual who is being served in a state institution is transferred to a correctional facility.

Corrections administrators and their counsel often have a difficult task in determining how federal and state statutes regarding the confidentiality of inmate mental health information applies to inmates. State statutes—or administrative regulations—should be established to clarify how the information of this distinct population can be used.

In addition, states should consider establishing statutes or administrative regulations that require the transfer of inmate mental health records between facilities under the purview of the state correctional agency. In Arizona, a statute requires transfer of records either prior to or at the time of the transfer; it also authorizes the records to be transferred between county and state facilities.

Example: Duty to Deliver Medical Records, Arizona State Law

Arizona state law requires the transfer of a prisoner’s “medical record file, including the prisoner’s mental health file or a standardized medical record.” The file must be transferred prior to or at the same time as transfer of the prisoner. This requirement applies to all transfers between jail and state department of correction facilities.

Louisiana takes this process a step further, allowing the correctional agency to obtain information from other state agencies, as necessary, while ensuring reasonable confidentiality protection.

Example: Access to Records, Louisiana State Law

Louisiana state statute gives the department of corrections access to “information and records under the control of any state or local agency which are reasonably related to the rehabilitation of the individual.” Access to such information may be obtained “during the course of any investigation which the department of corrections is authorized by law to conduct or any investigation necessary to the rehabilitation of persons in the custody of the department of corrections.” The statute also requires that all information obtained under this provision “be held as confidential and not be disclosed directly or indirectly to anyone except” when required by statute.

These examples illustrate how a state essentially can define the department, and/or the state as a whole, as a unified system of care, thus enabling mental health information to be freely passed between facilities and departments as though they were part of a provider enterprise, as occurs in community health systems. Confidentiality assurances can be established simply through policies and procedures that are consistent with statutes.

In cases where statutes do not provide for transfers across agencies, one solution would be for the agencies to enter into memoranda of agreement that include Qualified Services Agreements (QSA). QSA’s are agreements between providers that allow for the release of confidential information between the agencies, while transferring responsibility for adherence to federal and state confidentiality regulations.

m **Require appropriate staff to review mental health information received with the transferred inmate and to respond accordingly.**

Departmental policies and procedures should define what specific information is required at intake, who is responsible for reviewing and following up on obtaining complete mental health records, and what immediate services are to be provided. Time frames for conducting clinical review and approval of

medications should be specified throughout the intake process. Lastly, the procedures should specify a protocol for interinstitutional communication when proper documentation does not accompany the inmate at the time of intake.

Example: Statewide Weekly Mental Health Staff Teleconference, Arizona Department of Corrections

By administrative order, the facility health services administrators and other relevant mental health professionals at the Department of Corrections' (DOC) Alhambra Behavioral Health Treatment Facility, and all other correctional complexes and facilities teleconference every week to discuss the mental health treatment needs and issues of inmates being referred to or from the Alhambra complex and other Arizona DOC facilities and provide a forum for peer consultation on difficult cases.

Health Insurance Portability and Accessibility Act (HIPAA)

Federal Health Insurance Portability and Accessibility Act (HIPAA) regulations were promulgated in final form in March 2002 and are likely to have an impact on the way mental health information will be handled in the future. Not only are these regulations extremely complex, but legal experts disagree on their ramifications for prison and jail populations. Correctional administrators and correctional health officials should work with their legal counsel to familiarize themselves with these regulations and to consider their implications for their facilities.

n Identify appropriate technology and protocols for the development of an electronic patient records system.

Several jurisdictions have developed electronic data systems to improve records management and facilitate the instant flow of clinical records. To ensure a successful records transfer, electronic communication should be used in conjunction with the personal transfer of information between clinicians at the institutions. Officials should be mindful that most confidentiality regulations apply equally to paper and electronic records (HIPAA regulations specifically cover electronic records), and thus develop their electronic information protocols accordingly.

Example: Mental Health Record and Referral/Evaluation Systems, Michigan Department of Corrections

The Health Management Information System (HMIS) is a computer-based management system, which contains health care data for persons incarcerated in Michigan correctional institutions. Two mental health-related components of HMIS are the mental health record system and the referral/evaluation system. Staff from DOC Psychological Services and DCH Corrections Mental Health Program use these components. The Mental Health Record system enables mental health care services providers to systematically identify and track prisoners with mental illness at different levels and units within the correctional system. The referral and evaluation system ensures the identification and tracking of prisoner referrals for evaluations as well as the evaluation outcomes.

Example: Process of Transmitting Mental Health Treatment Histories of Inmates When Transferred to Other Facilities, New Jersey Department of Corrections

The New Jersey Department of Corrections uses an electronic medical record system that allows any professional health care practitioner within the Department to view any inmate's health record at any time. When an inmate is transferred from one facility to another, mental health professionals send an e-mail stating that the inmate has been transferred and the health record can be immediately accessed. Case conferences occur on the more difficult management cases.

Example: Interagency Case Conferencing, New Jersey Department of Corrections

When the New Jersey Department of Corrections participates in interagency transfers (e.g., between correctional and mental health agencies), it often organizes case conferences, in conjunction with the electronic transfer of data between the agencies, to enable clinicians from both sending and receiving institutions to meet to discuss and develop individual treatment plans.

State mental health agencies recognize the benefits to be gained from the development of an integrated and automated patient records systems that is operated system wide. The establishment of such a system is expensive, however, and the work on such systems in most states is far from complete. Indeed, implementation of electronic patient record systems is inconsistent across local agencies, making it impossible for state mental health authorities to gather complete information or to realize the gains that could be reaped from a state-wide system. Additionally, seemingly simple problems such as the incorrect spelling of a patient's name or an inaccurate social security number can create significant headaches for staff. In some states, efforts are under way to include state correctional agencies in the development of electronic patient/inmate record systems.

19

Subsequent Referral for Screening and Mental Health Evaluations

POLICY STATEMENT #19

Identify individuals who—despite not raising any flags during the screening and assessment process—show symptoms of mental illness after their intake into the facility, and ensure that appropriate action is taken.

Even when staff adhere to the most effective screening and assessment protocols, they may yet overlook a small proportion of inmates with mental illness that enter the facility. Some inmates, concerned about the stigma associated with mental illness, may conceal symptoms of their disease. In addition, inmates may not present symptoms of mental illness until they have been incarcerated for some time. In other cases, an inmate's mental status can change dramatically during the course of incarceration. The prison experience itself, and the inevitable exposure to intimidation, isolation, separation from family, violence, and sometimes victimization can precipitate serious depression or suicidal thoughts.

Furthermore, some inmates' symptoms may reappear as a result of change in medication, discontinuation of a prescription, or noncompliance with the treatment plan. In jails, offenders who are admitted directly from the streets are often under the influence of alcohol and/or other drugs. Once they are detoxified, mental illness symptoms can appear—sometimes several days later.

While it would be valuable to conduct periodic mental health screenings on all general population inmates, this is costly and rarely done in most correctional facilities. Nevertheless, there are several measures correctional administrators and mental health staff can implement, at relatively little cost, to identify these cases that may initially fall through the cracks.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Reassesses periodically the mental health status of inmates who are at the highest risk of showing signs of mental illness.**

Correctional mental health staff should incorporate regular, informal mental health screening into existing practices without burdening the service delivery system. Corrections administrators should also consider establishing a system

to code the mental health status (and risk of exhibiting signs of mental illness) of all inmates.

Example: Virginia Department of Corrections

Since 1992, all inmates in the Virginia correctional system are periodically assessed and a determination is made as to their mental health status and mental health needs. The determination is alphanumerically coded and sorted by the least to the greatest need for mental health services. The code is reviewed and, if necessary, updated annually. The code is used for programmatic and institutional assignments, as well as for release planning and community supervision.

Reassessing the mental health status of inmates enables corrections officials to maintain accurate, current data regarding the demand for services within the prison system, and it facilitates a projection of the need for community-based mental health services for inmates approaching their release date.

b **Conduct brief mental health assessments upon request of an inmate or by referral from any staff person.**

Prisons and jails should have effective mechanisms to permit and encourage inmates and detainees to self-refer for a confidential mental health assessment. Self-referral forms provided to inmates should be culturally sensitive and, given the generally low reading level of inmate populations, easily understandable. Institutional health staff might also consider instituting clinical rounds at intake facilities.

Example: Referral for Mental Health Services, Albany County (NY) Correctional Facility

The Albany County Correctional Facility utilizes a mechanism whereby facility staff, correctional officers, medical staff, inmate service unit staff, and the inmates themselves are able to put in requests for mental health contact. All written requests are followed up, and any inmate referred is seen face to face by a mental health staff member.

c **Minimize the stigma that staff and inmates may harbor regarding mental illness.**

Over the previous two decades, many corrections systems have successfully educated staff about HIV and AIDS, about how the virus is transmitted and how it is treated. Correctional systems should undertake a similar public health education initiative regarding mental illness. (See Policy Statement 30: Training for Corrections Personnel; also Policy Statement 32: Educating the Community and Building Community Awareness and Policy Statement 43: Advocacy, for more on stigma.)

20

Release Decision

POLICY STATEMENT #20

Ensure that clinical expertise and familiarity with community-based mental health resources inform release decisions and determination of conditions of release.

Inmates typically are released from prison through one of the three following ways:

- statutorily mandated release to supervision;
- discretionary parole; or
- mandatory release at the completion of a sentence without supervision.

Over the past two decades, numerous state legislatures have limited the discretion available to parole boards, or have eliminated discretionary parole altogether (see sidebar on following page).²⁰ A collateral consequence of limiting this discretion has been to reduce the opportunity to tailor release conditions for inmates who have a mental illness. In those states where parole boards still have some discretion, parole decision makers may be reluctant to exercise it when the potentially eligible inmate has a mental illness. Parole board members' lack of confidence in community-based mental health services also contributes to their reluctance to release from prison a person with mental illness. In the face of incomplete information, inadequate assessments, lack of confidence in community resources for this population, misconceptions about mental ill-

ness, or fear of a negative public response, parole board members may choose not to release the inmate, thereby compelling him or her to serve the maximum sentence allowed by law.

A study conducted in Pennsylvania illustrates this phenomenon. In 2000, 16 percent of all releasees in Pennsylvania served their maximum sentence. For inmates with mental illness, however, 27 percent served their maximum sentence; of those diagnosed as having a serious mental illness, 50 percent served their maximum sentence. Often, inmates with mental illness served their maximum sentence because they did not have an approved parole housing plan, which was due to the lack of housing, mental health, and substance abuse services available in the community, especially in rural areas.²¹

Determining the level of risk that an offender poses to the community is one of the central responsibilities of parole board members in making their decision as to whether to release an offender and the types of conditions of release that should be imposed. Even in states that do not have a discretionary parole system, corrections departments often use

21. From unpublished description of Forensic Community Re-Entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation, and Co-occurring Disorders program, courtesy of Angela Sager, grants manager, May 12, 2002.

a validated instrument to assess the risk of offenders who are eligible for release. These corrections departments and releasing authorities, however, rarely take into account factors involving the person's mental illness.

The recommendations that follow describe how to address these obstacles that impede effective release decision making: 1) the lack of professional,

clinical expertise as part of the prerelease consideration process; 2) the lack of sufficient, reliable information regarding the treatment history and needs of the offender; and 3) the lack of sufficient community-based resources and options for this population.

RECOMMENDATIONS FOR IMPLEMENTATION

a Develop guidelines regarding release decisions that address issues unique to inmates with mental illness, and consult with mental health professionals during the decision-making process.

State statutes and administrative orders, usually in the form of structured parole release guidelines, generally frame the parole board members' decision-making process. Such guidelines typically address the general offender population only, however, without recognizing the special needs of offenders with mental illness. For example, a person whose mental illness is particularly serious may have been unable to participate in job-training classes or other inmate programming opportunities that would improve the likelihood of the inmate's timely release. Existing guidelines, however, typically emphasize participation in such programs as nearly essential for release.

Many states are beginning to employ validated risk assessment instruments that can help guide their estimation of the potential risk offenders pose to the community upon release. As with structured parole release guidelines, however, employing risk assessment instruments designed for the general offender population may not adequately take into account the circumstances of offenders with mental illness. In fact, no known risk assessment instrument has been validated by research to predict accurately the nexus between mental illness and risk.²²

Until corrections systems develop or replicate such an instrument, they should rely on mental health experts to evaluate the instruments they are currently using to ensure that they take into account mental health issues appropriately. In addition, releasing authorities should engage appropriate mental health professionals to assess on a case-by-case basis offenders' mental health and potential risk. At least four states (Washington, Florida, Kansas, and Nebraska) require, by statute, evaluation of the mental health status of all in-

22. Polly Phipps and Gregg Gagliardi, *Implementation of Washington's Dangerous Mentally Ill Offenders Law: Preliminary Findings*, Olympia, WA: Washington Institute for Public Policy, March 2002, Appendix G.

mates prior to release to the community. Three of these states further require the development of individualized treatment plans and the identification of programs and resources in the community to carry out such plans.

Releasing authorities should enlist the support of a mental health professional to assist in conducting the hearing, reviewing the inmate's medical history within the institution, assessing the specific challenges he or she will face when returning to the community, and identifying community resources to help address the offender's needs.

Example: Pre-Release Risk Assessment, the National Parole Board of Canada

The National Parole Board of Canada incorporates psychological and psychiatric assessments into its risk assessment procedure, when appropriate, for all offenders being considered for parole. Certain categories of offenders receive mandatory prerelease psychological assessments, including those who have exhibited persistent or gratuitous violence or those serving indeterminate of life sentences. Offenders who have undergone treatment while incarcerated are required to have a post-treatment report completed by a psychologist, case manager, or program officer to address any changes of risk. A supplemental prerelease assessment is required only if the post-treatment report is considered insufficient to address the offender's progress. Psychiatric assessments are required for any offender with a life or indeterminate sentence seeking parole. Other issues that the parole board considers include the effects of any current medications prescribed, the risk if the medication is no longer used, and the programs and interventions in the community that will help the offender have a successful reintegration.

Example: Contract for Risk Assessment Services, Missouri Parole Board

The Missouri Parole Board contracts for independent mental health assessment services to assist in identifying risk associated with the release of persons with mental illness. The contract includes provision for the board to consult in person with psychiatrists when seeking information on particular cases, should they desire to do so.

b Develop protocols to share information and resources among parole agencies, departments of corrections, and mental health organizations.

The value of risk assessments for inmates with mental illness depends on the quality of information regarding an offender's mental illness and the assistance of a clinician to evaluate and interpret that information for a releasing authority. Nevertheless, releasing authorities (especially parole boards) report considerable difficulty in gaining access to this information or mental health expertise.

Terms of Release

Prior to the late 1970s, most prisoners were offered conditional (i.e., supervised) release through the decisions of parole boards that assessed individual risk and took into account behavior in prison. During the 1980s and 1990s, parole fell out of favor and at least 40 states passed "truth-in-sentencing" laws intended to lessen the disparity between the sentence imposed and the time actually served. In 1990, 39 percent of inmates were released via parole board decisions; by 1998 that fraction had dropped to 26 percent. Inmates are increasingly likely to leave prison after mandatory release, which is determined by statute or sentencing guidelines, not panel or board decisions. From 1990 to 1998 the rate of mandatory releases rose from 29 percent to 40 percent of prisoners. In addition, the rate of unconditional release (i.e., requiring no supervision) rose from 16 percent to 24 percent of prisoners during the same period. Though parole has decreased in popularity, in most states the parole reforms have not been retroactive, so many prisoners continue to be eligible. Many states also continue to perform some kind of supervision of prison releasees. The term "community corrections" refers to the multiple supervision strategies employed by different states including, but not limited to, parole.²³

23. Travis et al., *From Prison to Home*, p.14.

Parole officials typically rely on correctional health officials for information regarding an offender's mental health. Such information, however, is often dated and incomplete. Mental health information from community-based treatment agencies and providers would provide releasing authorities with a greater understanding of the inmate's mental health history. To that end, releasing authorities should enter into agreements with mental health organizations to ensure the confidential and appropriate sharing of information regarding a person's mental illness.

Several state parole boards have addressed these issues by collaborating with their counterparts in the state mental health agencies.

Example: Memorandum of Understanding Between the New York State Office of Mental Health and New York State Division of Parole

In 1994, the New York State Office of Mental Health and the New York State Division of Parole signed a Memorandum of Understanding (MOU) to identify and better serve people with mental illness. The MOU enhanced coordination of mental health evaluations for the board of parole; increased discharge planning for inmates with serious mental illness; implemented mental health training for parole officers; and established a Dedicated Parole Caseload initiative.

Example: Multidisciplinary Team, Missouri Parole Board

The Missouri Parole Board employs a specially trained staff person who sits on a team with institutional staff to develop a continued-care plan for inmates with mental illness. The continued-care plan is holistic, addressing all areas of the offenders' life connected to his/her success in the community. The program consists of both an institutional and a community release center phase. The institutional phase lasts for four months and selected inmates spend two months in the community phase for a combined minimum of six months. The program is used by the parole board as a pre-release planning mechanism, as well as an alternative to revocation for those who are parole violators.

Example: Forensic Mental Health Coordinating Council (UT)

In 2002, the Utah legislature expanded the membership and scope of the Mental Health and Corrections Advisory Council and renamed it the Forensic Mental Health Coordinating Council. The Forensic Mental Health Coordinating Council includes representatives from the Department of Human Services Division of Mental Health, the State Hospital, the Board of Pardons and Parole, the Attorney General's Office, Department of Corrections (DOC), Services for People with Disabilities, community mental health agencies, Division of Youth Corrections, and the state court administrator's office. The council was formed to develop policies for coordination between the Division of Mental Health and the Department of Corrections, advise the DOC on care for inmates with mental illness, promote interagency communication around issues of mental illness and mental retardation, address civil commitment issues, and oversee coordination of services and placement options for particular individuals.

Example: Texas Council on Offenders with Mental Impairments (TCOMI), Post-Release Aftercare

The TCOMI's Continuity of Care (COC) program provides a pre- and postrelease aftercare system for all offenders with special needs released from TDCJ jails and prisons. By identifying offenders prerelease who will need aftercare treatment, the chances for a more successful reintegration into the community are improved. When these offenders are identified prior to release, conditions may be imposed by the parole board or the courts that require mandatory participation in mental health treatment or other similar rehabilitative programs. TCOMI has set up a regionalized continuity of care system. Now, instead of a worker having to make repeated trips across the state, his/her counterpart in that area conducts the prerelease activities. This strategy is being implemented on a statewide basis. The majority of offenders released from TDCJ facilities are returned to communities where TCOMI and, in some cases, parole jointly operate community-based treatment programs. As a result, offenders are immediately enrolled in treatment services that are targeted exclusively for them, thus eliminating service delays. This approach, which was centrally developed but regionally implemented in association with community-based service providers, exemplifies what can be accomplished when interagency partnerships and cooperation are established at both the state and local levels.

"Offenders with mental illness will likely fail attempts at community supervision unless the conditions of probation or parole placed on them are realistic, research-supported and relevant considering their specific needs and capacities."

CARL WICKLUND
*Executive Director,
American Probation and
Parole Association*

Source: Personal
Correspondence, May 29, 2002

C

Establish special conditions of release that are realistic, relevant, and research-based to address the risks and needs of parolees with mental illness.

Conditions of parole are the centerpiece of the release plan for a person reentering the community from prison under supervised release. It is essential, especially when the parolee has a mental illness, that these conditions of release be tailored to the risks and needs that the individual presents. A parolee should not be set up for failure; the conditions of release must be realistic and enforceable. If the parolee has a mental illness, board members must confirm that the services can be made available before imposing conditions of release that require participation in certain community-based programs or treatment, and that the parolee can meet those conditions.

While release conditions will vary depending on the risks/needs of the individual parolee, outpatient and inpatient treatment, and methods to assure that any necessary medications are taken should be requirements of any release plan for parolees with mental illness.

Example: Medically Recommended Intensive Supervision Program, Texas Parole Board

The Texas Parole Board works in conjunction with the Texas Council on Offenders with Mental Impairments (TCOMI) to identify offenders who are eligible for the Medically Recommended Intensive Supervision Program. A special mental health panel, comprised of three members, considers special release conditions for these offenders. The conditions are imposed when the board determines that a mental impairment contributed to the commission of the instant offense(s) or may adversely affect a parolee's potential for success after release. The components of the conditions call

for the parolee to participate in psychological or psychiatric evaluation, participate in mental health treatment, and use medication as proscribed by the attending physician or psychiatrist.

In some jurisdictions, parole boards have the discretion to refer offenders with mental illness for assessment, treatment and hospitalization. State law in Utah authorizes the Utah Parole Board to place parolees with mental illness in state hospitals for treatment as a condition of release if deemed medically necessary.

Access to income through a job or benefit program and to housing are other key factors that should be reflected in the conditions of release. (See Policy Statement 36: Integration of Services and Policy Statement 38: Housing, for further discussion of employment and housing programs for people with mental illness.)

d Ensure that the releasing authority can identify and obtain access to community-based programs and resources adequate to support the treatment and successful community reintegration of parolees with mental illness and that such programs and resources are available in the communities to which parolees return.

Lack of resources in the community is a major obstacle in addressing the special needs of this group of offenders. When asked, “What community resource is most lacking in regard to placing parolees back into the community?” state parole directors polled in the year 2000 identified the inadequacy of services for people with mental illness. The two resources they identified most frequently—housing and licensed substance abuse treatment—are key to successful community reintegration for parolees with mental illness.²⁴

For instance, paroling authorities are put in a difficult position when prerelease program staff at the prison recommend specific conditions of release that are difficult to implement or enforce, given limited resources available. In these situations, the releasing authority may be understandably reluctant to approve the inmate’s release. In some cases, the inmate’s release is delayed due to the lack of an appropriate placement plan until they have completed their sentence, causing them to return to the community without any structured plan or supervision. Such delays serve neither the offender’s treatment needs nor the interests of justice.

Before placing an individual in the community, parole board members need to be assured that the services required for the successful reintegration of the offender with mental illness are available in the communities to which they return. Most jurisdictions engage staff or consultants to the parole board to

24. Information gathered from an informal survey of state parole directors taken at the winter 2000 meeting of the Association of Paroling Authorities International, as

reported by Gail Hughes, director, private correspondence, 2001.

investigate and report to the board the existence and adequacy of local services. Boards need this assistance to help them know and understand the degree of mental illness, needed elements of a release plan to the community, and alternatives to revocation.

Example: Forensic Community Re-entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation, and Co-occurring Disorders, Pennsylvania Department of Corrections

Due to the lack of sufficient community-based mental health services and adequate housing, inmates with mental illness in Pennsylvania state prisons are significantly more likely than other inmates to serve their maximum sentence. In response to this problem, the Pennsylvania Department of Corrections (DOC) developed the Forensic Community Re-entry and Rehabilitation program, which is a collaborative effort between the DOC, the Pennsylvania Board of Probation and Parole (PBPP), and the Pennsylvania Community Providers Association (PCPA). The program will employ a community placement specialist to develop, in conjunction with the parole board and community-based providers, comprehensive transition plans and conduct follow up for program participants. When necessary, the program will provide transitional housing for up to 60 days. Once the offender is paroled, the placement specialist will conduct follow up interviews with community-based providers to monitor the offender's progress.

The program will be launched in May 2002.

e Train parole board members to increase their knowledge of the risks/needs of persons with mental illness and factors that mitigate that risk so release decisions and special conditions can be determined appropriately.

Parole board members should have some familiarity with the nature and types of mental illness, and how these disorders can be diagnosed and treated. Training curricula should be developed and, depending on the jurisdiction, tailored for individuals appointed to serve as parole board members, both for new appointees as well as on an annual or on-going basis for all members. (See Policy Statement 30: Training for Corrections Personnel, for discussion and examples of training for parole boards and parole officers.)

21

Development of Transition Plan

POLICY STATEMENT #21

Facilitate collaboration among corrections, community corrections, and mental health officials to effect the safe and seamless transition of people with mental illness from prison to the community.

This policy statement addresses transition planning for sentenced inmates with mental illness who are released from state prisons and county jails. These releasees include inmates with mental illness who will remain under some form of supervision by the criminal justice system and inmates with mental illness who complete their sentence while in prison or jail. (See Policy Statement 13: Intake at County / Municipal Detention Facility, for a discussion of transition planning issues unique to jail detainees.)

Comprehensive transition planning is of paramount importance—especially when the inmate will finish his or her sentence in prison and not be subject to conditions of release. For inmates with mental illness, whose community adjustment issues are even more complex than inmates in the general population, the need for systemic discharge planning is particularly crucial. For example, individuals with mental illness leaving prison without sufficient supplies of medication, connections to mental health and other support services, and housing are almost certain to decompensate, which in turn will likely result in behavior that constitutes a technical violation of release conditions or a new crime.

Engaging the personnel and resources of institutional corrections, community corrections, and community mental health providers in developing and implementing comprehensive transition plans for offenders with mental illness can maximize the likelihood of a safe and successful transition to the community. Release planning, in principle, can begin upon intake. In practice, jurisdictions initiate and engage in prerelease planning at different times prior to the release date (e.g., one year, six months), and prerelease planning intensifies as the inmate approaches the release date.

The nature and function of discharge planning for inmates vary significantly depending upon whether the individual is being released from a detention facility, a county penitentiary (following completion of a jail sentence at a county correctional institution), or a state prison.²⁵ The extent of postrelease criminal justice supervision prescribed for the inmate will determine the extent to which a plan can or will be developed collaboratively among criminal justice and mental health agency staff, as well as the possibility of treating the discharge plan as a condition of continued release.

25. In the case of the detainee, there is rarely any warning of the timing of his or her release, resulting in little or no criminal justice supervision following release. Oftentimes, the best that can be done is for the discharge planner to provide the detainee with referrals for use post-release. In such cases, the provision of ongoing

case management is unlikely. Issues related to release planning for pretrial defendants and defendants sentenced to time served are discussed in Policy Statement 13: Intake at County / Municipal Detention Facility.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** Identify transition planners in each institution and charge them with coordinating a case management process, which incorporates representatives of institutional corrections, community corrections, social service agencies, and community-based mental health providers.

The position charged with transition planning varies among corrections systems. In some jurisdictions, correctional staff provide both transition planning and case management services. The most common arrangement is for prison staff to assume the lead role in transition planning, with some assistance from community corrections staff; once the inmate is released, community corrections staff assume the case management responsibilities. Regardless of the specifics of the arrangement, collaboration between the various agencies and service providers who will be involved in the release, supervision, treatment, and support of the releasee is essential to a successful transition planning process.

Example: Forensic Transition Team, Massachusetts Department of Mental Health

The Forensic Transition Team program was established in 1998 to provide transitional release planning services for offenders about to be released from correctional custody. The Forensic Transition Team conducts client interviews of inmates identified by mental health staff and coordinates appropriate community mental health resources. Team members work with offenders at least three months prior to their release, providing them with case coordination and consultation to community providers for up to three months after release to address any obstacles to client community adjustment. Arrangement of programs, treatments, and social support services is done in coordination with criminal justice officials to address public safety concerns. The team collaborates both with institutional corrections authorities and with probation and parole officials to coordinate the linkages for offenders with mental illness to receive community-based services upon release. The Massachusetts Department of Mental Health maintains a statewide database to track the progress of offenders served by the program, as well as to inform further program development and research efforts.²⁶

One particularly promising, albeit uncommon, strategy is to have the transition planner working with the inmate during the last months of his or her incarceration continue as a case manager (coordinating the delivery of services and facilitating the person's compliance with conditions of release) after the offender's release to the community. As part of such a strategy, community-based agency staff, who will eventually provide postrelease case management, can be brought into the institution to work with institutional-based discharge planners in devising and carrying out a comprehensive case management plan.

26. Stephanie W. Hartwell, Donna Haig Friedman, Karin Orr, "From Correctional Custody to Community: The Massachusetts Forensic Transition Program," *New England Journal of Public Policy*, Spring/Summer, 2001, pp. 73-81.

Example: Women's Discovery and Safe Release Programs, Rhode Island Department of Corrections

The Women's Discovery Program is a voluntary substance abuse treatment program offered to all women incarcerated in Rhode Island state prisons. All inmates who spend at least 30 days in the Discovery Program are eligible for an additional component called Safe Release. The Safe Release Program provides mental health treatment services and specialized mental health discharge planning services to inmates with mental illness. Case managers from a local community-based mental health provider, the Providence Center, work with corrections staff to oversee the discharge planning for these inmates as well as providing post-discharge case management services for up to one year, thus ensuring continuity of care.

Regardless for whom the transition planner works, it is essential that he or she be required to coordinate a team of people who, collectively, represent the agencies and organizations whose support and assistance are essential to the successful implementation of the transition plan.²⁷ These agencies usually include, at a minimum, corrections, parole (or releasing authority), mental health agencies, housing, employment, health and welfare agencies and private providers of treatment and support services all have a part in the individual's life.

The collective participation of representatives of the community in the development of treatment plan—and their subsequent investment in its success—serves many purposes. First, it encourages coordination between local outpatient services and correctional facilities. Second, it promotes the mutual accountability of correctional administrators and mental health treatment officials for the treatment of offenders with mental illness. Third, it facilitates the sharing of important information regarding the treatment history of the individual and his or her progress following release.

Missouri employs multidisciplinary teams to assess clients, plan interventions, and carry out services for parolees both in the institution and in the community.

Example: Multi-disciplinary Team, Missouri Parole Board

The Missouri Parole Board has a staff person who sits on a team with institutional staff to develop a continued care plan for persons with mental illness. The continued-care plan is holistic in nature, addressing all areas of persons with mental illness offenders' life connected to his/her success in the community. Once planned, the multidisciplinary team oversees the parolee's progress and the delivery of services. The program consists of both an institutional and a community release center phase. The institutional phase lasts for four months and selected inmates spend two months in the community phase for a combined minimum of six months. The program is used by the parole board as a prerelease requirement as well as an alternative to revocation for those who are parole violators.

²⁷ Individuals who are able to coordinate cross-systems activities such as transition planning are often referred to as boundary spanners. Boundary spanners must be able to understand and work within the different cultures, policies, and procedures of multiple areas (e.g., corrections, parole, and community mental health) and successfully bridge the gaps between different services systems that individuals

with mental illness often fall through. For more on boundary spanners see Henry J. Steadman, "Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems," *Law and Human Behavior* 16:1, 1992, pp. 75-86.

Successfully coordinating each of these teams and developing a transition plan that addresses the complex needs of people with criminal records who have a mental illness requires careful work and is extremely time consuming. Accordingly, the ratio of individuals conducting discharge planning and case management services to releasees should be low, ideally with caseloads no higher than 20 releasees per supervision officer.

b **Involve all relevant agents and individuals who will assist in carrying out the transition plan, including family members, in its development.**

If possible, all parties, including the inmate, should participate in a discharge planning meeting just prior to the inmate being released. This provides all parties with the opportunity to understand one another's roles and responsibilities set forth in the treatment and community integration plan, as well as to establish a working relationship to carry out the conditions of the arrangement. Ideally, family members should be part of this process. The offender or family may decline, however, especially if family members do not feel they are prepared to support the inmate upon his or her release.

c **Take steps to ensure that the inmate's release from secure housing to the community progresses in a gradual sequence of planned steps.**

Corrections systems have developed different approaches to ensure that an inmate's release into the community is gradual. In many state departments of correction, inmates nearing their statutorily mandated release date or those who have been granted a parole are assigned to prerelease programs. Some of these programs involve assignment to a prerelease housing unit either within a minimum-security unit or in a community-based setting (such as a halfway house). Correctional discharge planners assigned to these programs help make community contacts and referrals for housing, employment, and services.

d **Develop a transition plan that includes the inmate's assignment to a community-based provider whose resources and assets are consistent with the needs and strengths of the inmate.**

Transition planners' responsibilities include assessing offenders' needs and strengths and facilitating linkages to appropriate community-based services. Given the special needs of this population, transition planners need to be aware of what services are available in the jurisdictions they serve and which community-based mental health and habilitation services are necessary for the care and treatment of people with mental illness.

While institutional release planning staff reach out to identify resources in the community, it is equally important to establish a working relationship between the offender and a community mental health provider prior to his or her release to ensure continuity of care. As discussed above, encouraging and facilitating providers' access ("in reach") to the facility will foster community linkages and increase the likelihood that the offender will be engaged and served effectively upon his/her release from the institution.

Example: Dangerous Mentally Ill Offender Program (WA)

In 1999 officials in Washington State enacted legislation regarding "dangerous mentally ill offenders" released from Department of Corrections (DOC) facilities. The statute directed the Department of Social and Health Services (DSHS) and DOC to work together to expedite financial and medical eligibility for the offender and establish interagency teams for pre-release planning. The interagency planning teams include DOC Risk Management Specialists, a community corrections officer, a representative of the relevant Regional Support Network (RSN), representatives of community-based mental health and substance abuse providers, family members, and law enforcement. The interagency team begins to develop comprehensive release plans at least three months prior to release, including detailed plans for the 48 hours postrelease, service plans (housing, treatment, etc.), victim services, financial resources, and community corrections information. Case managers, community-based mental health and chemical dependency providers, and community corrections officers visit the offender where he or she is incarcerated, facilitating the development of relationships prior to release.

The case management plan should include dates, times, and locations for follow-up appointments with community supervision agencies and for appointments with treatment providers. Mental health case managers also can then be on hand to ensure that the releasee is engaged in the planned treatment and service programs and to monitor the initial delivery services.

Since such a large proportion of offenders with mental illness also have histories of substance abuse, it is likely that the community transition and case management plan will also include provision for substance abuse treatment (see Policy Statement 17: Receiving and Intake of Sentenced Inmates, for more on co-occurring disorder statistics in prisons; also Co-Occurring Disorders). Substance abuse treatment services may be provided at one site as part of a comprehensive program for dually diagnosed offenders. If substance abuse treatment is to be provided off site and/or by a separate agency, or if the releasee is to participate in 12-step or other community-based fellowship programs, the community-based case manager should also make arrangements for the offender to receive escort to initial meetings and appointments and ensure that engagement has occurred. Twelve-step fellowship programs, such as Alcoholics Anonymous and Narcotics Anonymous, provide escort services as part of their regional World Fellowship Networks. These organizations list local groups and fellowship networks in the white pages of regional phone books.

At a minimum, discharge planners can facilitate case conferences that include participating treatment and social service providers as well as the of-

"When I discovered that mentally ill inmates were dropped off in the middle of the night with two subway tokens and a few days worth of medication, I thought it was a joke. After all, what kind of system could be that apathetic to the needs of the mentally ill and society alike?"

KIM WEBDALE

Victim Advocate, NY

Source: U.S. House Committee on the Judiciary, *The Impact of the Mentally Ill on the Criminal Justice System*, September 21 2001

fender. When face-to-face case conference is not feasible (for instance, due to prohibitive distances between the institution and the home community), it may be conducted as a teleconference. A number of jurisdictions recognize the importance of case conferencing, and have taken steps to make sure that it occurs.

e

Integrate housing support services into the transition plan and provide releasees with mental illness an arrangement for safe housing or at a minimum, shelter.

Adequate housing is the linchpin of successful reentry for offenders with mental illness. Housing, especially when it is combined with support services, provides a stable base from which individuals can access treatment in the crucial days immediately succeeding release. Every person with mental illness leaving jail or prison should have in place an arrangement for safe housing (or, at the least, shelter).

Unfortunately, locating suitable housing for their clients is one of the greatest challenges for discharge planners and community-based case managers (see Policy Statement 38: Housing). They will need to know what type of housing arrangements are available in the communities they serve; how to make the appropriate connections between the offender and the landlord; and what provisions there are for indigents unable to pay the rent. Perhaps even more important, the discharge planners and community case managers must know how to overcome explicit or implicit prejudices and exclusions based on either mental illness or criminal history. For example, individuals convicted of certain violent, drug-related, or sex-related offenses are not eligible for federal housing subsidies.²⁸ Transition planners are likely to encounter considerable resistance from private-sector individuals and agencies, and, to be effective, will have to assume the role of housing and social services advocate for the releasee. At least one jurisdiction is developing a program to address this crucial issue.

Example: Parole Support and Treatment Program (PSTP), Project Renewal, New York City (NY)

Project Renewal is a New York City based nonprofit that provides an array of services for individuals who are homeless and have mental illness and substance abuse problems. The Parole Support and Treatment Program is a joint effort between Project Renewal, the New York State Office of Mental Health, and the New York State Division of Parole. The PSTP will provide 50 new units of transitional, supportive housing and intensive clinical services to newly released parolees who suffer from serious and persistent mental illness and co-occurring substance abuse disorders. The program will combine an “ACT-like” treatment team and 50 scattered-site supported transi-

28. Any offender who is subject to a lifetime registration requirement under a state sex-offender program is ineligible for public, Section 8, and other federally assisted housing. Similarly, anyone who has engaged in drug-related, violent, or other criminal activity that would “adversely affect the health, safety, or right to peaceful enjoyment of the premises” may be denied federal housing

assistance. The decision to deny this assistance is based on how recent the conviction for these crimes. See Legal Action Center, “Housing Laws Affecting Individuals with Criminal Convictions,” available at: www.enterprisefoundation.org/model%20documents/1150.pdf

tional housing beds. During their time in transitional housing parolees will work with the clinical team to transition into permanent housing, ranging from community residences to Section 8 apartments.

All individuals with serious mental illness leaving jail or prison should be physically transported to their housing arrangement or shelter and provided with a short-term supply of medication and a prescription (or provision) for long-term supply. In such cases, the mental health agency assigned to provide the offender with community services is the appropriate agency to provide transport from the jail or prison to the place where the offender will reside.

"If you have a schizophrenic walking the streets, do you think that person can hold themselves together until their benefits are reinstated?"

DAVE BRENNA

Salt Lake County Mental Health Director, UT

Source: Amy Joi Bryson, "Jails of the mind: End of incarceration brings end of meds—and new problems," *Desert News*, Sunday, May 19, 2002,

f Make arrangements for at least a week's supply of important medications, along with refillable prescriptions, to be provided to inmates at the point of release.

Offenders should have an adequate supply of essential psychotropic medications upon their release. They should be given at least a seven-day supply and prescriptions sufficient for the period up to when entitlements may reasonably be expected to be reinstated, typically within 90 days after release to the community. States that contract with private correctional health care providers for the provision of institutional health care should include in their contracts a requirement that these extra medications are provided to discharged inmates. Also, if it has not already been done by agents of the detention or corrections authority, the community-based agency or case manager responsible for the released offender should take steps to reinstate the individual on Medicaid in order to pay for necessary medications.

g Develop a process to ensure that inmates eligible for public benefits receive them immediately upon their release.

Community-based mental health providers are reluctant to provide services to people with criminal records for numerous reasons. Near or at the top of this list of reasons is this population's inability to pay for treatment. State and county government officials attempting to control the explosive growth of health care expenditures routinely warn providers about delivering services to individuals who ultimately do not qualify for federal benefits; providers will not receive back-payments for the delivery of these services. Given the crushing demand that they are attempting to accommodate, providers are understandably hesitant to deliver services to a person who does not have health insurance and whose eligibility for public benefits is not immediately apparent.

Corrections administrators and health officials can take several steps to facilitate inmates' participation in federal benefit programs (see Appendix C: Explanation of Federal Benefit Programs). First, state officials should require

corrections staff to distribute to inmates information and application forms for all relevant federal and state benefit programs, including Medicaid; federal SSI and SSDI benefits; Temporary Assistance to Needy Families (TANF); food stamps; veterans programs; and state general assistance. Staff should provide additional assistance, and in general pay particular attention, to subsets of the inmate population with mental illness who are especially likely to qualify for benefit programs, including those who meet the following criteria: 1) received federal benefits at the time of incarceration; 2) have very low incomes, particularly those under age 21; 3) are veterans; or 3) are parents of children under 18 and likely to be custodial parents upon release.

Example: Partners Aftercare Network (SPAN), San Bernadino (CA)

This initiative established a multi-agency team whose purpose is to link inmates with serious mental illness to needed mental health services upon their release from jail. The aftercare management team serves as a “bridge” between custody and community integration by providing, among other things, financial advocacy to assist clients in obtaining Social Security and medical and other benefits.

Second, appropriate authorities should establish a process through which the state Medicaid agency will accept applications from inmates while they are still in custody and will process these applications in a timely manner to ensure that those found potentially eligible are then able obtain access to the benefits immediately upon release. Corrections administrators must appreciate the difficulty in timing a person’s participation in benefit programs. Accordingly, corrections officials should inform local social security offices and the state Medicaid agency as early as possible of the exact date of release of inmates who qualify, or may qualify, for benefits.

Example: Medicaid Reenrollment for Inmates at Hamden County Correctional Center (MA)

At Hamden County Correctional Center, discharge planning begins at least three months before an inmate’s scheduled release. The mental health treatment division in the jail employs one social worker who focuses on discharge planning for inmates with mental illness. The discharge planner helps inmates to apply for Medicaid, SSI, Mass Health, and other appropriate entitlement programs. The goal is to have inmates considered eligible for entitlement programs at the time of their release.

In establishing this process, corrections administrators should work with local mental health authorities to arrive at an agreement regarding diagnoses of people who are disabled and therefore may be eligible for SSI (and, by extension, Medicaid). Corrections administrators should also assist inmates in applying for state identification cards, which will be provided upon the inmate’s release. Without such proof of identification, it is nearly impossible for a person to avail him or herself of many benefits or services.

Several federal benefit programs are particularly relevant for people with mental illness who will be released from a corrections facility: Supplemental Security Income (SSI) disability benefits; Social Security Disability Insurance (SSDI); Medicaid; Medicare; Temporary Assistance for Needy Families (TANF); Food Stamps, and Veterans Benefits. Implementing the recommendations under this policy statement requires an understanding of who is eligible to participate in these programs and how they qualify. These complex issues are described in Appendix C, a reprint of a policy brief that the Bazelon Center for Mental Health Law published. Recommendations regarding Medicaid eligibility of pretrial detainees who were enrolled in Medicaid immediately prior to their incarceration appear in Policy Statement 13: Intake at County / Municipal Detention Center.

h Notify the victim before the offender is released from prison, consistent with the requirements of the state's law or constitution, prior to release.

The vast majority of states have a statute or a constitutional amendment requiring that the victim be notified before the offender is released from prison.²⁹ Regardless of whether the inmate to be released has a mental illness, releasing authorities and correctional staff must comply with victim notification requirements.

Efforts should be made through correctional crime victim specialists and community-based crime victim agencies to reach out to crime victims and inform them of the pending release date of those who have victimized them, to educate them as to the decisions being made on behalf of the offender, and to provide them information about the measures being taken to ensure their safety.

"Our treatment programs tell us that...the *single* issue that is an impediment to the continuity of care is Medicaid eligibility."

GARY FIELD
Administrator, Counseling
and Treatment Services,
Department of
Corrections, OR

Source: Interview, January 11,
2002

i Monitor the inmate closely in the days approaching release and modify the discharge plan when appropriate.

Successful implementation of the transition plan is usually contingent on the following:

- updated examinations, which closely reflect the status of the inmate's mental health and psychotropic medication requirements on or near the release date;
- cooperation among at least two agencies to enable representatives from one agency to navigate another system credibly; and
- provision of a mental health status evaluation for the purpose of risk assessment and/or supervision. (See Policy Statement 19: Subsequent Referral for Screening and Mental Health Evaluation.)

A mental health professional should conduct a mental health assessment of the inmate at a point just prior to release to ensure that the discharge plan is fully adequate to addressing the inmate's current needs and circumstances. If it is not, the mental health professional should work with the releasing authority to modify the discharge plan accordingly.

j Provide enhanced discharge planning, including extensive coordination with the community treatment provider, to ensure continued case management for inmates with mental illness who will complete their sentence in prison.

Approximately one out of every five sentenced inmates in the United States is released from a correctional facility without any continued community-based

²⁹ See National Center for Victims of Crime, *Crime Victims Source Book*, Section 3, Right to Notice.

supervision.³⁰ These inmates complete their sentence in prison because, through the abolition of parole and other measures, state law prohibits the release of an offender from prison before his sentence is completed or because releasing authorities denied the inmate's request for release. Due to disciplinary histories and reluctance of authorities to release people with mental illness to the community before their sentence has expired, issues discussed earlier in this report, the percentage of inmates with mental illness who complete their sentence while in prison is probably greater than the 20 percent figure that applies to all general population inmates.³¹ (See Policy Statement 20: Release Decision.)

Offenders with mental illness released to the community without community supervision are particularly difficult cases to manage, both because supervision and participation in treatment and social service programs are completely voluntary and because many newly released offenders resist services and treatment. For those releasees who are unwilling to seek traditional mental health system services, an approach to consider is to link them to consumer-run programs, like a drop-in center, or to create peer (i.e., individuals with mental illness who has themselves once been incarcerated) contacts for outreach. Such programs or outreach provide contacts, appropriate socialization experiences, and can link individuals to services once they are ready. (See Policy Statement 39: Consumer and Family Member Involvement.)

Releasing authorities should strongly encourage offenders with mental illness to continue services after release, as well as encourage the community mental health programs as much as possible to conduct active monitoring and outreach to recently released offenders referred to them and otherwise attempt to provide such services.

Absent criminal justice oversight and supervision, referral to community-based mental health case management and advocacy programs is perhaps the best recourse. Again, reaching out to community-based organizations and agencies that would serve this population and facilitating their access to the institution/inmate prior to release will enhance the likelihood that an individual, upon release, would seek out services. It is also an attractive alternative to and adjunct of criminal justice supervision since community mental health case management services are often eligible for Medicaid reimbursement. (See Chapter VII: Elements of an Effective Mental Health System, especially Policy Statements 36, 37, and 39, for further discussion of mental health case management services.)

30. Travis et al., *From Prison to Home*, p. 15.

31. Based on the time of admission to the time of expected release, offenders with mental illness were expected

to spend 15 months longer in state prison than were offenders without mental illness. Ditton, *Mental Health and Treatment*, p. 8. See also note 21.

22

Modification of Conditions of Supervised Release

POLICY STATEMENT #22

Monitor and facilitate compliance with conditions of release and respond swiftly and appropriately to violations of conditions of release.

As explained earlier in this report, approximately 80 percent of sentenced inmates are released under some form of community supervision.³² Successful completion of a period of community supervision is particularly difficult for offenders with mental illness. The transition planning process described in the preceding policy statement often is not in place, and people with mental illness who are released from prison sometimes wonder whether they have been set up to fail. They must find a mental health provider willing to deliver services to a person who not only has a criminal record but who also is (often) without the resources to pay for treatment and has yet to demonstrate eligibility for Medicaid. Oftentimes, when a provider does accept a parolee, the person with the criminal record learns that he must identify a second provider who will treat his or her substance abuse problem.

Offenders with mental illness recently released from prison also must find housing and, despite not having any savings or a paycheck, pay the first month's rent in advance. Furthermore, to maintain some form of public assistance, they need to demonstrate that they are actively seeking a job. Yet

few employers are willing to hire anyone with a criminal record, and the stigma that surrounds mental illness compounds the problem. Overcoming these obstacles to successful reintegration into the community, while attempting to coordinate appointments in a schedule already crowded with meetings with a supervision officer, a mental health clinician, and a peer substance abuse support group is nearly impossible—and especially so for someone without access to transportation. Not surprisingly, these individuals often return to the types of criminal behavior that originally prompted their incarceration.

Community corrections officers also feel like they have been presented with an impossible situation. With caseloads sometimes reaching into the hundreds, supervision officers are without the time or resources to facilitate an offender's compliance with conditions of release. Furthermore, they are unable to observe the offender closely either to gain an improved understanding of the individual or to spot dangerous behavior.

At the same time, parole administrators are under significant political pressure to hold parolees accountable for violations of conditions of release

32. Travis et al., *From Prison to Home*, p. 20.

and to ensure that a parolee does not become a front-page news story. The absence of coherent policies regarding parole revocation decisions for parole violators who have a mental illness exacerbates the problem.

Given this situation, supervision officers often respond to any violation of supervision by recommending the reincarceration of the offender. Although in many cases these violations (“technical violations”) do not constitute a new crime, they demonstrate behavior (e.g., homelessness, substance abuse, lack of employment, or failure to take medication) to a community corrections officer that indicates the releasee is returning to a lifestyle that, if not changed, will result in recidivism. As a result,

many such parolees are returned to prison not for new offenses but rather for technical rule violations—such as missed appointments with a parole officer or testing positive for substance abuse.

Recognizing the complexity of this task, and the extent to which supervision officers lack many of the resources they need to perform their responsibilities, the following recommendations for implementation explain the value of tapping community-based resources such as mental health providers and family members. They also outline elements of a collaborative relationship among these entities, with the aim of encouraging an offender with mental illness to comply with conditions of release and to hold him or her appropriately accountable.

RECOMMENDATIONS FOR IMPLEMENTATION

a Assign small, specialized caseloads of parolees with mental illness to parole officers who have received advanced training in mental health issues.

As discussed in the preceding policy statement, people with mental illness released to the community usually have a long, complicated list of needs; monitoring and facilitating the releasee’s progress in the community is a complex, time-intensive responsibility. It is unrealistic to assume that, in their current situation, community corrections officers will have the time or the expertise to devote to all these cases.

Specialized training for these supervision officers is essential (see Policy Statement 30: Training for Corrections Personnel). Supervision officers who are trained and experienced in working with offenders with mental illness are much more likely to be attuned to available treatment options, signals of distress, and signs of decompensation. Under these circumstances, supervising officers are much more likely to seek out and arrange revised treatment options and other relevant remedies in lieu of issuing a warrant and instituting violation proceedings that would likely result in reincarceration. It is also worth noting that parole officers who seek specialized training are especially interested in working with this population and thus are likely to engage them in a particularly constructive way.

Example: Specialized Caseloads, New York State Division of Parole

The New York State Division of Parole (DOP), in conjunction with the New York Office of Mental Health (OMH), has established specialized caseloads in certain metropolitan areas to service parolees with mental illness. Parole officers in this program receive specialized training on mental illness and carry a reduced caseload of approximately 25 cases. The specialized parole officers work with community mental health agencies to link parolees to appropriate services. (See also Policy Statement 20: Release Decision, for more on collaboration between the New York DOP and the New York OMH.)

Example: Special Management Unit, Connecticut Board of Parole

The Connecticut Board of Parole has established a Special Management Unit to supervise parolees requiring ongoing intensive supervision or specialized treatment. The unit focuses primarily on supervision of paroled sex offenders but also works with parolees with severe mental illness. Special Management Unit parole officers receive training in supervision and in medical, and mental health issues and maintain a caseload of no more than 25 parolees. The unit emphasizes interaction between treatment providers and parole officers; officers participate in both group and one-on-one counseling sessions with offenders.

Small, specialized caseloads can also enable community corrections officers to develop effective working relationships with community service providers. Mental health providers, whose time and resources are already spread thin, are often untrained on how to take into account the criminal history (and the providers' obligations to the criminal justice system) of clients referred to them by the criminal justice system. (Training for mental health providers on working with criminal justice populations is essential to address this issue. See Policy Statement 31: Training for Mental Health Professionals.) Some community-based mental health providers, often citing liability concerns, explicitly refuse to serve individuals with criminal histories.³³ (See Policy Statement 1: Involvement with Mental Health System, for more on access to services and priority populations.)

In rural jurisdictions, where there may not be enough offenders with mental illness to merit a specialized caseload, supervision officers at a minimum should receive orientation and training to monitor and assess offenders on their caseloads who have mental illness. Like their urban counterparts, they should be prepared to make appropriate referrals in the event of new problems and/or technical violations rather than relying on revocation of parole. The availability of specialized services and resources for offenders in rural jurisdictions poses difficult transportation issues. Rural jurisdictions may be able to establish special services, transportation, and supervision arrangements in facilitating collaboration between criminal justice agencies and mental health service providers or other social service providers for whom the parolee is a member of a shared population.

33. According to Doug Bray, Court Administrator, Multnomah County, Oregon, community-based service providers' refusal to serve individuals with criminal records

contributed to the founding of the Multnomah County pretrial diversion program. Information provided in private correspondence, May 7, 2002.

b Encourage community corrections staff to conduct field supervision and other monitoring responsibilities within the communities, homes, and community-based service programs where the releasee spends most of his or her time.

Supervision officers should maintain contact with ex-offenders in their communities rather than monitoring them remotely from a centralized office. Community-based supervision enables the officer to monitor the offender more closely, thus improving the officer's familiarity with the unique obstacles that often impede the released offender's compliance with the conditions of his/her release. In addition, frequent contact with mental health treatment providers improves supervision officers' understanding of these services. It can also help them ascertain whether mental health treatment providers are offering the services needed.

In addition to the benefits derived from close community monitoring of ex-offenders, there has been some recent success in community mapping. Following the example of crime mapping in law enforcement, some jurisdictions have begun to use similar mapping techniques to identify specific districts and neighborhoods where significant numbers of ex-offenders are located. This information may be used to design community-based initiatives focusing on these neighborhoods. Such a technique might be used to identify clusters of offenders with mental illness who live in specific neighborhoods and where specialized field supervision and mental health services might be located and deployed. The mapping function can be a collaborative effort as well between criminal justice providers and social service agencies, with the dual benefit of collaboration and a work product in the end useful to all parties involved.

c Work closely with mental health administrators and providers to ensure that parolees receive services and resources specified in community reintegration and supervision plans.

The successful reintegration of offenders with mental illness back into the community depends, in large part, on their ability to obtain access to a range of mental health and related services. Oftentimes, it is the lack of adequate mental health resources—within both correctional institutions and the community—that impedes the decision to release offenders with mental illness who might otherwise be eligible for release. Those offenders with mental illness who are released to supervision are often required to maintain some level of mental health treatment. If mental health service providers do not make adequate services available to the offender, he or she may be violated and unnecessarily reincarcerated.

Institutional corrections, parole boards, and community corrections agencies can encourage mental health agencies and providers to provide adequate services through improved cross-system collaboration. The Texas Council on Mentally Ill Offenders (Policy Statement 20) and the Washington Dangerous Mentally Ill Offender Program, and Massachusetts Forensic Transition Team (Policy Statement 21) all help community corrections agencies work together with mental health service providers to ensure that offenders under community supervision receive the services that they need. The Rhode Island Fellowship Health Resources program is a similar model of collaboration between corrections and mental health providers.

Example: Fellowship Community Reintegration Services (RI)

Operated under contract with the Rhode Island Department of Mental Health, Retardation, and Hospitals by Fellowship Health Resources, a nonprofit agency, Fellowship Community Reintegration Services (CRS) provides discharge planning and advocacy for released offenders to ensure that they receive appropriate community placements and services as well as assistance with applications for entitlements and any needed education or employment referrals. Clients may be placed in any of a variety of community agencies, including residential substance abuse treatment facilities, or may be placed on home confinement with provisions made for service delivery. Fellowship CRS tracks its clients for one year postrelease to gather outcome data and determine the appropriateness of available placements.

"We would never tell a man with a broken leg, 'we'll give you treatment if you walk to the hospital.' Yet we tell a person in the most severe throes of mental illness, 'we'll give you treatment if you first think your way there.'"

CARLA JACOBS

*Board Member,
National Alliance for
the Mentally Ill*

Source: *Los Angeles Times*,
Monday, August 3, 1998

d **Ensure that released offenders are connected to a 24-hour crisis service.**

Crisis services provide community corrections officers with a quick intervention that enables them to respond effectively—without depending on reincarceration exclusively—to address technical violations, such as a missed appointment, of conditions of release. Correctional mental health professionals maintain that this type of brief intervention during points of crisis will reduce subsequent (and likely more serious) violations of conditions of supervised release.³⁴

e **Establish protocols to share information between community supervision agencies and community mental health providers regarding compliance with conditions of release.**

For community corrections officers to develop confidence in a community-based service, they must trust that providers will inform them about behavior that constitutes violations of conditions of release. At the same time, providers

34. Gary Field, Administrator of Counseling and Treatment Services, Oregon Department of Corrections, private correspondence.

do not want to be in a position of monitoring a parolee's conditions of release; that would likely undermine their relationship with the client.

Various jurisdictions have developed compromises between community corrections agencies and service providers, which enable both groups to adhere to their responsibilities.

Typically, community corrections officers do not need or want detailed information about the mental health treatment process. What they are most interested in are brief progress reports, and to be notified about behaviors that violate conditions of supervision. A transition plan should involve a written release from the offender, permitting mental health providers to share this information with community corrections agencies. (See Policy Statement 25: Sharing Information.)

Example: Forensic Transition Team, Massachusetts Department of Mental Health

The Forensic Transition Team in Massachusetts ensures that offenders participating in the program sign a release that allows open communication between mental health providers and parole staff. No information is exchanged without a written release except as required under mandatory reporting statutes. Parole field-staff are often involved in a primary way with treating staff upon release. Occasionally they are invited to case conferences or other gatherings of the treatment community to offer oversight on a case. In general, the parole officers are most interested in compliance with treatment as part of the conditions of release.

f

Develop a range of graduated sanctions to compel (and incentives to encourage) compliance with conditions of release.

Community supervision staff members need to be prepared to address the needs of the offender with mental illness who may be unable to comply with the traditional mandates of community supervision. Although reincarceration of the offender may be the most expedient response in the short run, it may not be the best use of criminal justice resources or, in the long term, be the response most likely to prevent the person from reoffending. Absent new criminal behavior by the probationer or parolee, alternative responses should be considered. Incarceration should be reserved for those cases that represent a threat to public safety.

To provide the most effective intermediate sanctions, criminal justice officials should develop agreements with case management service providers, advocacy organizations, specialized employment/vocational providers, crisis services, and mental health treatment programs to provide support for individuals with mental illness when problems arise. If a probationer or parolee with mental illness decompensates considerably after his or her release, increasing treatment should be considered prior to recommending the offender be returned to

custody. Providing aggressive treatment may stabilize the offender's mental condition much more effectively and economically than reincarceration.

Offenders with mental illness who are returned to the community may need more intensive services and supervision than originally planned prior to their release, particularly in relation to their reaction to the stresses of returning to the community. An effective approach to violations of conditions of supervision is to increase gradually the level of treatment intervention in combination with a graduated series of predetermined responses (rather than violating them immediately upon the first technical violation). There should be some flexibility for the officer to use a reasonable level of discretion while maintaining program consistency.

Agencies such as New York City's Center for Alternative Sentencing and Employment Services (CASES) provide interagency case planning and management services for "special needs" offenders, such as offenders with mental illness, who are in jeopardy of parole revocation due to noncriminal violations of conditions of community supervision.

Example: Parole Restoration Project, Center for Alternative Sentencing and Employment Services (CASES), New York City (NY)

CASES recently developed the Parole Restoration Project for technical parole violators incarcerated in New York City jails whose parole status would otherwise be revoked. The project attempts to increase the number of special needs parole violators returning to parole community supervision instead of state prison. The project's clients include substance abusers, people with a mental illness, people with co-occurring disorders, and women. Project staff identify eligible participants, assess their treatment needs, link them to community-based service providers, gain support for the treatment plan from parole field staff and assigned counsel, submit a comprehensive report to the administrative law judge and the board of parole advocating for restitution of parole under the recommended treatment program, and coordinate the release and monitoring of compliance.

Other agencies, such as the Cook County, Illinois, Department of Adult Probation and the Maricopa County, Arizona, Probation Office, employ a graduated ladder of sanctions and special, individualized services for probationers or parolees with special needs. Still others, like the Hawaii Paroling Authority and the Kentucky Department of Corrections, offer a structured living environment to parolees with mental illness where care, treatment, and housing are provided.

Incentives and positive reinforcement can also be useful tools in helping offenders with mental illness adhere to the conditions of their release.

Example: Dangerous Mentally Ill Offender Program (WA)

As part of the Dangerous Mentally Ill Offender legislation, Washington State appropriated additional funds to support the transition of offenders with mental illness back into the community. Regional Support Networks, components of the Washington mental health system, have used a portion of these funds for incentives (such as new clothing) as a means to increasing compliance with treatment plans.

23

Maintaining Contact Between Individual and Mental Health System

POLICY STATEMENT #23

Ensure that people with mental illness who are no longer under supervision of the criminal justice system maintain contact with mental health services and supports for as long as is necessary.

People with mental illness who come out of prison must have access to services they need to reintegrate into community settings successfully. The preceding policy statement discusses the importance of collaboration between mental health and community corrections agencies in ensuring that individuals with mental illness who are granted supervised release receive appropriate mental health services. This policy statement addresses the role of the mental health system in providing services and support for individuals released from prison who are no longer under continued supervision from the criminal justice system. This group includes those who have completed their sentence in prison or jail and are released without conditions as well as those who have successfully met the conditions of release and are no longer under supervision in the community.

Once offenders have completed the terms of their sentence or conditional release, ongoing monitoring by and reporting to the criminal justice system is neither warranted nor justifiable. However, in light of the high recidivism rates of offenders with mental illness, it is crucial that the mental health system maintain contact with individuals who have been incarcerated to prevent their renewed involvement with the criminal justice system.

As is true of anyone with mental illness attempting to live independently in the community, offenders have basic needs for housing and supports that must be adequately met if reentry is to succeed. By ensuring access to appropriate services and necessary supports, especially housing, and by developing and utilizing mechanisms to ensure ongoing contact, community mental health providers can play an important role in successful community reintegration of former prisoners who have mental illness.

Community mental health providers must be attuned to the special needs and circumstances of released offenders with mental illness and provide services that enhance their ability to live independently. By identifying recently incarcerated clients with mental illness as a “special needs” or “priority” population, community providers can develop treatment plans and provide services that ensure monitoring and outreach to fit an individual’s circumstances.

While services available to released offenders ultimately may not need to be more intensive than those available to other clients, mental health care providers should be prepared to help these clients meet challenges related to the transition to commu-

nity life. Treatment and rehabilitative models such as Assertive Community Treatment should be employed when appropriate to monitor the client's transition and address problems that could lead to rearrest and incarceration (see Policy Statement 35: Evidence-Based Practices, for more on Assertive Community Treatment). Special attention should be given from the outset to provision of rehabilitative services that will both address specific needs and help establish a routine for the released offender attempting to grow accustomed to new freedom.

Mental health providers have both an opportunity and an obligation when an offender with mental illness is released from prison. The opportunity arises from the fact that, unlike those people with mental illness with no prior criminal justice contact who seek services, released offenders with mental illness will have treatment histories and may have additional incentives to engage in care. Their criminal histories and service provision while incarcer-

ated are relevant to the mental health system in effectively designing an individual treatment plan. Whether an offender will be supervised in the community or released unconditionally, communication between the systems is key. (See Policy Statement 20: Release Decision and Policy Statement 21: Development of Transition Plan.)

It is the providers' obligation to seize the opportunity and to provide the services needed to ensure that the released offender does not return to the criminal justice system because services were not available, accessible, or effective. For mental health service providers to meet their obligation to people with mental illness who are leaving prison, sufficient resources must be made available to fund effective services and programs. Success in this endeavor should result in a reduction in demand for crisis services as well as in recidivism and the resultant drain on criminal justice resources. (See Policy Statement 1: Involvement with the Mental Health System.)

RECOMMENDATIONS FOR IMPLEMENTATION

a Develop mechanisms to engage ex-offenders with mental illness who have been released to the community.

Systems need to be in place to allow mental health and social service providers to coordinate with correctional and law enforcement agencies prior to and following the release of people with mental illness from correctional facilities. At a minimum, this means that community service agencies should be informed of the impending release of prisoners with histories of treatment for mental illness while in prison who will not be under community supervision. Mental health service providers should then maintain records documenting contact and treatment subsequent to release. There is no reason for these records to differ in form or content from the records kept on contacts with any community client.

Depending on the system configuration, a community reintegration program may require considerable spanning of both jurisdictional and systemic boundaries. Incentives should be created for the community providers to do "inreach" to the correctional setting and begin the process prior to release. Ex-offender contact information following release should be explicitly defined and

a mechanism should be developed for locating individuals who do not keep their first scheduled appointment.

The “moment of release” from prison is often a crucial juncture in an offender’s transition back to life in the community. This is especially true for offenders with mental illness; it is important that these individuals are connected as seamlessly as possible with housing and services. Mental health providers should be aware of the importance of the period immediately following a prisoner’s release and work with corrections officials to develop transition plans, even for individuals who will not be under community supervision, that provide detailed strategies for the first days after a prisoner’s release. Responsibility to assume care of the individual between the time of release and the first outpatient appointment must be explicit. This initial period of reintegration provides an opportunity for the mental health system to engage former prisoners from day one. (See Policy Statement 21: Development of Transition Plan.)

b **Develop programs to provide appropriate levels of service and supports to ex-offenders with mental illness who have re-entered the community.**

Ex-offenders with mental illness return to the community burdened by a double stigma. The problems posed by their criminal history and mental health condition to finding housing and employment have already been discussed. More subtly, their status as ex-offenders with histories of mental health treatment can affect their social networks and family relationships as well, often leaving them in the same social situation that led to their arrest in the first place.

People with mental illness emerging from prison also frequently report particular discrimination on the part of the mental health service community. In many instances, mental health providers are reluctant to take on the perceived risks associated with clients who have criminal histories, especially if they include violence.³⁵

It is important that programs be developed to meet the specific needs of offenders with mental illness who are transitioning from prison to the community. Correctional settings have had the responsibility for screening and identification of mental health issues as well as for providing treatment while incarcerated. After those functions, the principle transition planning responsibility is to establish linkages between the ex-offender and future community services. Working partnerships among probation, parole, the courts, neighborhood businesses, community housing organizations, and service providers can provide

35. Erik Roskes and Richard Feldman, “A Collaborative Community-Based Treatment Program for Offenders with Mental Illness,” *Psychiatric Services* 50:1, 1999, pp. 1614-19.

opportunities for the released offender to participate in restorative and therapeutic activities and community service projects. Transition planning is equally important for individuals who will not be under community supervision as it is for those who will have some conditions placed on their release.

Programs serving released offenders need to develop a broad menu of services that can be matched to offender needs. The service array should include attention to housing, health care, medications, case management, employment, income supports and entitlements, food and clothing, transportation, and child care. The result should be a community-based mental health service and support program that does not differ greatly from any intensely monitored community treatment program. If it is staffed by knowledgeable professionals and client-centered in its approach, it will best meet the needs of the released offenders with mental illness it serves.

Mental health staff need to be prepared to work with individuals who have been involved in the criminal justice system. This requires training that will help to overcome the stigma attached to incarceration, address the special needs of individuals who have been incarcerated, and promote appropriate coordination with criminal justice agencies. (See Policy Statement 31: Training for Mental Health Professionals.)

Mental health service providers should also consider encouraging development of a system of peer support for ex-offenders with mental illness. Finding that one is not alone in facing identifiable challenges associated with reentry can itself be an important support for men and women with mental illness coming out of prison. Peer support of this nature provides a ready and accepting social network, while those who have shared the experience can offer advice and suggestions likely to be received positively by the reentering ex-offender. (See Policy Statement 39: Consumer and Family Member Involvement, for more on peer services.)

C**Develop an understanding of the factors leading to community re-integration success or failure for clients with mental illness who have been released from prison.**

Much is already known about the factors that affect a client's chances of establishing him or herself in the community upon release from prison. For instance, many clients have an immediate need for income-assistance, so re-establishment of benefits is an important step to be addressed at the earliest possible opportunity. Similarly, safe, affordable, permanent housing is closely correlated with success in the community. For almost all persons with mental illness leaving prison, addressing housing needs must be seen as a high priority.

Maintaining contact between the mental health system and individuals who have entered it from prison also provides opportunities for other factors to be more clearly understood. It is important for the community provider to understand the factors that led up to arrest. The planning of effective services involves attention to these matters to ensure services are delivered that reduce the likelihood of rearrest. Community providers must incorporate this understanding into an individualized treatment plan. The needs of a mother who has been incarcerated for crimes directly related to substance abuse will necessarily differ from those of a young male imprisoned on a personal assault conviction. It is important for any service provider to systematically evaluate its approaches, and in this area especially it is necessary to build training curricula on the experiences of those staff, clients, and families attempting to bridge the worlds of prison and mental health. In a well-functioning system, recognition of individual needs will come with experience, and responsiveness will thus become more effective.

Example: Massachusetts Forensic Transition Program, Massachusetts Department of Mental Health

Operated by the Massachusetts Department of Mental Health (DMH), the transition program is a statewide initiative that assists DMH-eligible preadjudicated and convicted inmates. It provides tracking and release planning services. Program staff collaborate with relevant departments, agencies, and vendors to facilitate the transition of ex-offenders with mental illness into communities across the state. They work with inmates with mental illness in correctional facilities at least three months before release to coordinate relevant psychosocial and criminal information for the transition and treatment planning process after release. Staff also provide case coordination and consultation to community providers for up to three months after release to address any immediate obstacles to client community adjustment. The Forensic Transition Program works with inmates who will be under community supervision as well as those who have completed their sentence.³⁶

By maintaining contact with recently released offenders with mental illness and providing effective services for them, community mental health providers demonstrate their willingness and ability to perform an important public safety function.

36. Hartwell et al., pp. 73-81.

Overarching Themes

Improving Collaboration

People with mental illness who have become involved (or are at risk of becoming involved) with the criminal justice system frequently have multiple needs that can be addressed only through the collaborative efforts of several agencies working within the constraints of diverse systems. The failure of these systems to connect effectively endangers lives, wastes money, and threatens public safety—frustrating crime victims, consumers, family members, and communities in general.

For these reasons, the policy statements and implementation recommendations in this report stress repeatedly the importance of agencies, departments, and organizations working together, across systems. In fact, many of the policy statements do not address a criminal justice or mental health entity exclusively, but straddle the two systems, requiring the systems to respond jointly.

This report recognizes at the outset that an essential first step toward implementing any of the policy statements is to develop some degree of cooperation among stakeholders in the criminal jus-

tice and mental health systems. (See the section of the report’s Introduction entitled “Getting Started,” which explores this point in detail.) But cooperation—such as getting people to the table to define the problem and identify shared goals—is only a first step toward collaboration. Stakeholders need to get beyond informal handshake agreements largely dependent on personalities and unlikely to survive staff turnover or changes in leadership. To ensure the lasting, systemic change that this report contemplates, criminal justice and mental health policymakers will need to improve upon initial cooperative efforts, begin to collaborate, and, ultimately, enter into *partnerships*.¹

The impetus for collaboration can come from a variety of sources.² Sometimes, it is a tragedy involving an individual with mental illness that forces representatives of the criminal justice and mental health systems to recognize the need for working together more closely. This was the case in Seminole County, Florida, where a tragic shooting of a deputy by an individual with mental illness sparked cooperation among various stakeholders, which in turn prompted the creation of a task

1. Coalition-building experts stress the differences between coordination, cooperation, and collaboration, which reflect distinct degrees of commitment. In practice, however, these terms are used almost interchangeably. This report places a premium on partnerships, while recognizing the oftentimes difficult-to-distinguish dif-

ferences among coordination, cooperation, and collaboration.

2. A useful discussion of the elements of good coalition building, especially as they relate to the integration of criminal justice, mental health, and substance abuse systems, is provided in *The Courage to Change: Communities to Create Integrated*

force designed to improve system coordination.

Legislatures can also be extremely powerful in encouraging improved collaboration to address the issue of individuals with mental illness in the criminal justice system. In 1998, the California Legislature established the Mentally Ill Offender Crime Reduction Grant (MIOCRG) Program. The program provided \$50.6 million in grant monies for demonstration projects in 15 different counties that, collectively, target approximately 12,500 offenders with mental illness.³ To be eligible for a demonstration grant, the legislation requires counties to establish a Strategy Committee comprising criminal justice and mental health stakeholders.

At the local level, the success of cross-system collaboration often depends on strong leadership from high-ranking officials in both the criminal justice and mental health systems. These individuals can bring participants to the table, deal with conflicts that arise, and generally ensure that the partnership can overcome the inherent difficulties attendant to cross-system collaboration. One example of numerous such collaborative efforts is the Mental Health Coordinating Council in Travis

County, Texas. The Coordinating Council is headed by the probate judge and includes representatives from the local mental health agency, emergency services, the sheriff's office, the police department, the county attorney's office, social workers, consumer advocacy groups, the state hospital and others. The council meets once monthly to address issues of common concern to the participants. The probate judge develops meeting agendas, facilitates the meetings, mediates conflicts, and helps clarify legal issues.⁴

This report is replete with numerous, inspiring cases of stakeholders collaborating closely, across systems, and forming successful partnerships. In these cases, the stakeholders have cleared initial barriers to cooperation and coalition building, which are addressed in the introduction to this report. Furthermore, they have addressed three key issues, reviewed in this section, to ensure the long-term viability of the collaboration: obtaining and managing the resources to sustain the initiative; establishing guidelines for information sharing; and institutionalizing the partnership.

Services for People with Co-Occurring Disorders in the Justice System, National GAINS Center for People with Co-Occurring Disorders in the Justice System, December 1999.

3. California Board of Corrections, *Mentally Ill Offender Crime Reduction Grant*

Program: Annual Report, June 2000, available at www.bdcrr.ca.gov/cppd/miocrg/miocrg_publications/miocrg_publications.htm.

4. Barbara Misle, assistant county attorney, Mental Health Division, Travis County, Texas, interview, April 18, 2002.

24

Obtaining and Sharing Resources

POLICY STATEMENT # 24

Determine how the partners will make resources available to respond jointly to the problem identified.

An essential first step for communities or states interested in addressing mental health issues as they relate to the criminal justice system is to bring prospective partners to the table, define the problem, and establish which individuals will shepherd the partnership. After these issues have been resolved, however, numerous decisions remain before

the partnership can be launched. What will be the costs (both direct and in-kind) of operating this joint venture? Where will these resources come from? How will they be administered? The following recommendations serve as a guide to agents of change struggling with these questions.

RECOMMENDATIONS FOR IMPLEMENTATION

- a Identify the number of clients whom the prospective partners, under the current system, are serving in parallel systems and determine the nature of this overlap.**

Before the partners can develop a budget describing the costs of the joint venture, they will need to identify the number of people they will target and the needs of those individuals. To that end, they should analyze how their clientele overlap and then quantify that overlap. For example, the courts may work with the local mental health centers to identify a number of jail detainees who meet criteria for pretrial release and, prior to being charged, were receiving mental health services in the community.

Example: Department of Community and Human Services, Crisis and Engagement Services, Mental Health, Chemical Abuse and Dependency Services Division, King County (WA)

In an effort to lay the groundwork for collaboration between different service agencies, officials in King County collected data concerning the overlap between high utilizers of

substance abuse and mental health services and the jail population. By facilitating the cross-referencing of information between separate databases (with the appropriate protections for the privacy of identifying information), the Division of Crisis and Engagement Services discovered that, in fact, many of the individuals who were spending considerable time in substance abuse and mental health treatment facilities had also been arrested and incarcerated in the county jail multiple times. Though these individuals seemed to be benefiting very little from their involvement in these services, the cost of providing those services was high—approximately \$1.1 million for 20 individuals. Gathering this data helped officials throughout the mental health and criminal justice systems in King County to better understand their shared clientele and helped spur improved collaboration there.

"I believe there must be alignment between the mental health community, law enforcement, the courts, and corrections if we are to have any ability to deal with this ever spiraling issue of mental illness in our communities. Collaboration at the local level can only enhance problem solving."

**SHERIFF DAN
CORSENTINO**
Pueblo, CO

Source: Personal
correspondence

b Share resources among organizations to ensure an effective and efficient response.

Obtaining new dollars to support a partnership is difficult. Even when jurisdictions are successful in securing appropriations or a grant, this funding assistance is unlikely to cover all of the costs associated with the initiative. Accordingly, the partnering organizations will need to review their existing resources to determine how they can be shared or shifted to make the partnership work. In many cases, staff, space, equipment, or expertise donated by one or more of the partnering organizations is as good (if not better) than a contribution of actual dollars.

Example: King County (WA)

Partners in King County, Washington, each made considerable in-kind contributions to make their joint effort to develop a prebooking diversion program work. The Seattle Police Department, without new staff or resources, identified more than 100 volunteers from the existing ranks of the police force, who agreed to receive 40 hours of specialized training regarding people with mental illness, drug and alcohol problems, and developmental disabilities. Representatives of the treatment systems, consumers, and family members conducted the training, donating their time. For its part, the King County Hospital provided the space and part of the staffing required to reconfigure an existing psychiatric emergency room into a Crisis Triage Unit capable of managing pre-booking diversion referrals made by police officers.⁵

c Shift savings generated by the new response—or a related initiative—to the partnering organization in need of additional resources.

When the criminal justice and mental health stakeholders begin to implement a joint response to a segment of the population with mental illness in contact with the criminal justice system, the new approach is likely to generate

5. See "Creating Integrated Service Systems for People with Co-Occurring Disorders Diverted from the Criminal Justice System: The King County Experience," The Na-

tional GAINS Center for People with Co-Occurring Disorders in the Justice System, Summer 2000.

some costs savings for the criminal justice partner. For example, a small study of 46 participants in Project Link in Monroe County, New York, found that the partnership among various mental health organizations in the county and county government officials reduced the mean number of jail days per month for the program participants from 9.1 to 2.1 and the mean number of hospital days per month from 8.3 to 3. Based on per diem costs, this translates to a savings of more than \$23,000 in jail costs and more than \$155,000 in hospital costs for the 46 program participants.⁶

Partners should work together (ideally, before the costs savings are even realized) to redirect the resources saved to the organization or agency assuming the expense incurred by absorbing the additional clients. Moving fund balances to different state or county agencies is usually complex, and it often requires the involvement of a state budget authority and the legislature.

Example: Connecticut Jail Diversion Project

In Connecticut, in 2000, the General Assembly authorized the statewide replication of a successful jail diversion pilot program based in New Haven. To provide the state mental health agency with the resources necessary to expand the program, legislators worked with the state corrections department (which also operates all facilities in the state that house pretrial detainees), whose commissioner recognized that the expansion of the program would save a number of corrections beds and thus save the agency money.⁷ The General Assembly, with the consent of the corrections commissioner, effected the shift of approximately \$3.1 million from the corrections budget into the state mental health agency's budget.⁸

Partners may also decide to apply savings generated by another initiative to an effort regarding people with mental illness in contact with the criminal justice system.

Example: King County (WA)

In King County, Washington, partners used savings generated from the managed care system to fund the diversion programs they developed. The managed care system, when held accountable to its stated goal of promoting increased client choice and individualized and tailored care, can support jail diversion efforts. System integration advocates argued that a portion of the systems savings (“fund balance”) generated by the managed care model could be reinvested in services targeting those for whom the managed care paradigm worked least well—including people with co-occurring disorders involved in the justice system. This meant that fund balance dollars produced by the managed care process could be applied to supplementing the staffing needed to create the hospital's Crisis Triage Unit and the mental health court.

For services provided to custodial parents who qualify for Temporary Assistance for Needy Families (TANF) cash assistance or TANF-funded services, this entitlement may be an important resource. Generally speaking, TANF-funded services are more readily available than cash benefits, especially when

6. “Prevention of Jail and Hospital Recidivism Among Persons With Severe Mental Illness: Project Link, Department of Psychiatry, University of Rochester, Rochester, New York,” *Psychiatric Services* 50:11, November 1999, pp. 1477-80.

7. In fact, the state corrections system was so short on bed space that they contracted with the Commonwealth of Virginia to house 500 inmates in that state.

8. Ellen Webber, director of the Connecticut Jail Diversion Project, interview, March 16, 2002.

the eligible recipient is or recently has been incarcerated. Tapping TANF funds facilitates state and local government officials' efforts to make services such as case management, vocational rehabilitation, mental health and substance abuse counseling, and job training, search, and placement services available. Indeed, TANF funds have the potential to ease a financial burden for corrections budgets while putting little new strain on the mental health service budget.⁹

d Identify one of the partnering organizations—or establish a new entity—to serve as the locus for grants, new appropriations, and other resources contributed to the partnership.

Deciding which of the partnering organizations will be the recipient of a new appropriation or the share of a grant can be a thorny and divisive process. In some cases, it may make sense for the partners to establish an independent, not-for-profit organization, with representatives from each of the partnering organizations would help to govern, to receive and administer these funds.

Example: PERT, Inc., San Diego County (CA)

In San Diego County, in 1993, mental health and law enforcement professionals, consumers, and family members of consumers established a task force in response to several high-profile shootings of individuals with mental illness. The task force developed a series of Psychiatric Emergency Response Teams (PERT) to improve the response of the criminal justice system to individuals with mental illness. County and state agencies agreed to fund part of the initiative with a portion of the jurisdictions' share of federal block grant that the Substance Abuse Mental Health Services Administration administers. Members of the task force could not agree on which organization should receive the grant, so they formed an independent organization: "PERT, Inc." PERT, Inc. supervises the PERT staff and coordinates billing for services rendered. The board for PERT, Inc. is made up in part by NAMI board members and board members from the Community Research Foundation, the largest private, non-profit mental health service provider in the county.

9. See *Getting to Work: How TANF Can Support Ex-Offender Parents in the Transition to Self-Sufficiency*, Legal Action Center, Washington, D.C., April 2001; and *Finding the Key*, Bazelon Center for Mental Health Law, March 2001.

25

Sharing Information

POLICY STATEMENT #25

Develop protocols to ensure that criminal justice and mental health partners share mental health information without infringing on individuals' civil liberties.

Appropriate information sharing between mental health and criminal justice systems ensures that criminal justice officials make informed decisions regarding a defendant or offender and that providers meet the treatment needs of people with mental illness in the criminal justice system. Nevertheless, line staff and policymakers alike often cite information-sharing restrictions as one of the biggest barriers to collaboration between mental health and criminal justice system officials. Mental health professionals have legal and ethical obligations not to divulge clinical information without consent, unless certain conditions apply, including imposition of a judge's order. Law enforcement officers and prosecutors concerned about safety issues, judges who must make informed pretrial release and sentencing decisions, and corrections officers charged with maintaining safe institutions and providing consti-

tutionally adequate levels of care are all looking for information that will help them in their duties.

In fact, maintaining appropriate confidentiality of a person's mental health records, delivering effective mental health services, and ensuring the safety of the community and the victim are consistent goals. Moreover, partnerships exist in many jurisdictions in which officials have overcome traditional barriers to information sharing without endangering public safety, violating the ethics of providers, or invading the privacy of the individual.

Policy statements appearing elsewhere in this report include specific recommendations that explain how information can be shared appropriately within certain contexts. The recommendations below should serve as general guidelines regarding information sharing.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** **Ensure that mental health clinicians, law enforcement personnel, officers of the courts, and jail and corrections staff are familiar with and abide by state and federal law and regulations governing the transfer of mental health records and information.**

The laws of every state contain provisions that govern how mental health practitioners may share clinical information. While the statutes are not entirely consistent across state boundaries, they generally call for the patient to provide written consent if information is to be shared beyond the immediate clinical team currently providing services. Mental health providers are generally trained to take a conservative approach to information sharing, and for reasons tied to both ethics and liability many are reluctant to share clinical information without consent. Indeed, licenses for some mental health professions can be revoked if confidentiality rules are not observed. In some states, restrictions on the sharing of clinical information apply even when the patient is moving from one treatment setting to another. In most states provisions exist that allow for information to be shared in a health care emergency. Some states have specific provisions for sharing information with a law enforcement officer or agency if doing so, will benefit the patient.¹⁰

Federal statute and regulations also cover the transfer of information regarding treatment of someone for mental illness or a substance abuse disorder. Federal statute governing information related to substance abuse treatment is more ironclad than counterpart provisions covering mental illness treatment records.¹¹

Routine training for both mental health practitioners and criminal justice staff should include familiarization with laws and regulations covering confidentiality and the transfer of medical information. If possible, criminal justice and mental health trainers should find or create training sessions or other forums where issues of confidentiality and information transfer can be addressed in one place by staff from both fields with the goal of reaching a common understanding of the applicable laws.

Additionally, mental health agencies and criminal justice entities should examine internal policies to ensure that they reflect and encourage compliance with relevant laws and regulations.

"The criminal justice system and the local and state mental health systems are not set up to share information. They are set up to protect an individual's constitutional and statutory rights. The adversarial system currently in place is effective in reaching resolution on criminal cases. It is not a very effective system in resolving issues related to mentally ill defendants."

HON. MICHAEL D. SCHRUNK
*District Attorney,
Multnomah County, OR*

10. Indiana is an example of a state with such a statute.

11. See (42 U.S.Code §290dd-2).

b Obtain an individual's specific, written consent before a mental health agency or provider shares his or her information with criminal justice personnel, except when federal or state law (or a judicial order) supercedes.

Deeply ingrained in the training and ethical code of mental health providers is the principle that the individuals they treat have the right to determine who is to know that they are in treatment and what that treatment consists of. For this reason, the first option whenever there is a request for information or reason for information to be shared is to ask the patient to provide consent. In the majority of cases, individuals will sign a form they understand will help them receive needed or continued treatment. Even in instances where the law does not strictly require providers to obtain consent from a client for information to be transferred, the exercise can be an important way of demonstrating goodwill and building trust between providers and between the provider and the patient.¹²

Written consent should be drafted in a way that indicates the purposes for which the requested information may be used, the period for which consent is valid, and with whom it may be shared. (See Policy Statement 7: Appointment of Counsel for more on the role of defense counsel in obtaining consent.)

c Limit access to mental health databases to authorized mental health personnel; provide information about an individual's mental health status and treatment on a case-by-case basis only.

In view of the confidentiality statutes and ethical standards already mentioned, and recognizing the limitations of most mental health system databases, access to them should be limited. Mental health staff should be the only personnel to access information maintained in mental health databases. Protocols should be put in place to ensure that information provided to clinical staff is kept confidential.

By the same token, mental health staff should not present unreasonable roadblocks to information flow that can help law enforcement, courts, and corrections officials make informed decisions about individuals in their custody. If possible, they should set up protocols that can enable an appropriate flow of information to law enforcement, detention, and other criminal justice personnel while preserving the confidentiality and right to privacy of individuals in the system.

Mental health systems in this country maintain databases for a variety of reasons. Some may hold clinical treatment information; many more are main-

¹². At the same time, providers and criminal justice officials should exercise good judgment. In situations where consent is not required, there is no point in seeking it from someone who is not likely to provide it.

tained exclusively for billing purposes. It should be noted that, currently, few databases can be counted on to provide comprehensive information about the individuals treated in the system. The information usually sought by law enforcement and jail officials, however, can be obtained by development of alternative protocols or practices. (See Policy Statement 13: Intake at County / Municipal Detention Facility.)

d **Ensure that mental health information shared is the minimum needed to address the intended recipient's needs.**

The nature of information that can be shared may be governed by state statute. In some places it may be limited to diagnosis, admission to or discharge from a treatment facility, and the name of any medication prescribed. For many purposes, this limited information may suffice. On the other hand, there may well be instances in which more information would be appropriate and helpful in developing treatment plans for individuals whose needs are not immediately apparent or who have complex histories with a bearing on future treatment decisions.

e **Ensure that information shared for the purpose of arranging appropriate treatment not be used to jeopardize a person's rights in criminal proceedings.**

Information intended to help police or jail officials arrange for appropriate treatment for an individual with mental illness who has been arrested or is in custody may prove harmful if utilized by a prosecutor in criminal proceedings. It is not always in the best interests of an individual for his or her mental illness diagnosis to be generally known. While mental illness may be an obvious factor in many cases, it may not come to the fore immediately in others. In such cases, only the individual (and counsel) should determine whether it is appropriate to bring the fact of mental illness into the case.

f **Encourage consumers to engage in advance planning that includes consent for mental health providers to share specified information with criminal justice authorities if necessary.**

One promising mechanism for allowing a consumer to decide whether and how much information should be divulged is through some form of advance planning. Some consumers now write psychiatric advance directives to govern

their care when they become incompetent or when they are involuntarily hospitalized. A more practical alternative for mental health/criminal justice partnerships is a specific form of advance planning relating to any future contacts with the criminal justice system. Individuals who have had previous contact with the law or individuals whose behaviors put them at significant risk should be offered the opportunity through the mental health system to indicate consent for sharing of certain information. Especially important is the sharing of the name of their case manager or other provider who, once notified, can follow up to ensure appropriate clinical treatment is furnished following the incident.

g Eliminate any reference to the identity of the person with mental illness when turning over information for research purposes or for systemic assessments of criminal justice systems.

There is no need for information collected and used for the purposes of research or data collected to assess the effectiveness of systems to retain identifying information. Data such as name, address, phone number, birth date, social security number, and other information that clearly points to the specific individual should be redacted before such databases are compiled or before mental health system information is shared within criminal justice systems. If the particular analysis to be conducted does require such identifiers, there must be procedures in place to keep these confidential and thus they should be stripped from the analysis and aggregate reports that are eventually prepared and circulated.

h Criminal justice authorities should share information (with consent) with the mental health system in order to facilitate appropriate and quick follow-up services from mental health upon release.

As recommended elsewhere in this document, correctional facilities should engage inmates in pre-release planning, which should include a discussion of the necessity of sharing clinical information with community providers in order to ensure continuity of care. Consent should then be readily obtainable and either a detailed summary or a complete clinical record can be transferred to the appropriate community mental health program. As in other information sharing situations, information shared should be the minimum necessary for the purpose at hand. (See Policy Statement 21: Development of Transition Plan.)

26

Institutionalizing the Partnership

POLICY STATEMENT #26

Institutionalize the partnership to ensure it can sustain changes in leadership or personnel.

Successful partnerships depend on collaboration between individuals. Over time, officials in mental health and criminal justice agencies may develop exemplary working relationships that lead to improved collaboration and better service to individuals with mental illness. It is crucial, however, that the leaders of collaborative efforts make an ef-

fort to institutionalize their partnership, ensuring its longevity beyond their own tenure. The following recommendations suggest some steps that can be taken to ensure the endurance of collaborative efforts between the criminal justice and mental health system partners.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** Charge an individual with maintaining the vision of the collaborative effort and managing on a day-to-day basis communication among staff working for each of the various collaborating organizations.

Interactions among separate organizations—each with its own goals, policies, jargon, and organizational structures—tend to be extremely complicated. Successful collaboration often requires communication between multiple individuals across organizational lines. Many successful partnerships can be traced to the establishment of a position, sometimes referred to as a “boundary spanner” position, whose responsibility it is to be the traffic cop for the various people responsible for managing this communication on a day-to-day basis.

The organization employing the boundary spanner often depends on a variety of factors, such as local politics, history, economics, and personalities in each community. Nevertheless, researchers have found some common aspects

of successful boundary spanners. A clear conceptualization of the functions of a boundary spanner position is often more important than the exact location of the position. In addition, it is important to find experienced, well-respected individuals to staff these positions; these individuals are often veteran staffers who are familiar with the formal and informal norms of multiple systems. Boundary spanners should be well compensated and given a title that appreciates the importance of their cross-systems work.¹³

Example: **Court Monitor, Mental Health Court, King County (WA)**

The court monitor in the King County Mental Health Court serves as the link between the criminal justice and mental health systems. The court monitor first interviews candidates for the Mental Health Court in an effort to understand the defendant's mental health issues. She then requests approval for the release of information from the defendant and communicates with the case manager who handled the defendant's past treatment. Next, the court monitor prepares a report of the defendant's history and a proposed treatment plan to the court while explaining the workings of the court to the defendant. Finally, the court monitor meets with the public defender and prosecutor to discuss the case.¹⁴

b

Determine how to share responsibility for positive and negative outcomes.

Partnerships are often severely tested when the joint initiative draws bad publicity or suffers an unfortunate turn of events. For example, joint ventures are typically dissolved (sometimes appropriately) when a program participant commits a high-visibility crime. In other cases, a lawsuit involving a person working on the initiative can threaten the sustainability of a partnership.

Partners should establish a plan, in advance, to respond to incidents that attract negative publicity in order to ensure that each does not simply engage in finger-pointing. This plan should include an agreement on how to respond to inquiries from the legislature, other state or local governing bodies, the media, or attorneys representing a plaintiff.

Officials working together as part of a collaborative venture should develop a similar plan to respond to positive news trumpeting the success of an initiative. In some cases, failing to share credit or to recognize the value of the partnership publicly can be as destructive as an uncoordinated response to negative publicity.

13. Henry J. Steadman, "Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems," *Law and Human Behavior* 16:1, 1992, pp. 75-86.

14. John S. Goldkamp and Cheryl Irons-Guynn, *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage*, Bureau of Justice Assistance, April 2000.

C Prepare contracts or memoranda of understanding defining the terms of the partnership.

Documents that describe the nature and scope of collaboration between distinct agencies or organizations can be crucial to solidifying a partnership. Contracts or memoranda of understanding (MOU) also provide a guiding document to which partners can turn to resolve confusion or disagreement. The structure of any such agreement will vary depending on the partners involved, the goal and scope of the collaboration, local policies and regulations, and many other jurisdiction-specific issues. Despite these necessary variations, certain elements are consistent across such agreements, and criminal justice and mental health partners should consider referring to the following list when developing written agreements.

Elements of a successful memorandum of understanding:

- Well-defined target population
- Overarching purpose that underlies the agreement
- Discussion of any relevant legislation or regulations
- Elaboration of specific goals, both shared and germane to a particular partner
- Definition of any new responsibilities
- Time lines for the implementation of new initiatives and for review of the implementation process
- Provision for the resolution of disputes

Training Practitioners and Policymakers and Educating the Community

The successful implementation of many (if not all) of the policy statements in this report depends on criminal justice staff who understand mental illness and the mental health system. Similarly, failure by mental health professionals to learn how the criminal justice system works in their jurisdiction will undermine any efforts to build partnerships between the criminal justice and mental health communities. While training is not a panacea—and even with the best education and guidance, criminal justice or mental health personnel may not always know what the best course of action is—it can significantly improve services to people with mental illness, their families, and the community and reduce the stigma associated with mental illness. For these reasons, training (and cross-system training) must be a part of any comprehensive effort to improve the response to people with mental illness who come into contact with the criminal justice system.

In addition, because the involvement of individuals with mental illness in the criminal justice system is a problem that concerns the community and requires solutions at the local level, it is incumbent upon criminal justice and mental health stakeholders to educate the community about the issue.

Every organization, at a minimum, should expect the following of any of their employees who come into contact with a person with mental illness:

- minimize the risk of injury or harm to the responder, the community, and the person with mental illness;
- respect the individual and the rights of that person;
- be conscientious of responses most likely to aggravate or improve the condition of the person;
- understand that a person with mental illness is no more likely to be violent than a person without mental illness (except in cases where a mental illness is accompanied by a co-occurring disorder); and

- know, at least generally, the mental health resources that are available to them.

Familiarizing practitioners with the above issues, while a huge accomplishment in and of itself, is usually not sufficient to ensure the successful implementation of a program that targets people with mental illness. Whereas every good training program ensures that all staff have a basic familiarity with mental illness, agencies differ considerably in their efforts to provide staff with the additional expertise needed to implement many of the policy statements included in this report. Indeed, many of the policy statements in this report contemplate extensive training that goes far beyond the fundamentals described above. For example, a defense attorney needs specific skills to represent effectively a client who has a severe mental illness and who is offered an opportunity to participate in community-based supervision in lieu of incarceration.

In some jurisdictions, policymakers insist that all personnel have some elements of a sophisticated

understanding of mental illness and appropriate responses. In other agencies, officials identify only a special cadre of staff to receive highly specialized training. In smaller jurisdictions, including most of those in rural areas, the size of the police agency and jail and court staff is so small that it is more likely that training and experience will be gained in less structured or specialized formats. The policy statements in this section of the report recognize that approaches to ensuring that staff have a sufficient set of skills, background, and general degree of competence must vary accordingly.

At the same time, the recommendations for implementation of the policy statements vary according to the criminal justice audience (i.e., law enforcement, courts, and corrections). For example, sworn staff in large police departments or state prison systems typically are required to participate in extensive annual in-service training programs. On the other hand, training for judges, prosecutors, or defense attorneys is less routine; there are fewer opportunities available to incorporate mental health issues into existing training programs.

That said, there remain several common elements of an initiative to improve practitioners' skills in responding to people with mental illness. The policy statements are organized according to these elements:

- Training goals and objectives
- Training curriculum
- Trainers
- Evaluation of training

One theme that is apparent in nearly every training initiative that addresses mental health issues as they relate to the criminal justice system is the need for practitioners to be educated about the missions, procedures, and policies of the systems with which they collaborate. The mental health treatment system and the various parts of the criminal justice system have different—sometimes even contradictory—goals and methods. For example, treatment providers and parole officers may view very differently a consumer's incomplete adherence to a treatment plan, such as missing counseling sessions. Whereas many treatment providers view such setbacks as part of the recovery process, a parole officer may view a temporary lapse in treatment as grounds for violation and reincarceration. Cross-training efforts, in which members of different criminal justice and mental health agencies educate one another about the basic premises and objectives of their various systems, is crucial to helping bridge these gaps that may stifle successful collaboration.

When designing and implementing training, agencies should be cognizant of local, state, and federal standards. A curriculum that has been successful in one state may not be effective in another due to different laws, standards, and requirements. In Oklahoma, for example, police academy training is state-run and individual agencies do not have control over the training mandated for new recruits. Additionally, commitment laws may vary drastically from one state to another. In Florida, under the Baker Act, only certain facilities are designated for people with mental illness whom officers believe are a danger to themselves or to others.¹

Recognizing the value of training while acknowledging the expense of providing this service, this section of the report suggests in numerous places how jurisdictions can minimize the expense of training by tapping existing resources in the community or government. Stakeholders should also recognize the value of informal training, often known as experience exchange. For example, a ride-along program that exposes mental health service providers to the daily experiences of a police officer is not costly, except in terms of staff time, but is instrumental to improving collaboration and trust across systems. The same is true for training programs that allow criminal justice personnel to visit mental health crisis centers or community mental health facilities.

1. The Florida Mental Health Act, a comprehensive revision of the state's mental health commitment laws, is widely referred to as the Baker Act, in honor of the bill's sponsor, State Representative Maxine Baker. The Baker Act

was passed in 1971 and has been amended several times since. In 1996 the act underwent a major reform, which included increased protections for individuals in the commitment system, strengthened consent and guardianship

Paying for Training

Training, in and of itself, can be an expensive undertaking. Many agencies or departments already have extensive training programs in place. Expanding training topics to include mental health issues (or to improve the thoroughness with which mental health issues are addressed) increases further the time staff are not at their posts or in court. This, in turn, can increase an organization's overtime costs or relief factor. There are other expenses beyond the staff costs: trainers, training facilities, and written materials, to name a few. Despite these costs, many city, county, or state agencies simply cannot afford to refrain further from training their staff on these issues. Effective training can have a dramatic impact on the number of injuries, and deaths, that staff untrained to respond to a person with mental illness sustain. Such incidents generate high costs—both directly (overtime, compensatory time, lawsuits) and indirectly (community trust). Nowhere in the country have such impacts of training been touted as impressively as in Memphis, Tennessee where the police department's pioneering work training officers to serve on crisis intervention teams reduced dramatically staff injuries and use of lethal force incidents.²

Although the discussion in this section of training curricula for various criminal justice and mental health constituencies recommends numerous topics that should be included in effective training, it is by no means an exhaustive description. It is important for every community to evaluate its own needs and resources when determining what information should be included to improve the response to people with mental illness who come into contact with the criminal justice system.

"Money for training should be on top of the priority list. Without training, we cannot implement the recommendations in this report."

**SENATOR
LINDA BERGLIN**
*Chair, Health, Human,
Services & Corrections
Budget Committee, MN*

Source: Interview, 11 January, 2002, Washington, DC.

provisions, and provided for significant record keeping regarding commitment proceedings. Annual reports regarding the implementation of the 1996 reforms are available at: www.fmhi.usf.edu/institute/pubs/pdf/abstracts/bakeract.html.

2. Randolph Dupont, "How the Crisis Intervention Team Model Enhances Policing and Community Mental Health," *Community Mental Health Report*, November/December 2001.

27

Determining Training Goals and Objectives

POLICY STATEMENT #27

Determine training goals and objectives and tap expertise in both the criminal justice and mental health systems to inform these decisions.

The goals, development, and administration of a training program will vary considerably depending upon the audience. Across the criminal justice and mental health systems there are numerous discrete training audiences—police officers, corrections officers, prosecutors, community members, mental health practitioners, and many more. Even within the distinct parts of the criminal justice system, such as the court, training audiences, and thus goals, will differ; training programs for public defenders, prosecutors, and judges will all be unique.

Training is such a cornerstone for most criminal justice organizations that these agencies typi-

cally have an individual—or sometimes an entire division—responsible for administering the training programs within the agency. Although these officials will play a key role in implementing the recommendations described below, it is important that they tap the expertise of mental health experts to develop training curricula that deals with mental illness. Similarly, officials responsible for training mental health practitioners will need to reach out to criminal justice professionals when preparing training materials regarding the operation of the criminal justice system and the delivery of services to people who have been involved with the criminal justice system.

RECOMMENDATIONS FOR IMPLEMENTATION

a Identify the training audience.

Criminal justice practitioners have often observed that a generic training program intended for anyone working in the criminal justice system is of little value. For example, when a generic training program discusses people with mental illness in the community, correctional officers are likely to view the material as largely irrelevant.

Various authorities could prompt a training initiative by singling out a particular segment of personnel in the criminal justice or mental health systems who should develop an improved understanding of issues concerning mental health and the criminal justice system. For example, the chief executive of a department or agency may decide that his or her entire department, or a particular subset of the organization, needs training. A corrections commissioner may choose to require certain staff, such as those responsible for intake mental

health screening, to receive more intensive and specialized mental health training, in addition to the pre-service and in-service training provided to all uniformed staff. In other cases, an internal curriculum development committee may arrive independently at that same decision. In still other jurisdictions, a cross-system coalition, task force, or some other body that reflects a partnership among various stakeholders in the criminal justice and mental health systems may determine that a particular constituency needs training.

Small, rural communities, which often do not have the resources to develop and implement training initiatives for one constituency within the criminal justice system, should consider coordinating with neighboring jurisdictions. For example, it may be only be feasible to train probation officers in a small rural county if probation officials in neighboring communities agree to include their staff among the trainees and supply resources to make the training possible.

Training criminal justice or mental health personnel alone is not sufficient to implement many of the recommendations in this report. Indeed, prospective training audiences should be expanded to include nontraditional audiences; educating consumers, their families, victim advocates, public policymakers, and even the public at large, is essential. For example, family members and friends of people with mental illness should be educated about the type and amount of information they should convey to dispatchers when making a call for police service and how to encourage a loved one who is incarcerated to seek treatment. Victim advocates need to be in a position to explain simply but thoughtfully to crime victims the conditions of release imposed on a probationer or parolee with mental illness.

b

Develop a training committee or task force to focus on the issue of people who have mental illness and are involved in the criminal justice system or at high risk for such involvement.

A committee or task force can broaden the knowledge base of the individuals involved in guiding training for a particular department or system. It also provides a mechanism through which criminal justice agencies and mental health practitioners, consumers, family members, and other stakeholders can collaborate to educate personnel in various departments.

The chief executive of the criminal justice agencies (e.g., police chief executive, sheriff, director of public safety, presiding judge, court administrator, jail administrator, corrections director), whose employees may be the primary target audience for the training, should oversee the formation of the task force, in consultation with the corresponding mental health authority. This level of involvement from top-ranking decision makers conveys to all subordinate staff the importance and value of the training program. It also helps to ensure that, ultimately, the person or division within an agency charged with coordinating training activities will likely be responsible for administering any training initiative that is developed by a cross-system task force.

A task force should have diverse membership that includes representatives of other criminal justice agencies, departments, state and local mental

health agencies, and mental health service providers to identify or tap resources (e.g., facilities, training materials, trainers) that might not otherwise be available to the initiative. Given the different situations faced by jurisdictions, the precise number and type of task force members will vary locally. Critical stakeholders for training development can include representatives from law enforcement, the judiciary, prosecution, defense, pretrial services, probation, mental health prosecutors, community mental health professionals, substance abuse treatment providers, family members, victim advocates, consumers (especially those who have been incarcerated), and corrections personnel.

Example: Forensic Intervention Consortium, Albuquerque (NM)

This interagency partnership resolves issues and barriers that people with mental illness face who become, or are at risk of becoming, involved in the criminal justice system. The consortium unites consumers, their family members, representatives of law enforcement and judicial agencies, treatment providers, advocates, and other representatives from the community. The consortium supports The Albuquerque Crisis Intervention Team (CIT), and CIT members are trained by consumers, family members and mental health professionals on de-escalation techniques, assessing consumer's history, medication information and support systems, and the use of pretrial services that are sensitive to consumer needs.

Example: Mental Health Task Force, Fort Lauderdale (FL)

Established in 1994, this task force brings together community leaders from the criminal justice, mental health, and law enforcement communities to tackle concerns regarding the treatment, management, and community placements of defendants with mental illness. As a result of the task force's success, a mental health court was established in Broward County, Florida, to address the needs of people with mental illness. The role of the task force was expanded in 1997 to create five subgroups (consisting of representatives from law enforcement, criminal justice, and mental health) that identify solutions to various obstacles facing people with mental illness in the criminal justice system. The subgroups' objectives are the integration of community-based mental health systems into the criminal justice system, and the appropriate diversion of consumers from arrest and incarceration.

C Determine training goals and objectives.

Before the training committee can begin developing the training curriculum and identifying trainers, members must determine what outcomes they expect from the training. For example, the goal may be to implement a particular policy statement in this report, or it may be more general, such as reducing the stigma associated with mental illness or reducing the number of police referrals to detention that could more effectively be diverted to the mental health system. Training goals should be based on improving awareness and developing particular competencies. Specific goals for different training audiences are discussed in more depth in the subsequent policy statements and recommendations. One goal that should underlie any training initiative is to help criminal justice and mental health personnel better understand the components and methodologies of the different systems. This is especially important at the outset of an effort to improve collaboration between the two systems.

d**Evaluate existing training materials, identify gaps in the curricula, and tap available resources to address these gaps.**

The coordinators of a training initiative should determine what training materials already exist in agency curricula to address the specified goals and objectives, where deficiencies exist, and where additional community resources can be brought to bear. Before developing training for their Crisis Intervention Teams, for example, the Montgomery County, Maryland, Police Department enlisted the help of NAMI to conduct a needs assessment. The assessment helped the department identify areas in which training was needed and community resources that could assist with that process.

Once the agency has identified the gaps in its existing training, the committee should tap all available resources for developing the material. For example, agencies should solicit training materials from other agencies or programs. Materials that are obtained from other agencies should be tailored to the unique needs of the jurisdiction. Jurisdictions should build on the successes of others and then, based on their own needs assessment, shape the training. This should all be done in partnership with relevant stakeholders.

Example: Roanoke County (VA) Police Department

When the Roanoke County Police Department wanted to develop a CIT program, the county sent a sergeant and a mental health practitioner to Albuquerque, New Mexico, to observe their 40-hour training class. The team left with the PowerPoint® outline and notes of the Albuquerque training. They presented these materials to the relevant stakeholders in Roanoke and adapted it to the needs of their community.

Local colleges and universities often are an excellent resource in developing training programs for criminal justice and mental health personnel. Not only do academic institutions frequently have experience with cross-training strategies, but they also help to minimize the cost of implementing the training initiative. In addition, the involvement of academic partners may prompt research projects and grant proposals, which can improve knowledge in the field and bring attention to successful training and collaborative endeavors.

Substance abuse treatment programs that work with people arrested, detained, or incarcerated are likely to have experience developing cross-trainings. Given the three-way overlap among issues of criminal justice, mental health, and substance abuse, involving these programs is likely to greatly enrich the training. Community mental health centers and other local partners, such as board members of local advocacy groups like NAMI and mental health associations, also may be able to donate space for training, training materials, and staff time.

Example: Seminole County (FL) Sheriff's Department

When it became unfeasible for the Seminole County Sheriff's Department to hold their own 40-hour training course, deputies were sent to the Florida Regional Community Policing Institute to participate in their training on responding to people with mental illness.

28

Training for Law Enforcement Personnel

POLICY STATEMENT # 28

Establish new skills, recruit, in-service, and advanced skills training requirements for law enforcement personnel about responding to individuals with mental illness, and develop curricula accordingly.

Training for law enforcement personnel is classified according to the period when training is received and the depth of the training provided. This report uses the following terms to describe these different levels of training:

- **New skills (basic) training.** This training is often instituted at the outset of a new departmental initiative to ensure that all personnel have a basic level of knowledge concerning mental illness. It is typically provided when personnel have not received any of the training listed below or if a department-wide refresher is warranted.
- **Recruit (pre-service/academy) training.** Training required by police and sheriffs' departments for new recruits at the academy. Recruit training includes curricula on criminal law, defensive tactics, conflict management/crisis intervention training, and many other topics. Content and length of training offered varies in each jurisdiction depending on state and local guidelines.
- **In-service training.** Annual training required by most jurisdictions of all officers. Training topics can include orientation to the agency's role, purpose, goals, policies, and procedures; working conditions and regula-

tions and firearms qualifications; any new department policies or procedures; and relevant legal updates. In-service requirements differ in every state and requirements can change annually depending on state and/or local guidelines.

- **Advanced skills (specialized) training.** Training provided, often to a select group of staff, to prepare them to take part in a special departmental initiative. In the case of mental illness, advanced training is generally offered to officers who will participate on Crisis Intervention Teams (CITs) or other specialized units responding to calls involving mental illness.

The following chart describes suggested training topics and suggested hours for different levels of law enforcement training:³

3. Many training topics in this chart are relevant for various levels of training. Accordingly, the depth in which these topics are covered will depend on the time and purpose of the training. For example, a topic may be covered briefly in new-skills

training and covered in more depth during in-service refresher courses. It should be remembered that training curricula for law enforcement personnel should be tailored to be consonant with state and local mandates.

Training Topics for Law Enforcement Personnel*

	New Skills 2 hours	Recruit 8-15 hours	In-service 20 hours	Advanced 40 hours
A. UNDERSTANDING MENTAL ILLNESS				
1. Who and where are people with mental illness	X	X		X
2. Differences between mental illness and developmental disabilities		X		X
3. Differences between mental illness and neurological disorders (epilepsy, Alzheimer's disease, Tourette's syndrome, and autism)			X	X
4. What is mental illness? Specific mental illnesses		X		X
5. Common medications and side effects	X	X		X
6. Co-occurring disorders	X	X	X	X
7. Attitudes about mental illness (misconceptions, discrimination, and stigma)	X	X	X	X
8. Cultural and gender differences			X	X
B. STATUTORY INFLUENCES ON POLICE RESPONSES				
1. Federal laws				
a. Rehabilitation Act of 1973		X	X	X
b. Americans with Disabilities Act (ADA) (1990)	X	X	X	X
c. Civil Rights Act (1983)	X	X	X	X
2. State and local statutes				
Review of specific state statutes and local ordinances	X	X	X	X
Civil liability of police officers		X	X	X
3. Confidentiality issues				
Confidentiality of medical information	X	X		X
Police report writing		X		X
Limits of information sharing	X			X
C. POLICE RESPONSE TO CALLS FOR SERVICE				
1. On-scene assessment				
a. Recognizing characteristics of impairments and crisis behavior		X	X	X
Signs and symptoms of mental illness—verbal and behavioral cues	X	X	X	X
Medical or situational causes of crisis behavior		X	X	X
b. Crisis intervention				
De-escalation techniques/communication skills	X	X	X	X
Suicide prevention and other high-risk situations	X	X	X	X
Victim/witness assistance	X	X	X	X
2. Response Options				
a. Noncustodial police options				
Counseling, release and referral		X	X	X
Voluntary emergency evaluation and noncustodial transport		X	X	X
b. Partnerships with mental health resources				
Working with community-based resources	X	X	X	X
Local hospital-based psychiatric and substance abuse services		X		X
NAMI and other advocacy organizations	X	X		X
Mobile Crisis Teams and community-based services and supports	X	X	X	X
3. Booking				
a. Custodial police options				
Arresting and interviewing suspect with mental illness		X		X
Involuntary emergency evaluation and custodial transport		X	X	X
Involuntary commitment orders and civil criteria	X	X	X	X
b. Police lockup				
Suicide screening	X	X	X	X
Medications management				X
4. Follow-up				X

*Many of the same topics are suggested for each training type. There will be differences, however, in the detail provided. For example, in the basic training, participants would be given only an overview of the topic, while the in-service or advanced training would be more in depth.

RECOMMENDATIONS FOR IMPLEMENTATION

a Provide at least two hours of new skills training regarding mental health issues to all law enforcement personnel who come into contact with people with mental illness.

In every jurisdiction, a lead training official or a training development committee is likely to identify law enforcement personnel who interact regularly with people with mental illness but have received little or no meaningful training on this subject. These staff, who have already met their recruit training requirements but are not prepared to take refresher courses during in-service training sessions, need new skills training.⁴ Recipients of this training should include call takers and dispatchers, front desk personnel, new hires, and patrol officers, as well as some detectives, drug-enforcement officers or others. Depending on the size and needs of a particular jurisdiction, it may be necessary to train additional personnel not covered in these categories, such as communications officers, or other civilian personnel.

New skills training should occur at the outset of any new departmental initiative regarding mental illness. The first goal of this training is to teach department personnel and affiliated staff to recognize signs of mental illness so they can respond accordingly. The purpose of this training is not to enable these line staff to be diagnosticians; rather, officers and staff should emerge from this training capable of identifying observable behaviors that might point to the existence of mental illness. Furthermore, officers should be encouraged to consider how a potential mental illness may have contributed to an incident.

The second goal of this training is to teach officers and staff to stabilize and de-escalate the situation, while conveying an attitude of respect for people with mental illness and their families. They must understand relevant statutes and how to respond to not escalate the problem while a response is developed. By helping personnel to understand how they may inadvertently use language or take actions that stigmatize mental illness, trainers can also teach police personnel to change actions that may previously have been viewed as disrespectful. To this end, the direct involvement of consumers and family members in this new skills training will help to emphasize destigmatization as a training goal as well as the partnership between mental health personnel, advocates, and law enforcement personnel. The importance of partnerships can develop from the start of an officer's career. (See Policy Statement 33: Identifying Trainers, for more on incorporating consumers and family members into training initiatives.)

"I want the first person who touches me to be educated."

JACKI MCKINNEY

*National People of Colour
Consumer/ Survivor
Network*

Source: Panel discussion, meeting regarding mental health court grant program, March 18, 2002, Chicago, IL

4. It may be appropriate to provide new skills refresher training even for staff that has received in-service training about mental illness.

Third, this orientation to mental health issues for personnel should teach them the importance of getting the right assistance and referrals for those with mental illness and victims of crime. Understanding local resources, their criteria for gaining access, and other sources of assistance will be of tremendous benefit to personnel.

b Incorporate at least eight (and as many as fifteen) hours of training in general mental health issues into existing recruit (academy-level) training programs for law enforcement staff.

Recruit training refers to the fundamentals taught to each new law enforcement officer (“recruits”). Regardless of educational level attained, all new recruits are required to train in the academy before beginning service at a law enforcement agency. (The duration of academy training for lateral transfers will vary by state.) Academy-level training should incorporate at least eight hours (and as many as fifteen) of training on general mental health issues. These may be integrated into existing training modules. State mandates for training and existing curricula differ across jurisdictions. Agencies will need to tailor training models to their unique needs and requirements.⁵ (See chart for suggested training topics.)

Given the complex nature of many situations encountered by law enforcement officers, recruit training should touch on signs and symptoms of mental illness, dual diagnosis of mental illness and drug/alcohol abuse, and related issues. Again, although recruits cannot and should not be trained as diagnosticians, they must be trained to respond to a range of aberrant behavior, regardless of whether it can be attributed to mental illness, a medical disorder such as epilepsy, drug abuse, or a combination of these factors. (See Policy Statement 4: On-Scene Response, for a more thorough discussion of people with co-occurring disorders, especially as they relate to law enforcement; also Policy Statement 37: Co-occurring Disorders.)

After finishing academy training, recruits (now considered “new hires”) are assigned to work with more senior Field Training Officers (FTOs) before beginning independent duty. Like all new employees, new officers are extremely impressionable. FTOs are responsible for introducing the new officers to agency culture and priorities. Additionally, the FTO may contribute to the new officer’s patterns of behavior. For these reasons, it is important that among the issues FTOs review, they understand the recruit mental health training to be able to reinforce topics covered at the academy.

To complement pre-service training for recruits, law enforcement agencies should make an effort to acquaint new hires with community members who

5. Agencies have different minimum educational requirements for new recruits ranging from a high school diploma, to an associates degree to a bachelors degree. As a result, when developing training for new recruits, educational re-

quirements must be taken into consideration. If one agency requires a four-year degree, and another requires very little formal education, the kind/level of training may be influenced.

have mental illness and family members of people with mental illness. Familiarity with consumers is of particular importance, as many new officers may have had little to no contact with this population. Officers should be encouraged to visit consumer clubhouses and peer support projects, offer to sit on ACT program boards of directors, speak at local mental health group meetings, and participate (when invited) in social events where consumers are regularly present. Interactions with people who have mental illness who are not in crisis can put a “human face” on mental illness that will challenge myths or misconceptions officers may have.

Example: Long Beach (CA) Police Department

The Long Beach Police Department requires that all new recruits attend “Field Contacts with People with Mental Illness.” Through this course, recruits are introduced to consumers both in the classroom and in mental health facilities.

Example: Montgomery County (MD) Police Department

The Montgomery County Police Department holds part of its training in the physical space of a public mental health facility to familiarize officers with people with mental illnesses.

Through such training exercises, officers see that people with mental illness do not always exhibit signs of their condition. The officers also come to understand the effects of unintentionally stigmatizing people with mental illness, and the impact that an inappropriate response in a situation involving mental illness can have on a person, a family member, the victim, or the community.

C Provide to patrol officers at least twenty hours, over a three-year cycle, of in-service training about mental illness that includes in-depth reviews of topics covered generally in recruit training and on additional topics.

As discussed at the outset of this policy statement, in-service training refers to periodic courses provided to all officers at some interval (e.g., annually, biannually) to expand on previous training or as a refresher. Though some of these topics may be addressed in new skills or recruit training, in-service training is an important opportunity to reinforce the department’s sensitivity to people with mental illness and to update staff about changes to the department’s response protocols. At least twenty hours of in-service training should be provided over a three-year cycle. In some cases, it may be inappropriate to wait until such training sessions; in such an event, the updates can be provided during informational roll calls, integrated into related modules such as those on use of force, cultural diversity, or special populations. Stand-alone modules are preferable, but recognizing the many mandate training topics, an integrated

model that uses some stand-alone modules may be necessary. Issues such as the difference between mental illness and disorders such as epilepsy or autism, cultural and gender differences among individuals with mental illness, and medication issues may all be suitable topics for in-service training (see chart for more suggested topics).

Example: Seattle (WA) Police Department

The Seattle Police Department requires all officers to attend a mandatory eight-hour block of instruction to develop an adequate competency level when encountering citizens with mental illnesses.

Trainers should consider including nontraditional exercises such as having police officers attempt tasks associated with daily living while being exposed to “voices.” Training should also include opportunities to meet with consumers and their families in the field, at clubhouses, shelters, soup kitchens, and NAMI support parties and meetings, just as is recommended for recruits. In addition, training should provide the chance for law enforcement officers to visit crisis centers and mental health facilities in order to gain resource awareness. Officers should be given ample opportunity to practice de-escalation techniques, such as talking to the person with mental illness and waiting out a violent episode, as well as to run through diversion protocols that rely on contacting community-based mental health services and supports. (See Policy Statement 3: On-Scene Assessment, for more on de-escalation techniques.) Role-playing exercises are one way to help officers model these behaviors prior to using them in the field. As a caution, the training facilitator should carefully monitor role-playing exercises. When left unchecked, officers can disengage and not fully participate in role-play exercises or, at the other extreme, participants can become overinvolved to the detriment of the class and ultimately to the detriment of people with mental illness.

Example: Montgomery County (MD) Police Department

The Montgomery County Police Department employs an exercise in which officers are required to wear headphones that blare loud music and voices, conveying disconnected thinking. Officers are asked to go about their routine tasks while wearing the headphones. The purpose of the activity is to simulate some of the challenges that people with mental illness face.⁶

For larger jurisdictions, more sophisticated training technologies may be available, including computer-simulated shoot/don't shoot scenarios or other media requiring officers to make split-second decisions involving people with mental illness. In these situations, what the officer chooses to do determines what he or she sees next. These methods enhance critical-incident decision making skills and promote compliance with use of force protocols.

6. See www.power2u.org (the National Empowerment Center) for more on the cassette tape series “Hearing Distressing Voices,” which employs this training technique.

This technology could be used in this context so officers can see the results of their decisions in a training environment. Videotapes are useful for refresher courses or roll-call training, as they usually succeed in getting people talking. They can augment discussions and stimulate debate, but they are not the sole response to training needs.

d Prepare select law enforcement staff to serve on a special team by providing them with advanced skills training on the fullest range of mental health topics every three years.

Advanced training courses should typically be at least 40 hours and should be geared toward officers who will serve on special teams that focus on calls involving people with mental illness. (See chart for topics.)

Consumers and their families, advocates, and mental health care providers should be included extensively in specialized training. Additionally, as specialized training entails more time than in-service training, information provided to the officers should be more in-depth. The Memphis Police Department, Albuquerque Police Department, Montgomery County Police Department, Roanoke Police Department, Pinellas County Sheriff's Office, and Athens-Clarke County Police Department are among those law enforcement agencies that have developed a 40-hour advanced training course.

Ideally, class size for advanced training classes should be kept manageable to ensure a facilitator-to-student ratio that allows for total participation. Some agencies may decide that only a special team of officers will receive this training course, while other departments will mandate the advanced training for all officers. The audience does not affect the information that should be included in an advanced training. Field Training Officers and others engaged in training or supervising patrol officers and dispatchers should be required to attend the advanced training.

Advanced skills trainings should include all of the techniques referred to previously, including extended visits to local mental health facilities to learn about treatments offered and opportunities for computer simulations. As an additional consideration, an emphasis may be placed on less-than-lethal (LTL) alternatives and on education to destigmatize mental illness and lessen fear should be provided to enhance shoot/don't shoot decisions.

e**Train communications personnel (call takers and dispatchers) that work with law enforcement on how to deal with calls that may involve mental illness.**

Communications personnel who work with law enforcement agencies play an important role in an agency's response to people with mental illness. Training communications personnel is not possible for every law enforcement agency, especially where 911 services are under the jurisdiction of the county or larger municipality. When it is possible, however, law enforcement agencies should involve call takers and dispatchers in training to enhance law enforcement service to people with mental illness.

Training communications personnel is imperative because the nature of their actions will frame how much information callers provide to them and how callers perceive the agencies' sensitivity. These personnel also shape the responding officer's state of mind upon arriving at the scene by emphasizing information that can increase or decrease officer fear or other preconceptions. The questions call takers ask and the information relayed by dispatchers ensure that responders have access to all possible information so that they are aware of disposition options. The responding officer can direct citizens to proper services, treat them effectively and with dignity, and de-escalate situations.

Example: Houston (TX) Police Department

The Houston Police Department credits the training of dispatch and communications staff as a key to their success in working with people with mental illness. Personnel were trained to ask necessary questions in a timely and appropriate manner. The goal of this training is to ensure that responding officers are provided with as much information as possible

29

Training for Court Personnel

POLICY STATEMENT #29

Provide adequate training for court officials (including prosecutors and defense attorneys) about appropriate responses to criminal defendants who have a mental illness.

Successful implementation of the policy statements described in Chapter 3: Pretrial Issues, Adjudication, and Sentencing depends in part upon prosecutors, defense attorneys, and judges who are familiar with mental illness, the mental health system, and the type of information they need to make informed decisions on behalf of their clients, on behalf of the state, or in the interests of justice. Educational opportunities regarding mental health and the law have traditionally tended to focus on case law addressing scenarios, such as the not-guilty-by-reason-of-insanity plea or other issues regarding competency. As a result, new attorneys only rarely are well familiar with mental health and the law. Of those attorneys who have established an understanding of the issue through law school, few have any practical preparation to defend or prosecute—or assist the court with—a typical criminal case involving a person with mental illness. The result is that most criminal lawyers learn about how best to proceed with a case that involves a person with a mental illness through discussions with colleagues and case-by-case research—essentially on-the-job training. While in many instances this can be ad-

equated for preparing the lawyer to handle an individual case, consistent with practices in his or her jurisdiction, the lawyer may be woefully unaware of current findings concerning issues unique to processing such cases. Given this situation, the recommendations under this policy statement review a variety of ways for court-related officials to develop knowledge and skills that would improve their response to people with mental illness who are involved in the court system.

Training for court personnel should include the following topics:

- signs and symptoms of mental illness
- stigma associated with mental illness
- prevalence of substance abuse among individuals with mental illness and the effects of substance abuse on mental illness
- gender and cultural differences among people with mental illness and the potential impact on criminal case processing
- the mental health system and available community resources
- privacy rights and regulations relevant to mental illness

RECOMMENDATIONS FOR IMPLEMENTATION

a Incorporate into continuing judicial education programs classes about mental illness and the participation of mental health professionals in the criminal process.⁷

Judges who are able to recognize the symptoms of mental illness and understand the treatments and services available in the mental health system will be better equipped to deal with defendants with mental illness. It is important that support for such judicial education come from the jurisdiction's highest appellate tribunal or its judicial supervisory authority with responsibility for continuing judicial education. Judges should also be aware of the prevalence and interaction of co-occurring substance abuse and mental health disorders. This can be accomplished through direct training for judicial officers, or by identifying court liaisons available to court officers when individuals with mental illness are before the court.

Example: Course on Co-Occurring Disorders, The National Judicial College

The National Judicial College has a course that helps judges become better informed about co-occurring substance abuse and mental health disorders. The course is intended to help judges recognize the signs of a substance abuse or mental health disorder, select the appropriate judicial strategies for the treatment and monitoring of such individuals, and design a plan for the implementation of systems or ideas to address co-occurring disorders in their own jurisdiction.

Example: Mental Health Liaison, Texas Judicial System

The state of Texas has created a mental health liaison to provide technical assistance to judges and attorneys in the pretrial and presentence phases. The state is also developing a bench manual for judges, which provides guidelines on sentencing and alternatives. A separate section of this manual will deal specifically with persons with mental illness.

b Provide training for defense attorneys and prosecutors regarding defendants with mental illness.

It is crucial for defense attorneys and prosecutors to develop a basic understanding of mental illness and the mental health system. Training topics can include information about the major mental illnesses, the high potential for recovery with proper diagnoses and treatment, and the prevalence and effects of substance abuse among individuals with mental illness (especially those involved in the criminal justice system).⁸ In addition, prosecutors and defense

"We have basically made mental illness a crime in this country. And it's imperative that we educate judges about this issue [of incarcerating people with mental illness]. It has a huge impact on the court system. I don't think most judges appreciate or understand that."

HON. STEVEN LEIFMAN

Associate Administrative Judge, Miami-Dade County Court, Criminal Division, FL

Source: *Psychiatric News* May 3, 2002 Volume 37 Number 9, p. 8. 2002 American Psychiatric Association p. 8

7. ABA, Criminal Justice Mental Health Standards, Standard 7-1.3.

8. Angela D. Vickers, "Saving Lives: Creating Partnerships with your Legal Communities," presentation at National Mental Health Association Conference, 2001.

attorneys should be trained to understand how mental illness can be a contributing factor to criminal behavior.

Some courts (such as Washington State’s King County Mental Health Court) that focus exclusively on cases involving mental illness have used the expertise of mental health partners to help defense attorneys and prosecutors develop this awareness. Mental health service providers can offer brief in-service training sessions about different diagnoses, medications, service needs, and the components and contours of the mental health system. These sessions also can provide an excellent opportunity for court personnel to educate personnel from the mental health system on the functions, concerns, and procedures of the courts. Successful collaboration depends on criminal justice and mental health partners who understand each other’s missions and methodologies.

Prosecutors who are interested in pursuing alternatives to incarceration for defendants with mental illness should have a comprehensive understanding of the mental health treatment opportunities in their community. Again, this goal can best be pursued through collaborative cross-training with local mental health providers. The goal here is not just to develop awareness for prosecutors but to help representatives of both systems understand the needs and concerns of their counterparts.

The primary goal of defense attorneys—protecting the best interests of their clients—similarly requires that counsel should have a base of knowledge about mental illness as well as an up-to-date understanding of the types of mental health services available in the community, their individual requirements, and their experience working in the justice system. It may be especially helpful to have consumers and family members participate in these trainings to help assist defense attorneys in understanding the concerns of defendants who have mental illness.⁹ Defense attorneys who will be specializing in cases involving defendants with mental illness, such as commitment hearings, should receive more in-depth training.

Example: Mental Health Litigation Unit, Massachusetts Committee for Public Counsel Services

The Mental Health Litigation Unit (MHLU) of the Massachusetts Committee for Public Counsel Services provides training for defense attorneys who represent individuals with mental illness in civil and criminal cases. The MHLU offers a mandatory two-part training program for attorneys in Massachusetts who wish to accept assignments in mental health proceedings (e.g., civil commitment cases, involuntary treatment cases). The first part of the training offers a comprehensive two-day review of mental health law and procedural rules applicable in mental health proceedings, with an emphasis on litigation technique and strategy. The day-long second part of the training also provides an overview of the diagnoses and treatment of mental illness, emphasizing the issues typically raised in mental health proceedings (e.g., the predic-

9. Derek Denckla and Greg Berman, *Rethinking the Revolving Door: A Look at Mental Illness in the Courts*, Center for Court Innovation, 2001. Available at www.courtinnovation.org/pdf/mental_health.pdf.

Interviews with defendants with mental illness in this “think piece” demonstrate the distance between the client’s and defense attorney’s understanding of the client’s best interests. In these interviews, some defendants suggested

tion of dangerousness, medication). The MHLU also offers training on mental health issues to public defenders and private attorneys who will be appointed in criminal proceedings.

C Train pretrial services and probation personnel to recognize symptoms of mental illness and to respond appropriately.

There are two critical points in the criminal justice process where decisions as to an arrestee's interests are at stake: at the initial appearance before a judicial officer when the decision as to release or detention is made, and at sentencing, when the judicial officer decides for those convicted of a crime whether the offender should be incarcerated or supervised in the community for his conviction. In both instances the judicial officer has available a neutral agency, whose role is to provide the decision maker with all information about the individual that is relevant to the decision. For the pretrial release decision the agency—pretrial services—identifies and provides all information that might be indicative of the arrestee's likelihood to return to court as required and remain arrest free pending disposition. For the sentencing decision, the assisting agency—probation—looks more broadly at the issues of rehabilitation, punishment, deterrence, and other legitimate concerns. In both instances it is critical that the officers be sensitive to the possibility that the arrestee suffers from mental illness. It is not suggested that either agency attempt to become mental health diagnosticians; rather, both should be adequately trained to be able to refer (or recommend that a judge refer) people who may suffer from mental illness to trained mental health clinicians for a complete mental health assessment. Furthermore, both agencies should be trained on confidentiality issues—the importance of obtaining consent for the release of mental health information, when and to whom information can be released, and the principle of conveying the least information necessary.

Example: Handbook and Training for Working with Mentally Disordered Defendants, Federal Judicial Center

The Federal Judicial Center, the research and education agency of the federal judicial system, has developed a handbook and training program for federal probation and pretrial service officers regarding working with individuals with mental illness. The handbook and training program cover a variety of issues, including basic information about different mental disorders and treatments; a discussion of how to identify the potential that an individual may have a mental health disorder or co-occurring substance abuse disorders; and supervision issues that may arise for individuals with a mental illness, such as issues of treatment, safety, and the potential for suicide.

Since developing initiatives that address the issue of clients with mental illness, a number of court officials have hired staff with a background in mental health. These individuals may serve in pretrial positions, as probation officers, or as boundary spanners between the courts and mental health systems. Similarly, prosecutors and public defenders have enhanced their offices' capacity to work on cases involving mental illness by hiring social workers or other professionals with some expertise in mental health. While such staff may require training regarding court-related processes, their familiarity with clients with mental illness and the mental health system can make them a valuable asset to many court-based programs. For example, pretrial service programs in Bernalillo County, New Mexico, and Hamilton County, Ohio, employ staff with a mental health background, as does the King County, Washington, Mental Health Court.

that defense attorneys who better understood mental illness would try to help their clients obtain treatment as opposed to encouraging a guilty plea—the avenue to minimizing the

client's short term involvement with the criminal justice system.

Example: Pretrial Services Training, Hamilton County (OH)

The Hamilton County Pretrial Services Program offers training for staff on a variety of issues surrounding clients with mental illness. Staff members receive basic training on the variety of mental illness diagnoses, medications, symptoms, and co-occurring disorders. In addition, pretrial staff members receive training on interview techniques, referral procedures, and confidentiality regulations. The program provides both in-service trainings and outside training opportunities offered through a combination of in-house staff, independent contractors and workshops, and county-offered classes.

d Offer advanced courses on mental health law and participation by mental health professionals in the criminal process for students who desire to concentrate on criminal law practice.¹⁰

The American Bar Association (ABA) recommends that education about mental illness be incorporated into law school curricula. There are a variety of legal education topics relevant to mental illness that are appropriate for law school classes, including mental health law, disability law, confidentiality rights, civil commitment proceedings, treatment rights, competency proceedings, among many others. Some of these topics are already covered widely in law school courses around the country. Some law schools, such as Virginia, Arizona, Nebraska, and Villanova have taken a focused look at mental health and legal issues.

Example: University of Virginia Institute of Law, Psychiatry, and Public Policy

The Institute of Law, Psychiatry, and Public Policy is an interdisciplinary program in mental health law, forensic psychiatry, and forensic psychology. The institute offers academic offerings on a wide array of topics in mental health law, including ethical issues in mental health services, the interaction between psychological science and law, civil commitment proceedings, and many others. The institute also provides training for medical students on relevant criminal justice issues.

e Develop and conduct programs for which continuing legal education (CLE) credit can be provided that offer advanced instruction on mental health law and participation by mental health professionals in the criminal process.¹¹

Continuing legal education provides an opportunity for attorneys to improve their knowledge and skills regarding mental health issues. The American Bar Association standards suggest that “bar associations, law schools, and other organizations having responsibility for providing continuing legal educa-

10. ABA, *Criminal Justice Mental Health Standards*, Standard 7-1.3.

11. *Ibid.*

tion” incorporate programs about mental health law and participation by mental health professionals in the criminal process into their curricula. Furthermore, the ABA recommends that prosecutors, public defenders, and other attorneys who specialize in criminal law should participate in these programs. Continuing legal education for defense attorneys and prosecutors can include basic information about mental illness (e.g., diagnoses, symptoms, treatment) as well as more specific material concerning mental health in the courts, such as different dispositional options, appropriate charging, and proper information sharing procedures.

To encourage the development of and participation in programs concerning mental illness and the courts, some state bar associations have made education about mental illness part of the CLE requirements. This designation can help raise awareness about the importance of this type of education, but requires the development of curricula and educational opportunities to ensure that lawyers have the opportunity to become educated about this important issue. Any organization providing or coordinating training programs concerning mental health and legal issues should make sure to obtain CLE certification, or credit toward professional certification, from the appropriate agency within the jurisdiction. This will provide added incentive for lawyers and other court personnel to take advantage of these training opportunities.

Example: Continuing Legal Education Requirements, Florida Bar

In February 2001, the Florida Supreme Court unanimously approved an amendment to the Continuing Legal Education (CLE) Requirements of the Florida Bar to include education on mental illness among the mandatory categories of continuing legal education. Florida Bar members are required to undergo 30 hours of CLE every three years, five hours of which must be in one of four mandatory categories (professionalism, ethics, substance abuse, and, now, mental illness).

30

Training for Corrections Personnel

POLICY STATEMENT # 30

Train corrections staff to recognize symptoms of mental illness and to respond appropriately to people with mental illness.

As is the case with law enforcement executives, corrections administrators place a premium on trained staff. In addition, like those in policing organizations, training efforts in corrections agencies typically fall into one of four categories: new skills (basic), pre-service (academy), in-service, and advanced. (See Policy Statement 28: Training for Law

Enforcement Personnel, for brief definitions of the different levels of training.) At the county level, however—especially in small jurisdictions—correctional staff may receive minimal pre-service training, and the level of in-service training varies widely across different jurisdictions.

RECOMMENDATIONS FOR IMPLEMENTATION

- a Provide basic training regarding mental health issues to all corrections staff who come into contact with detainees or inmates with mental illness.**

There are some staff in some prisons or jails who, despite being in regular contact with inmates with mental illness, have received little or no meaningful training regarding mental health issues. These personnel may be uniformed security staff who received academy training but are not prepared for in-service refresher training on mental illness. This audience may also be program staff, such as case managers, teachers, or vocational counselors, who did not attend an academy and may have received minimal pre-service training. Whatever their background, any corrections personnel who have regular interaction with inmates with mental illness should receive basic training on how to better serve those inmates.

Basic training for corrections personnel should be geared toward the following goals:

- improve staff's ability to identify inmates with possible mental health issues;
- enable staff to understand when to refer an inmate for a mental health screening and/or assessment;
- teach staff to recognize symptoms of an adverse reaction to psychotropic medication;
- provide basic information on issues related to co-occurring substance abuse and mental illness;
- reduce stigmatization of inmates with mental illness by sensitizing corrections staff to the unique needs of these individuals;
- assist correctional staff in recognizing cultural factors that may influence their awareness of signs and symptoms of mental illness; and
- improve the ability of corrections officers to communicate facility procedures/rules to inmates with mental illness.

Many states have established policies that require basic mental health services training.

Example: Virginia Department of Corrections

The Virginia DOC has established a comprehensive training program to train both institutional (security and nonsecurity) staff and clinical staff. The Department has engaged a full-time mental health training coordinator who is stationed at the DOC's Academy for Staff Development.

Training of correctional mental health staff should include experiential, in-service activities in addition to didactic, classroom instruction. For example, the Oregon Department of Corrections trains mental health staff on the housing units directly alongside the correctional officers. In developing training programs regarding mental illness for corrections staff it can be especially helpful to collaborate with personnel from state mental health agencies, community-based mental health providers, or other professionals with mental health expertise.

Example: Training Video, New York State Department of Corrections, New York State Office of Mental Health

In New York State, the commissioner of the Department of Corrections reached out to the commissioner of the Office of Mental Health to request collaboration and expert assistance in producing a training video on managing inmates with mental illness. The video is designed for use in the corrections pre-service training academy as well as for in-service training purposes for those already through the academy.

Some jurisdictions, such as the New York City Department of Corrections, provide training regarding mental health issues for inmates, too. Although this training is somewhat controversial, its goals are laudable. Inmates who receive a basic orientation to mental health issues and the issues involved in responding to the needs of offenders with mental illness can provide assistance to staff in observing or identifying other inmates in need of mental health services—often before staff become aware of the needs of those inmates.

b Incorporate competency-based training in mental health issues in existing academy (pre-service) training programs and in-service programs for corrections staff.

Training academies and pre-service training programs offer an opportunity to begin sensitizing corrections staff to issues regarding mental illness. This training should focus on the development of competencies. Though a number of hours may be designated for academy training on mental health issues, it is critical that the measure of training success be improvements in the trainees' knowledge and abilities. Suggested topics for academy training include the following:

Basic issues concerning mental illness

- signs and symptoms of mental illness
- attitudes about mental illness (e.g., stigma)
- understanding and assessing mental illnesses
- the relationship between violence and mental illness
- dual diagnoses: substance abuse and mental illness
- developmental disorders
- homelessness and mental illnesses

Management of inmates with mental illness

- de-escalation techniques
- officer safety
- calming approach methods
- interviewing techniques
- medications: noncompliance; side effects
- internal services and referral procedures
- suicide prevention

Administrative issues

- civil rights, including privacy rights
- confidentiality
- victims with mental illness
- available community resources
- cultural diversity/gender difference
- consumer and family perspectives

Example: Pre-service and In-service training, Connecticut Department of Corrections

The Connecticut Department of Corrections (DOC) offers pre-service and in-service training to corrections officers on how to work with inmates with special needs,

including those with mental illness. This training addresses a number of issues, including legal requirements regarding confidentiality, symptoms of different mental illnesses, collaboration with correctional mental health staff, and suicide prevention, among other topics. Correctional mental health staff, who are employed by Correctional Managed Health Care, receive training facilitated by both psychiatric professionals and corrections officers.

Example: Correction Officer Training, New York State Department of Corrections

The New York State Department of Corrections (DOCS) Training Academy has teamed with the Capital District Psychiatric Center (CDPC) Mental Health Players to develop an enhanced pre-service training curriculum concerning mental health issues. The full-day training emphasizes hands-on experience in dealing with inmates with mental illness. The morning session provides background information on types of mental health issues encountered most often in correctional facilities, including suicide prevention. The afternoon module is unique in that volunteers from the CDPC Mental Health Players role play inmates experiencing mental health problems, providing correction officer candidates a chance to practice communication skills in a “real-world” setting. Feedback from training academy staff and candidates has been overwhelmingly positive.

c Provide advanced training to corrections staff assigned to work specifically with inmates with mental illness.

Corrections staff who are assigned to work specifically on units with inmates at high risk of mental illness (e.g., special housing units, administrative segregation) and/or already diagnosed with mental illness (e.g., psychiatric intensive care units) should receive intensive training in mental health issues and management of inmates with mental illness. In Florida, state law requires that corrections officers employed by a mental health treatment facility receive specialized training beyond that required for basic certification. It is important to tap the expertise of professional mental health crisis workers when offering specialized training, especially in dealing with de-escalation techniques, restraints, and lethal force.

d Provide parole board members with training in order to inform them about issues regarding the release of people with mental illness from prison.

Parole board members come from a variety of backgrounds and areas of expertise. Some may have experience that helps them understand people with mental illness, but most do not. The stigma of mental illness, especially the common association between mental illness and violence, may cause parole board members to be wary of offering parole to offenders with mental illness (see

Policy Statement 20: Release Decision). Training can enhance parole board members' understanding of the complex issues presented by this offender group, and enable them to make informed decisions regarding parole candidates.

Example: New Board Member Training, National Parole Board, Canada

The National Parole Board in Canada offers extensive training about mental illness to new board members. Of the 15 days of total training required of new board members, two of the days are devoted to mental health issues. The board relies on two general reference documents—the *Diagnostic Manual for Mental Disorders* and the *Historical, Clinical and Risk Guide for Violent Offenders with Mental Illness*—and one internal risk-assessment manual, which has a chapter on mental illness. The parole board is also developing an even more in-depth guide for board members on dealing with offenders with mental illness.

Training curricula should be developed and, depending on the jurisdiction, tailored for individuals appointed to serve as parole board members, both for new appointees as well as on an annual or ongoing basis. Parole board members should have a fundamental understanding about the nature and types of mental illness and how mental illness is diagnosed and treated. They should also be provided with training about the risks and needs associated with mental illness and the types of treatment, resources, and support services that can mitigate that risk.

There is also opportunity in this context to provide cross-training, which would include training for mental health personnel about a jurisdiction's criminal justice system as well as its public safety issues, needs, and processes. In many jurisdictions, these two systems, while having a significant shared population, have operated substantially apart from each other. Only in recent years have these barriers begun to break down. Cross-training is one opportunity to develop shared understanding about the potentially competing criminal justice and treatment needs of the offender who has a mental illness.

Example: Cross Training, Massachusetts Parole Board, Massachusetts Department of Mental Health

In 1998, the Massachusetts Department of Mental Health (DMH), The Massachusetts Parole Board, and the Department of Corrections developed a broad agreement to strengthen the delivery of mental health services to individuals with mental illness incarcerated in state correctional institutions or eligible for parole. Cross-training between the DMH and the parole board provided background on new policies and procedures developed as part of the agreement and helped staff from the different agencies better understand the roles of their colleagues. Regional groups engaged in roundtable discussions to develop specific goals and strategies for realizing the objective of improved service to inmates with mental illness. DMH staff has also offered training to senior parole officers in support of the collaborative agreement.

e**Provide training for parole officers to improve their ability to supervise parolees with mental illness.**

Parole officers have a varying degree of exposure to people with mental illness. Parole officers with typical caseloads will undoubtedly encounter some clients with mental illness. These parole officers need basic training on how to best serve these clients. This training should cover topics similar to those dealt with in the basic training offered to corrections personnel discussed above. In addition, parole officers need training on the availability of community mental health resources, intervention services, alternatives to revocation, sensitivity to victims, and updates on the changes in mental health treatment law. Parole officers should be able to recognize when a person with mental illness is decompensating and when a person with mental illness is not complying with conditions of release because of an inability to obtain access to effective treatment.

It is especially important to reconcile the different missions of community corrections agencies and mental health service providers. Most mental health and substance abuse treatment providers view relapse and setbacks in treatment as part of the recovery process. Parole requires offenders to follow certain release conditions or risk violation and reincarceration. These two outlooks can conflict when mental health (or substance abuse) treatment is part of a parolee's release conditions. Cross-training between parole officers and mental health providers, consumers, and family members can be effective in synthesizing the goals of parole and mental health treatment.

Some parole officers have caseloads dedicated to parolees with mental illness. Because the primary focus of these parole officers is to supervise parolees with mental illness, it is appropriate to provide more in-depth training on mental health issues. Parolees who work with a dedicated mental health caseload will likely be collaborating frequently with mental health service providers. It is crucial that these providers work together to understand each other's roles in supporting an offender's reintegration into the community.

31

Training for Mental Health Professionals

POLICY STATEMENT # 31

Develop training programs for mental health professionals who work with the criminal justice system.

Just as staff in the criminal justice system recognize the need to learn new skills that will allow them to provide appropriate care for people with mental illness with whom they have contact, those who work in the mental health field must develop awareness of the special needs of people with mental illness who have been arrested and/or incarcerated. If they are to help people with mental illness who have criminal histories to live in the community at large, mental health staff must understand the implications of those histories as well as the imprint arrest and incarceration may leave on a person. They also must understand the criminal justice system itself so that they can interact productively with their counterparts in that system.

Criminal justice agencies and community mental health programs have different traditions, missions, and often even different values. Their staff have typically been trained very differently. One way of looking at these differences is to think of them as different cultures. In order to achieve successful collaboration and integration of resources, staff from both arenas will need to understand their cultural differences as well as appreciate their overlapping missions.

An analogous situation arose when substance abuse treatment began to increase in jails and prisons. What was discovered at that time was that cross-training was necessary for solid collaboration and integration of services. Cross-training here simply means that each staff train the other, so that criminal justice personnel learn more about mental health and mental health staff learn more about criminal justice in a combined learning environment.

Training topics for mental health providers and administrators include the following:

Training about law enforcement

- the public safety responsibilities of law enforcement officers
- police protocols for the use of force
- responsibilities of first and backup responders
- officers' expectations of community providers
- familiarity with law enforcement officers and officials
- the booking process

Training about the court

- general court procedures
- information sharing in the court setting

- responsibilities of prosecutors, court administrators, defense attorneys, and judges
- conditional release programs and their administration in the jurisdiction

Training about corrections agencies

- jail classification procedures
- jail personnel and the jail environment
- correctional procedures, including intake and classification
- scope of behavioral health services available in prison
- correctional medical staff and facilities
- corrections release planning staff and procedures
- community corrections (e.g. probation, parole) procedures and protocols

- familiarity with the rules of Medicaid, SSI, SSDI, TANF, and other benefit programs for those who are incarcerated in jail or prison

Training about working with consumers who have been involved with, or are at risk of being involved with, the criminal justice system

- advance directives
- the effects of correctional incarceration on mental illness
- obstacles faced by individuals who have been incarcerated
- ensuring the safety of the provider and consumer
- cultural competency
- housing options in the community for people with mental illness

RECOMMENDATIONS FOR IMPLEMENTATION

a

Work with university and other mental health professional training programs to enhance their curricula on the criminal justice system.

Training programs for mental health professionals around the country are slowly changing their curricula to address working with a criminal justice system population. Training in this area has several purposes. By enabling mental health staff to use and understand terminology common in the criminal justice system, the training would allow them to work more effectively with staff in that system. Training also could have a more clinical orientation, helping mental health staff to better understand the complex needs of people with mental illness who are in contact with the criminal justice system. Depending on the approach of the program, topics to be addressed might include everything from the basics of criminal law and the criminal justice system to applying relapse prevention techniques to criminal thinking.

With law schools and criminology programs adding courses on mental illness, mental health practitioners may also wish to enroll in them for the purpose of better understanding the criminal justice system's orientation. This would be especially true in areas or settings where criminal justice issues have not yet penetrated professional mental health training programs. (See Policy Statement 29: Training for Court Personnel, for more on law school and continuing legal education classes regarding mental illness.)

b **Develop in-service curricula for mental health staff that address obstacles to working with criminal justice clients.**

In-service training is likely to be of more use to mental health staff already working in the field. In many mental health agencies, training in a number of clinical and nonclinical areas is already frequently scheduled. Adding training in criminal justice issues will generally not pose great logistical difficulty.

This in-service training would have several purposes. It would provide current information to mental health staff about provisions in the criminal justice system for treatment of people with mental illness. It would allow mental health and criminal justice personnel to build and enhance relationships. And it would provide a forum for problem areas to be identified, potentially leading to plans for subsequent training.

In-service training also could provide opportunities for mental health staff to learn from clients themselves and their families about the challenges they face when reentering the community after time in jail or prison—or even after an arrest with no time having been served. People with mental illness who have criminal justice histories often find they face an additional stigma. Training that involves mental health staff and clients with histories of criminal justice involvement can provide opportunities to address this stigma and the discrimination faced by many such clients.

Example: Transitions Training, New York State Office of Mental Health

The New York State Office of Mental Health has developed a training program for mental health agency administrators and supervisors to help them better serve individuals with mental illness who have been incarcerated in state prison. The training program addresses coordination with parole staff as well as the stigma attached to involvement in the criminal justice system. The training is delivered by mental health consumers who have experienced the struggles of incarceration in state prison and release back into the community. A mental health advocacy group provides consumer-trainers with support.

Example: Connecticut Jail Diversion Project

Mental health clinicians in Connecticut's Jail Diversion Project receive periodic in-service training about the missions and procedures of the different criminal justice agencies with which they collaborate. Representatives from the Department of Corrections, the State's Attorney's office and the Public Defender's office (among others) participate in the training and discuss case scenarios with the clinicians. The clinicians learn how to maintain the integrity of their role as treatment professionals while operating in the criminal justice system.

32

Educating the Community and Building Community Awareness

POLICY STATEMENT # 32:

Educate the community about mental illness, the value of mental health services, and appropriate responses when people with mental illness who come into contact with the criminal justice system.

RECOMMENDATIONS FOR IMPLEMENTATION

a Educate community members about mental illness to help combat stigma and improve the community's understanding of mental health as a community issue.

Despite the prevalence of mental illness and the cost to taxpayers of inadequate mental health treatment, communities have not made access to effective mental health service a priority. Furthermore, when a person with mental illness is involved with the criminal justice system, the public typically assumes, incorrectly, that the person is inherently violent and cannot function in the community.

Indeed, the Surgeon General's recent report on mental health argues that the stigma around mental illness is one of the most significant challenges to the development of effective mental health policy.¹² This stigma has intensified over recent decades, despite the advancement of scientific knowledge about the causes of mental illness and the effectiveness of certain treatments; studies show that a greater portion of people associated mental illness with violence in the 1990s than the general public did in the 1950s.¹³

Combating the stigma surrounding mental illness and enlisting broad-based support for improvements to mental health policy requires education. Until the general public comes to understand mental illness as a disease similar to physical illnesses, public support for improved mental health services is un-

"Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders...It deters the public from seeking, and wanting to pay for, care. In its more overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society."

Source: *Mental Health: A Report of the Surgeon General*, p.6

12. U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of

Health, National Institute of Mental Health, 1999, p. 6.

13. Little Hoover Commission, *Being There: Making a Commitment to Mental Health*, Sacramento, CA, November 2000, p. 31.

likely to increase. To this end, California’s Little Hoover Commission’s report *Being There* suggests the formation of a statewide commission on mental health advocacy to build public support for adequate mental health services. Changing public opinion about mental illness is a difficult task, but one for which the criminal justice system can be an extremely effective partner. Criminal justice personnel are charged with ensuring public safety. They have, therefore, a singular credibility advocating for improved community-based mental health services and dispelling notions that people with mental illness in the community compromise public safety. Criminal justice officials, who deal with the influx of individuals with mental illness into their system on a daily basis, can help the public and policymakers become aware of the need to improve community-based mental health services.

Example: Commission on the Status of Mental Health of Iowa’s Corrections Population

The Community Corrections Improvement Association, the private foundation arm of the Iowa Sixth Judicial District Department of Correctional Services, formed the Commission on the Status of Mental Health of Iowa’s Corrections Population to provide a forum for public discussion about issues at the intersection of mental health and criminal justice. During November 2001, the commission held a series of eight public hearings, supported by a panel of experts, across the state of Iowa to consider the issues from a local level. The commission also administered a survey to assess public attitudes and knowledge, developed a video and media relations campaign, and planned a conference to raise awareness about mental health and criminal justice issues.

b Educate consumers, family members, friends, and advocates for people with mental illness about the processes and procedures of the criminal justice system.

Consumers and their loved ones often want to cooperate with the criminal justice system—or seek the assistance of officials in the criminal justice system—but lack the knowledge to successfully interact with representatives of the various criminal justice agencies. Criminal justice agencies can improve consumer awareness and initiate positive relationships through community outreach programs. Such programs can be important preventative tools, which improve the safety of both criminal justice personnel and consumers during future interactions.¹⁴ Similarly, consumers and families who know whom to call and what to ask for are much more likely to have their needs met at the outset, which will make these interactions less frustrating for both parties.

14. Police departments have done similar community outreach to improve their service to individuals with hearing impairments. See Christine Stolba and Marci Sliman, *Policing the Deaf and Hard of Hearing Populations*, Cul-

tural Diversity and the Police. Available at: www.policylab.org/deaf.pdf.

Example: Chapel Hill (NC) Police Department

The Chapel Hill Police Department conducts community trainings in conjunction with NAMI and the local clubhouse (an organization that provides support services through a self-help community-based center) to educate family members as to their rights and responsibilities when in contact with the police department. These interactions have also helped increase the level of trust between the community and the police department.

When a person with mental illness becomes involved in the criminal justice system, his or her family, friends, mental health service providers, and other advocates may want to help in a variety of ways. Family members may want to inform the defense attorney about the defendant's mental health history, to advocate for the defendant's placement in a particular treatment program, or generally to help their loved one navigate the criminal justice system. Advocates in some communities have developed resources for such situations.

Example: When a Person with Mental Illness is Arrested: How to Help, A New York City Handbook for Family, Friends, Peer Advocates, and Community Mental Health Workers

Staff at the Urban Justice Center's Mental Health Project developed a practical handbook for supporters of people with mental illness who have become involved in the criminal justice system. The handbook provides general information about the criminal justice process (arrest, arraignment, meeting with counsel), relevant statutes and advice for advocates on working with defense attorneys, as well as information specific to the New York City criminal justice system.

Example: Mental Health Services for Mentally Ill Persons in Jail – A Manual for Families and Professionals Including Jail Diversion Strategies, NAMI Wisconsin

NAMI Wisconsin, in conjunction with a variety of mental health and criminal justice professionals, developed a manual to help families and professionals better understand the issues that arise when an individual with mental illness becomes involved in the criminal justice system. This manual includes sections dedicated to the mental health system, the criminal justice system, jail diversion programs, and other relevant issues. Though originally targeted to families of consumers who are involved in the criminal justice system, the manual has proved useful to professionals throughout the mental health and criminal justice fields.

Family members and other supporters of people with mental illness should also receive information about the prerelease and discharge planning processes from corrections personnel, and receive instruction on how they can participate in helping their spouse or relative make a smooth transition from the jail/prison back to the community. It is especially important that they know what resources are at their disposal to assist them and their recently released family member when a crisis occurs.

C**Educate victim advocates about mental health services and procedures for offenders with mental illness.**

Victim advocates should be informed about mental health services and procedures within correctional facilities and how discharge planning occurs. They should receive orientation, education, and assurances about what services are available for offenders and what supervision the offender will undergo in addition to what protection they can expect from the criminal justice system. These matters can be included in the overall community education and training curriculum developed by criminal justice agencies.

"Like any crime victim, a person victimized by a person with mental illness immediately wants that person to be held accountable. But they also want to participate in creating a system to make sure the same thing doesn't happen to someone else."

ELLEN HALBERT

*Director, Victim Witness
Division, District
Attorney's Office,
Travis County, TX*

Source: Personal
correspondence

33

Identifying Trainers

POLICY STATEMENT # 33

Identify qualified professionals to conduct training.

RECOMMENDATIONS FOR IMPLEMENTATION

- a Identify criminal justice professionals, mental health professionals, consumers, and other appropriate individuals to conduct staff training.**

The success of a training program usually hinges on the quality and appropriateness of the trainer. Criminal justice system personnel may be skeptical of new approaches—sometimes with good reason. Training loses its effectiveness when participants detect that a facilitator is advancing a political agenda or training largely for financial profit. Accordingly, it is important to choose credible trainers who reflect the shared goals of the criminal justice agency and the mental health community and who are committed to a long-term working relationship.

Involving criminal justice system personnel in leading the education process sends a potent message to those being trained that responses are being instituted because the agency is invested in enhancing service to people with mental illness. For example, law enforcement trainers have the knowledge base and credibility to cover sections on officer safety, enforcement protocols, and other response topics that a civilian may not.

Involving the chief executive of the agency to commence the training or to provide completion certificates also conveys the message that enhancing the response to people with mental illnesses is a priority for the agency.

Example: Sheriff and County Commissioner, Pinellas County (FL)

In Pinellas County, the sheriff or the county commissioner has been to each of the training classes to speak about the importance of the topic and show support. This interaction has proven to be invaluable in highlighting to class participants the importance of responding appropriately to people with mental illnesses. Additionally, the County Commissioner's office presents a plaque to every officer who completes the 40-hour course.

Frontline mental health professionals who have knowledge and field experience relating to the criminal justice system should be included in training for frontline officers. Street-level crisis intervention workers, for example, are a good resource for law enforcement officers because they have relevant field experience. Mental health experts with significant criminal justice or forensic experience or community mental health crisis staff are also good choices. These experts should be coached to concentrate on the basic elements of their expertise that provide a framework for understanding the essential concepts. They should provide a model that everyone can use to detect and respond appropriately to general classes of mental illness. Detention facility inspectors and state public defenders who specialize in mental health issues may be useful trainers for addressing an audience of mental health professionals.

Most important, whoever is chosen to train personnel in the criminal justice system must be familiar with the challenges and risks that these individuals face in the field. Noncriminal justice trainers should be encouraged to participate in ride-alongs or other experience exchanges in corrections or court settings to better understand these challenges and concerns.

b Facilitate delivery of training in small or rural jurisdictions where there may be a shortage of trainers.

Smaller jurisdictions may need to consider creative resource sharing to make training more feasible. These jurisdictions may create regional training classes, where one or two staff people are sent from several different areas. These staff members would then be responsible for training others in their jurisdiction. This type of training can also help address cross-jurisdictional issues and problems and enhance coordination among neighboring agencies. Although distance-learning mechanisms such as CD-ROM or online courses may be an option for those who cannot otherwise obtain access to training, they should not be favored over in-person training sessions. While small, rural jurisdictions face limited resources, they do have access to national groups that will help to provide training resources (e.g., the National Sheriffs' Association, the National Institute of Corrections). Key to the success of training remote, rural jurisdictions is the commitment of agency managers to access the resources that are available.

Example: Athens-Clarke County (GA) Police Department

The Athens-Clarke County Police Department conducts mental health training in conjunction with Advantage Behavioral Healthcare, the local community mental health care provider agency. Local mental health care professionals (some in private practice) teach the Crisis Intervention Team class and each instructor donates his or her time to the department. Additionally, officers are taken to a local hospital or mental health facility to meet with staff and consumers. This has been a helpful method for personalizing the discussion about people with mental illness for officers who have had limited contact with this population.

Because criminal justice personnel are exposed to the same myths about mental illness as the public, communities must involve consumers in criminal justice system training to debunk these myths and to make personal connections with appropriate personnel. It will be critical to invite consumers who are articulate and have a range of personal experiences to share. This involvement should not be limited to a trip to an inpatient mental health facility. Instead, criminal justice personnel should meet with people with mental illness who are living independently, employed, and managing their illness. Another effective mechanism to personalize mental illness may be for agencies to identify someone within the agency who has a family member with a mental illness and is willing to share his or her experiences. Similarly, it is important for trainees to have a full understanding of the experience of the victims of crimes committed by offenders with mental illness. Including victim advocates in the design and delivery of training programs is helpful to this end.

34

Evaluating Training

POLICY STATEMENT # 34

Evaluate the quality of training content and delivery; update training topics and curricula annually to ensure they reflect both the best practices in the field as well as the salient issues identified as problematic during the past year.

(See Chapter VIII: Measuring and Evaluating Outcomes, for a more comprehensive discussion of assessing the results of policies and programs that are suggested by this report.)

RECOMMENDATIONS FOR IMPLEMENTATION

a Test whether trainees have effectively learned the material presented.

Some law enforcement, court, or corrections veterans may participate reluctantly in a training session, confident that they have “seen it before” or “done it all.” Administering a pretest at the beginning of the training session can challenge such beliefs. Immediate post-testing of course content is valuable as well, in order to assess changes in attitudes and knowledge. It might be useful to conduct a third test, six months after the training, to evaluate how training played out on the street, in case adjustments need to be made. As a caution, while testing is important it can be considered counterproductive if participants think they have to memorize terminology. Tests should address information that will inform and improve responses to people with mental illness in contact with the criminal justice system.

b**Ensure that current national trends and facility-specific needs guide the training agenda.**

New topics and recommendations for training are being developed across the country on a continuing basis. Mental health training curricula should be updated regularly in accordance with the best practices in the field. Sources for current information can be obtained from such organizations as the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), the National GAINS Center, the American Correctional Health Services Association (ACHSA), the American Psychiatric Association (APA), and the National Commission on Correctional Health Care (NCCHC). Criminal justice training officials should use the experts within the mental health community to evaluate current training procedures.

Example: NAMI Evaluation of National Institute of Corrections Training Programs

The National Institute of Corrections worked with NAMI to evaluate National Institute of Corrections training for mental health correctional teams from 22 different jurisdictions. NAMI provided feedback to the corrections training personnel in charge of those training programs.

c**Promote workshops and seminars on mental illness at conferences and professional associations.**

Most members of the criminal justice system attend professional conferences and belong to professional associations. This includes law enforcement line and staff, court officials, and corrections administrators and staff.

A number of organizations exist that provide training to court officials, including the National Judicial College, National District Attorneys Association, National Legal Aid and Defenders Association, National Association of Pretrial Services Agencies, and the American Probation and Parole Association, to name just a few. Several organizations also provide training on topics for law enforcement, including the Police Executive Research Forum (PERF), the Police Foundation, the International Association of Chiefs of Police (IACP), the National Organization of Black Law Enforcement (NOBLE), the Major Cities Chiefs' Association (MCCA), and the National Sheriffs' Association (NSA). Organizations such as the Association of State Correctional Administrators (ASCA), the National Institute of Corrections (NIC), and the American Correctional Association (ACA) provide training geared to corrections administrators.

Many of these organizations have been including sessions on various aspects of working with individuals with mental illness at their regular meetings. These organizations should consider the recommendations contained in this document when planning such sessions in the future.

Elements of an Effective Mental Health System

Many of the recommendations contained in this report are predicated on the availability of effective mental health services in the community. Police, judges, jailers, community corrections officials, and others who refer a person with mental illness to community-based mental health services expect the delivery of certain services and outcomes. A well-functioning mental health system will reduce the number of people with mental illness who come into contact with the criminal justice system. Policy statements and recommendations in this chapter are intended to point the way toward an effective mental health service system.

Mental health systems in many states across the country have undertaken examinations of the services they offer, their funding mechanisms, and the administrative systems needed to manage them effectively. Systems have looked at overarching is-

ssues such as the legislative mandate for the state to provide services or the population to be targeted for these services. They have also looked at the details of reimbursement and relationships with other functions within state government. Legislative commissions have put some state systems under the microscope of examination and in at least one state, California, a state-funded independent oversight agency has recently studied the quality and availability of mental health services.¹

It would not be surprising if different states taking different approaches came up with highly varied recommendations for improvements to the mental health system. However, as much as details may vary, there is remarkable consistency in elements recommended by state commissions and those described by the U.S. Surgeon General's 1999 report on mental health.² For a comprehensive examination of the way mental health services are provided in this country, the Surgeon General's re-

1. Little Hoover Commission, *Being There: Making a Commitment to Mental Health*, Sacramento, CA, November, 2000.

2. Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*,

Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

port is the single best resource available. State policymakers considering improvements in their state-based systems should make themselves familiar with the contents of the report and consider adapting many of its recommendations to fit the needs uncovered by their efforts.

It is at the community level, however, that mental health services are delivered, and it is there that policies prove to be effective or not. Policymakers and partners seeking change in community responses must be aware of the structure of the community mental health system in the towns and cities where they live. They should focus not just on what exists, but most intently on what a community mental health system could look like if all pieces were in place. Mental health experts in this country know what works and what doesn't. They agree for the most part on services that should be available in community mental health systems. Yet, for a variety of reasons, our public mental health system has been unable to implement much of what we know. The following policy statements argue for and enumerate practices and approaches shown to be effective.

Finally, it is important to consider the role played by funding in determining the scope and depth of the public mental health system. While this report does not provide sufficient analysis to develop recommendations specific to funding issues, readers must bear in mind the funding ramifications inherent in many of the steps recommended herein.

At a minimum, it is important for those who use this report to consider three funding issues as they contemplate implementation of its recommendations. First, are there sufficient funds available to the system for it to meet the expectations of its various constituents? Second, are funds allocated appropriately to ensure the system's priorities are met? And third, is there a mechanism to determine whether allocated funds are achieving the outcomes appropriators think they are purchasing?

As funding for public mental health services has evolved, it has become an extremely complex system. Each funding stream brings with it conditions and constraints that determine for whom and for what services it can be used.

Funding for Mental Health Services

Readers of this report and virtually everything written on this nation's public mental health system understand that funding for services involves an exceptionally complicated mix of local, state, and federal monies. To provide the full spectrum of services envisioned in this report, a local provider agency must weave together funds derived from sources that may have different guidelines, fiscal years, and stated purposes. Some funding comes to agencies on a per capita basis, some on a "fee for service" or reimbursement basis. Some services are paid for regardless of who accesses them, while most require clients to qualify for programs by demonstrated poverty or disability.

Local support – In many communities, local tax levies provide a source of operating support for community mental health agencies. Levels of community support can vary widely. Many agencies serve several towns and therefore may draw support from each of them. It is not at all unknown, however, for one town to provide substantial support, while its neighbor contributes meagerly to the agency.

County support – A number of states have developed mental health systems that are financed and managed at the county level. In many of these states, this has been a conscious process of devolution. Again, there is considerable variation among states that have developed county-based systems. Typically, state general funds are provided to counties in block grants based on formulas that may include population, anticipated need, and historic contribution. As with federal block grants to states, however, the idea is to promote local control.

State support – State general revenue funds are traditionally the largest funding source for mental health services. For a variety of reasons, however, the share of state funds has been falling for close to a decade, whether measured as the percentage of state budgets or as the portion of the total mental health budget in a given state. At the same time, the amount of state funding needed to provide the required "match" for federal Medicaid funds has continued to rise, as states have increased their reliance on Medicaid for many services. In a typical state, for example, general revenue funds for mental health services may have made up approximately 32 percent of the overall public mental health budget in 1996. By 2001, that portion had decreased to 19.5 percent. By contrast, the state Medicaid match had risen from 20 percent to 29 percent of the overall budget over the same period.

Federal support – Each state receives a share of the Mental Health Block Grant, which is administered through the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration. These Block Grant funds typically comprise approximately 1.5 percent to 3 percent of a state mental health system's budget. States also receive Substance Abuse Block Grants, which make up a higher proportion of the budget for substance abuse services. Even in systems where mental health and substance abuse services are administered together, however, the two Block Grant programs are subject to rules that prevent their blending.

Federal entitlement programs provide the largest sources of funds for the public mental health system. As already noted, the program that has the largest impact on the system is Medicaid. To be eligible for Medicaid, most adults with mental illness must qualify for Supplemental Security Income (SSI).

Medicaid funding poses a great problem for states. While the federal program does provide funding for some services used by people with mental illness, it also comes with many restrictions. To begin with, many people who need public mental health services do not qualify for Medicaid, which was created to address the medical needs of needy and disabled persons. Secondly, only certain services are eligible for Medicaid reimbursement. Since these are services based on medical needs, many state Medicaid authorities do not allow reimbursement for important rehabilitative services required by people with mental illness. Thirdly, Medicaid has never allowed for hospitalization of adults aged 21 to 64 in large psychiatric institutions, although it pays for costs in institutions used by people with developmental disabilities, for example. With fewer people than ever in institutions, this exclusion for "institutions for mental diseases" – IMDs – may not seem to be a great problem. However, Medicaid pays out large amounts for services to developmentally disabled people receiving services in the community, on the theory that the community services are preventing more costly institution-based services. Mental health services do not qualify for such "waivers" since there are no savings to be realized by diverting adults with mental illness from noncovered institutional care.

Support also comes through programs administered by other agencies in the federal government. Housing programs, for example, are funded through the Department of Housing and Urban Development (HUD), vocational rehabilitation programs are administered by the Department of Education, and so forth. In addition, qualifying veterans receive mental health services through programs operated by the Veterans Health Administration of the Department of Veterans Affairs. In most states, these programs are operated independently of the state-administered public mental health system. It is often the case that if an individual receives services through a VA program, he or she may not be deemed eligible for non-VA services.

35

Evidence-Based Practices

POLICY STATEMENT #35

Promote the use of evidence-based practices and promising approaches in mental health treatment, services, administration, and funding.

In recent years, enormous advances have been made in treatments available for persons with mental illness. New medications have emerged; new services, supports, and interventions have proven effective. Researchers have conducted studies and collected data—they have developed an “evidence base”—which demonstrate the effectiveness and applicability of some of these treatments and approaches. Gradually, a body of research literature is growing to support the choice of particular interventions in certain situations. While some researchers might argue over the standards by which an intervention or treatment approach is judged to be evidence-based, there is general agreement that the

term and designation imply that a given practice has withstood rigorous scientific examination.

The public mental health system must take steps to ensure that practice keeps pace with research. By ensuring that what is done meshes with what is known, mental health policy makers and providers can reduce the numbers of homeless individuals on the streets, the numbers of individuals with mental illness whose behavior or crimes attract the attention of police officers, and the numbers of attempted and completed suicides by people who have not received effective treatment for their mental illness.

RECOMMENDATIONS FOR IMPLEMENTATION

a **Implement evidence-based practices into the public mental health system.**

Dr. Robert Drake, a national leader in the move toward evidence-based practices, characterizes evidence-based practices as standardized treatments and services subjected to controlled research involving objective outcome measures and more than one research group. Evidence-based practices are built on scientific principles, and while they are supported by certain values and as-

sumptions they are not themselves values; rather, they are specific interventions and treatment models that have been shown to improve client functioning and the course of severe mental illness.³

Among the evidence-based practices experts believe should be available in the public mental health system are: appropriate use of all available psychotropic medications; assertive community treatment; supported employment; family psychoeducation; illness self-management; and integrated treatment for co-occurring mental illness and substance abuse disorders. This is by no means an immutable list. In fact, it is expected that these currently identified practices represent just the leading edge of a much larger body of evidence-based practices that will result in more reliable standards for mental health services. Promising practices exist in a variety of areas, including rehabilitative services, supported housing, and case management, among others. Properly implemented, existing evidence-based practices have been shown to improve outcomes for both the client and the system. There is every reason to believe that if they were implemented more broadly, fewer people with mental illness would become involved in the criminal justice system.

Studies show, for example, that people who are prescribed the newer, “atypical” antipsychotic medications experience fewer debilitating side effects than do clients taking the older classes of medications, with the result that they are more likely to adhere to their treatment regimens and thus to see the course of their illness improve. Yet the schizophrenia PORT study shows that the newer medications are seriously underutilized, especially in African-American and other minority populations, resulting in higher noncompliance with treatment and the familiar consequences of untreated mental illness.⁴ The evidence shows that mental health service providers should make the newer medications routinely available to those who would benefit from them.

The Assertive Community Treatment (ACT) model (also known as Program of Assertive Community Treatment, or PACT) has been the subject of more than a quarter century of research showing its effectiveness with clients who do not respond to less comprehensive approaches. Since its inception in Madison, Wisconsin, in the 1970s, the ACT model has demonstrated that a mobile, multidisciplinary team approach, with services available twenty-four hours a day, significantly improves outcomes for persons with hard-to-treat mental illnesses. In some sites, persons with histories of criminal justice involvement or deemed to be at risk of criminal justice involvement have been identified as priority clients of ACT programs.

Despite the abundance of research that demonstrates ACT’s effectiveness, providers and systems have until recently been reluctant to make the changes necessary to implement the program. Research is less clear on the factors that

"When it comes to suicide and mental illness, the gap between what we know and what we do is lethal."

**KAY REDFIELD
JAMISON**
Researcher, Author

Source: *Night Falls Fast: Understanding Suicide*, Knopf, 1999

3. Robert E. Drake, presentation at National Corrections Conference on Mental Illness, July 18 - 20, 2001, Boston, MA.

4. A. F. Lehman and D.M. Steinwachs, “Translating Research into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations,” *Schizophrenia Bulletin* 24, 1998, pp. 1 -10.

may have impeded implementation of ACT, but many providers note that it is difficult to change staff habits, program configurations, and patterns for state funding and federal reimbursement. In this way, the story of ACT is illustrative of some of the hurdles to be overcome by all evidence-based practices. So, too, is the recent upturn in ACT implementation, which stems from increased advocacy for the program at both the federal and grassroots levels, as well as clarification of reimbursement rules under Medicaid and other funding streams.

It is important to note that evidence-based practices are not all treatment interventions. Supported employment, family psychoeducation, and illness self-management are better seen as support techniques that ultimately allow a client to develop his or her self-reliance and personal strengths. Each in its own way can be a critical element in a person's recovery and ability to function, but none of these practices can be seen as direct treatment.

The U.S. Surgeon General and others have made efforts to gather and disseminate information about evidence-based practices, but it is apparent that a huge gap remains between knowledge and practice, between what is known through research and what is actually implemented in many public mental health systems across the country. A particular challenge for public mental health stakeholders is to ensure that evidence-based practices become more broadly available and more seamlessly integrated into existing systems of care.

The Surgeon General's 1999 report on mental health makes this challenge particularly clear. "Exciting new research-based advances are emerging that will enhance the delivery of treatments and services in areas crucial to consumers and families—employment, housing, and diversion of people with mental disorders out of the criminal justice systems. Yet a gap persists in the broad introduction and application of these advances in services delivery to local communities, and many people with mental illness are being denied the most up-to-date and advanced forms of treatment."⁵

Example: New York State Office of Mental Health

The departments of mental health in Illinois, Maryland, New York, Ohio, and Virginia, among other states, have held or plan to convene conferences on evidence-based practices. The most ambitious of these was held in New York by the Office of Mental Health for the clear purpose of acquainting county-level policymakers and local service providers with national best-practice trends. The New York conference was the first step in a projected series of initiatives designed to make adherence to best practices a top priority in the New York public mental health system.

Example: NASMHPD Research Institute

The National Association of State Mental Health Program Directors (NASMHPD) Research Institute is joining with the New Hampshire Dartmouth Psychiatric Research Center and the Medical University of South Carolina to develop methods for the dis-

Replicating Evidence-Based Practices Successfully

Researchers point out that the history of ACT implementation also raises another of the complex questions in the promotion of evidence-based practices. There are communities in which providers claim to be operating ACT teams. On examination, however, it is evident that the model has been incompletely applied, raising serious concerns about its ability to live up to expectations based on research documenting the complete model. For example, the original ACT standards call for a psychiatrist to participate as a full member of the treatment team, not just as a consultant. Some agencies, however, see an opportunity to save money by restricting participation of the psychiatrist. Inevitably, this changes the nature of the team and, thus, potentially erodes reliability of "ACT" in that community. Researchers remind us that an evidence-based practice cannot succeed if its local implementation does not maintain fidelity to the original model. Worse, when a practice such as ACT is corrupted and improperly applied, results can be very different from those intended.

5. Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*.

6. The NASMHPD Research Institute (NRI) has recently launched a center for evidence-based practices, performance measurement, and quality improvement. The full range of the center's activities is still under development.

semination of evidence-based practices. This effort, which various government and foundation sources support, is intended to provide hands-on assistance with replication of proven interventions. At the same time, research is under way to determine those factors that improve acceptance and implementation of proven models. This work has tremendous implications for the future of effective mental health services.⁶

b

Incorporate recent findings, best practices, and promising practices into existing approaches at the agency level.

Identification and implementation of evidence-based practices should not prevent innovation or the development of new practices. Many practices employed in the public mental health system have not yet been well researched. This does not mean that they aren't effective; in many cases, they simply have not attracted the attention of researchers or they do not easily conform to traditional research methodologies. Researchers, providers, and practitioners should be encouraged to continue to develop new methods to serve people with mental illness who enter the system. Incentives for this activity should include an emphasis on outcomes in funding and contracting structures used for community services. Reliance on performance measures that emphasize recovery and improvement in a person's quality of life can lead to development of practices geared towards these outcomes. Providers should incorporate innovative approaches and methods expected to achieve good outcomes, paired with appropriate evaluation methods, into the practices employed by their agencies.

c

Promote and support research in the government, academic, and private sectors into the causes and treatment of mental illness.

Research into effective medications and services is vitally important to the mental health field. Medical and rehabilitative advances of the past quarter century have changed our society's understanding of what is possible for someone with mental illness to achieve. Yet most researchers and practitioners agree that much remains unknown about mental illness and its treatment. As the Surgeon General's report on mental health notes, the nation must continue to invest in research at all levels to continue the trends benefiting many people today.⁷

The federal government sets much of the nation's agenda in basic, clinical, and services research. The research agenda is broadly encompassing; it should not overlook concerns of those people with mental illness who have contact with the criminal justice system. Practitioners and policymakers at the community level should be familiar with the research process and should promote

See the NRI Web site at: <http://nri.rdmc.org/> for more details. NRI also presents an annual conference that has evolved into a leading venue for services researchers and practitioners to meet and exchange information.

7. Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, pp. 453-54.

continued support of federal agencies, such as the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration.

At the same time, the government should ensure that its policies and relationships with academic research centers and with industry promote research expected to benefit the same core group of disabled individuals. Close attention should be paid to provision of incentives that will ensure continuation of the progress this field has experienced in recent decades.

The research community also has an obligation to guard the safety of any human subjects involved in its programs. Mental health service providers must work with researchers to ensure that clients who participate in research understand the potential risks and benefits of the programs in which they take part.

d **Employ effective mechanisms to disseminate research findings and promote promising practices and evidence-based practices to practitioners in the field.**

Researchers and policymakers have noted the unfortunate truth that practice in the field too frequently fails to reflect what is known about the most effective practices available. This wide gap between what is known and what is in fact done results in lost lives, failed systems, and wasted resources.

Policymakers should ensure that practitioners employ effective mechanisms for knowledge dissemination of findings regarding promising practices and evidence-based practices in the systems they oversee. These mechanisms might include conferences, professional journals, academic partnerships, and regular in-service training opportunities. Contracts should include bonuses or other incentives for the use of evidence-based practices as well as for training and other dissemination practices.

Example: Ohio Department of Mental Health; Illinois Office of Mental Health

Some state public mental health systems are accepting the challenge and taking steps to bridge the gap between research and practice. For example, the Ohio Department of Mental Health has established “coordinating centers of excellence” responsible for disseminating evidence-based or promising practices across the state. Eight of these centers are planned with the hope that they can promote local initiative and raise statewide quality measures. In Illinois, funding from the state Office of Mental Health has helped to establish the Illinois Staff Training Institute for Psychiatric Rehabilitation at the University of Chicago.

36

Integration of Services

POLICY STATEMENT #36

Initiate and maintain partnerships between mental health and other relevant systems to promote access to the full range of services and supports, to ensure continuity of care, and to reduce duplication of services.

People with serious mental illness generally have service needs that extend well beyond core mental health treatments such as medication and counseling. This is especially true of people with co-occurring mental illness and substance abuse disorders (see Policy Statement 37: Co-Occurring Disorders) but applies equally to any person with mental illness who has concerns related to health care or other disabilities. In many cases, these needs are best met by agencies or providers who can combine specific expertise in other areas with these or other traditional mental health services. It is certainly easier for clients to access services through providers able to link acute clinical services with necessary support services such as housing assistance, vocational rehabilitation, and educational ser-

vices—and consumers cite ease of access as an important reason for sticking with or abandoning treatment. Similarly, when they are served by a single agency or by a well-coordinated partnership, consumers usually feel they are treated with greater respect. They are not asked for the same information again and again, and they may even be spared filling out quite so many forms.

From a clinical standpoint, provision of coordinated services simply makes sense. Even when a client sees different clinicians in the same agency, it is more likely that charts and records are consistent and there is agreement on treatment goals. Coordinated care, a value expressed by many health care providers, is much more achievable when all related services are provided by the same agency.

RECOMMENDATIONS FOR IMPLEMENTATION

- a Promote services and systems integration for co-occurrence of mental illness and other chronic conditions.**

While the disorders thought of most frequently as co-occurring are mental illness and a substance abuse disorder, these are by no means the only disorders to overlap. Mental illness can also coincide with developmental disability

(mental retardation), traumatic brain injury, HIV, diabetes, or any disabling condition or chronic illness. In each instance, it is now understood, the person with co-occurring conditions meets with greater success if his or her needs are considered as a whole and the disorders are treated in an integrated manner. The goal of integrated treatment is to combine treatments for more than one disorder at the level of clinical intervention. Ideally, the individual with co-occurring disorders should find services to be delivered seamlessly, “with a consistent approach, philosophy, and set of recommendations.”⁸

Example: Fountain House, New York City (NY)

Fountain House, in New York City, is the founding site and leading example of the clubhouse model of rehabilitation. Its program has been replicated in communities worldwide. It provides education, housing, employment programs, and social opportunities for its members. While clubhouses such as Fountain House do not directly provide clinical treatment services, they generally have strong links with appropriate agencies to ensure that members who need treatment are able to receive it. In operation since 1948, Fountain House itself is able to meet the needs of members who are elderly or disabled by illness or disability. Ten percent of its members, for instance, are deaf or hearing-impaired. Approximately half of its members have histories of substance or alcohol abuse. And one in five are elderly. Like other successful and long-standing models, Fountain House appears to meet the needs of its clients by accepting them as they present themselves and working with them from that point forward.

"The organization of services for adults with severe mental disorders is the linchpin of effective treatment. Since many mental disorders are best treated by a constellation of medical and psychosocial services, it is not just the services in isolation, but the delivery system as a whole, that dictates the outcome of treatment."

Source: *Mental Health: A Report of the Surgeon General*, p. 285

b

Integrate primary health care and mental health care services.

People with mental illness are at greater risk for health problems than is the general public. Smoking and poor nutrition are more prevalent among people with mental illness. Because of poverty or disorganization associated with their illness, people with mental illness are also less likely to visit primary health care providers on a regular basis. As a result, people with mental illness are in poorer health than the general population, and they rarely benefit from early intervention for health problems. When they do receive treatment for health problems, their conditions may already be in advanced states, so the treatment itself is typically more involved and more costly.

Some mental health providers have explored integration of primary health care and mental health care as a way to improve general health among people with mental illness. A recent study has demonstrated the benefits of this approach.⁹ Subjects in the study were enrolled in a Veterans Affairs (VA) mental health clinic, where some were randomized to receive primary care through an integrated care initiative located in the mental health clinic, while others received medical care through the general medicine clinic. Those who received

8. Robert E. Drake et al., "Implementing Dual Diagnosis Services for Clients with Severe Mental Illness," *Psychiatric Services* 52:4, April 2001, pp. 469-76.

9. Benjamin G. Druss et al., "Integrated Medical Care for Patients with Serious Psychiatric Illness," *Archives of General Psychiatry* 58:9, September 2001, pp. 861-68.

primary care through the integrated care clinic had significantly better outcomes than those with mental illness who received primary and mental health care in separate settings. Policymakers and providers should consider adopting this approach to improve the general health of people with mental illness and to lower the incidence of emergency interventions in that population.

c **Develop blended funding strategies to sustain comprehensive, integrated services.**

Funding is the major challenge faced by advocates and managers who wish to start or maintain integrated or comprehensive service programs. Those who have managed to start programs and operate them successfully do have experience that can be useful to others in the field. According to a report by the GAINS Center, there are several strategies that increase the likelihood of success.¹⁰

Programs focusing on integrating several types of services in order to provide comprehensive treatment should identify a mix of funding sources that, in a sense, reflects the blending of services. Reaching out to different funding sources may appear to be more difficult than traditional mental health funding, which usually relies on categorical funding streams. Approached creatively, however, adopting a mix of services can also expand the range of funding possibilities. Approaching the development of services in this manner may also help providers to better understand what they are looking for in services as well as in funding and where the service deficiencies lie for the target population.

d **Adjust licensing and other regulatory functions to encourage development and operation of comprehensive, integrated services.**

Funding is by no means the only issue keeping systems from supporting more effective services. Key providers in a given community, perhaps competing for funding, may operate with different philosophies, undermining opportunities for cross-training, effective communication, or service coordination. At the same time, conflicting or confusing licensing regulations can thwart one agency's efforts to provide integrated services.

To achieve widespread service integration, policymakers will need to coordinate or consolidate regulatory and reporting mechanisms. The purpose is to make creative and effective integrated service models available for people who have mental illness and a variety of other needs.

10. National GAINS Center, *Courage to Change*, December 1999, pp. 17-22.

Example: Assertive Community Treatment

The Assertive Community Treatment model (known as ACT or PACT) was developed in Madison, Wisconsin, in the 1970s. Six states (Delaware, Indiana, Michigan, Rhode Island, Texas, Wisconsin) currently have statewide ACT programs. Nineteen states have at least one or more ACT pilot programs in their state. It is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illness. Unlike many other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, delivered in the “real world” settings of their homes, local coffee shops, or other places they may frequent. To have the competencies and skills to meet a client’s multiple treatment, rehabilitation, and support needs, ACT team members are trained in psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. Recently, ACT teams have placed a greater emphasis on inclusion of consumers as treatment team members, either in the traditional professional positions or as peer counselors able to communicate more effectively with a team’s clients. The ACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year. To make ACT programs more accessible, states have adopted funding strategies approved by Medicaid for this purpose. As part of their contracting process, states monitor ACT programs for compliance with certain agreed-upon practice standards.

Example: Village Integrated Service Agency, Long Beach (CA)

The Village Integrated Service Agency in Long Beach was initially developed through state legislation (1989) that attempted to remove administrative and funding barriers from the delivery of comprehensive, individualized mental health services. The three basic elements of Village’s program design are collaborative case-management teams, case-rated funding, and a psychosocial rehabilitation/recovery philosophy. As in the ACT model, services at the Village are primarily delivered to the client wherever he or she is: at home, on the job, in the supermarket. Teams of clinicians work with each client and bring complementary skills to the process. Case-rated funding is an important principle because it is focused on outcomes rather than on delivery of units of service. The overarching recovery philosophy imbues staff and clients with a willingness to seek the rewards that come with higher risks, knowing that support will be available when needed. The Village offers a clear, single point of responsibility for everyone it serves and provides coverage 24 hours a day, seven days a week.

37

Co-Occurring Disorders

POLICY STATEMENT 37

Promote system and services integration for co-occurring mental health and substance abuse disorders.

In the view of many practitioners and researchers, co-occurrence of mental illness and substance use disorders in individuals is so common as to be the norm rather than the exception. In fact, it is estimated that 75 percent of people with mental illness within the criminal justice system meet criteria for drug and/or alcohol abuse or dependence; some cite figures indicating that up to 90 percent of those behind bars with either mental illness or substance abuse disorders have co-occurring disorders.¹¹ As a result, increased attention has been given to identification of the most effective models for the provision of services to the “dually diagnosed”

population. For the past 15 years, extensive efforts have been made to develop integrated models of care that bring together mental health and substance abuse treatment. Recent evidence from more than a dozen studies shows that comprehensive integrated efforts help persons with dual disorders reduce substance use and sustain mental health recovery. Integrated approaches are also associated with a reduction in hospital utilization, psychiatric symptomatology, and other problematic negative outcomes, including rearrest.¹²

RECOMMENDATIONS FOR IMPLEMENTATION

a **Employ an integrated approach to treatment of persons with co-occurring mental illness and substance abuse disorders.**

While there is widespread agreement that models featuring integrated services for individuals with co-occurring disorders are far more effective than those delivering services in a fragmented or sequential fashion, access to integrated programs is not available in most localities.

11. Teplin and Abram, “Co-occurring Disorders Among Mentally Ill Jail Detainees,” pp. 1036-45; see also Policy Statement 17: Receiving and Intake of Sentenced Inmates.

12. Robert E. Drake et al., *Psychiatric Services*, pp. 469-76.

Barriers to integration exist at policy, program, and clinical levels. The terms “substance abuse disorder” and “mental illness” are often integrated under the phrase “behavioral disorders.” Because substance abuse disorders can both mimic and exacerbate psychiatric disorders, the differentiation of what may be contributing to abnormalities in mood, thinking, or behavior is a difficult task requiring sophisticated assessment strategies. It is unfair, and unwise, to put the burden of differential diagnosis on law enforcement, the courts, corrections, or community corrections staff. The responsibility for assessing and responding to the behavioral needs of arrestees, defendants, inmates, and parolees must rest with community behavioral health providers. These providers must offer an integrated behavioral health service package to the criminal justice system if the shared vision of effective treatment and efficient justice is to be achieved.

The essence of integration is that the same clinicians, working in the same setting, provide and coordinate both mental health and substance abuse interventions. For the dually diagnosed individual or the referring agent, the services appear seamless. Clinicians take responsibility for combining the interventions to address the individual’s clinical and legal circumstances, and the recommendations are consistent with the best practices of both the mental health and addictions fields. Neither disorder is considered primary, and it is recognized that successful resolution of the symptoms of both the addiction disorder and the nonaddiction psychiatric disorder are interdependent on integrated treatment strategies.

Integration involves modifications of traditional approaches to both mental health and substance abuse treatment. While there are numerous “right” ways to deliver services, and dual diagnosis programs differ from one another in many ways, successful programs incorporate several critical components that make them comprehensive.

Effective integrated programs do more than add a cross-trained staff member or a dual diagnosis group to existing traditional programming. Experts have defined comprehensive programs by the presence of intensive case management models, motivational interventions to advance clinical goals, the involvement of family and natural supports, and a long-term treatment perspective.¹³

Example: Dependency Health Services and Central Washington Comprehensive Mental Health, Yakima (WA)

The Integrated Crisis Stabilization and Detoxification Programs in Yakima are two separate programs that work in close collaboration. Each has learned to offer integrated services to persons with co-occurring substance abuse and mental health diagnoses. The two programs complement each other and offer “seamless” programming.¹⁴ The staffs in the two programs, which share a medical director, together initiate joint clinical interventions. They also collaborate with other agencies, including the hospital (for ambulance response and medical care) and local law enforcement.

Intensive case management is often accomplished through the use of multidisciplinary teams that include both mental health and substance abuse specialists who share responsibility for treatment and for training each other. Adhering to the principles of assertive community treatment that are designed for individuals who are difficult to engage in traditional services, intensive case management services perform outreach to the client’s home (or street outreach if the client is homeless) and natural support system. Even where there are court-ordered conditions for treatment, noncompliance may be an early feature, due to the disabling effects of co-occurring disorders, and assertive outreach may be required for some individuals. Without such efforts, clients may be expected to drop out of treatment, with ensuing revocation or rearrest.

13. Ibid.

14. James B. Bixler and Brice D. Emery, *Successful Programs for Individuals with Co-Occurring Mental Health and*

Substance Abuse Disorders: Examples from Five States, National Association of State Mental Health Program Directors, National Association of State Alcohol and Drug Abuse Directors, August 2000.

b Recognize that relapse is a common feature in the experience of many individuals with co-occurring disorders.

Effective programs accept that recovery from dual disorders is a long-term process. Both mental illnesses and addictive disorders are characterized by periods of higher functioning interrupted by periods with disabling symptoms. Recovery takes place over months and years. Scarce resources should not be diverted from long-term community-based care to high-cost, short, intensive interventions. Relapses are anticipated and contingency plans are made to minimize the duration and severity of the relapse. Close collaboration with community corrections staff is critical to ensure the responses to relapses serve both public safety and clinical goals.

c Integrate mental illness and substance abuse treatment policy, funding, and regulation at the federal, state, and agency levels in order to achieve desired clinical outcomes.

To facilitate service integration, there need to be integrative policies and administrative support at the system level. State, county, and local mental health authorities either promulgate, or are bound by, financing mechanisms and regulations that impede integrative service delivery. In most states, for example, licenses for mental health and substance abuse facilities are handled by two different state agencies with separate regulatory, financial, and oversight procedures. Frontline providers are often caught between doing what is clinically indicated and what is financially reimbursable with the dual diagnosis client suffering the consequences of ineffective care. New interorganizational structures and policies are required to enable the seamless provision of requisite services. These structural changes do not necessarily require more resources, and integration has the potential to be cost efficient.¹⁵

Advocates and practitioners agree that much can be done at the systems level to remove impediments and ease the provision of integrated mental health and substance abuse services. Supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in June 1998, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) conducted a formal dialogue intended to explore the issues related to the provision of integrated services. A report on this dialogue was issued by the two organizations in March 1999. In signaling their desire to collaborate in finding solutions, they have initiated a process each hopes will bring movement at both the federal and state levels.¹⁶ More recently, the SAMHSA work plan for 2002

"...dual diagnosis is an expectation, not an exception."

KENNETH MINKOFF
 Medical Director, Choate
 Health Management Care,
 Assistant Clinical
 Professor of Psychiatry,
 Harvard University, MA

Source: "Dual Diagnosis: An Integrated Model for the Treatment of People with Co-occurring Psychiatric and Substance Disorders," Available at: www.dualdiagnosis.org/library/dual_network/minkoff_summer_01.html

15. Kenneth Minkoff, "Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders Psychiatric Services," *Psychiatric Services* 52:5, May 2001, pp. 597-99.

16. National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders, June 16-17, 1998, Washington, D.C., sponsored by the National Association of State Mental Health Program Directors (NASMHPD) and the National

and beyond gives the highest priority to addressing the issues involved in providing services for people with co-occurring disorders.¹⁷

It is not surprising that financial questions are among the thorniest facing policymakers seeking integration of substance abuse and mental health services. For example, the federal Substance Abuse Block Grant and Mental Health Block Grant are separate funding streams administered in different centers within SAMHSA. They often flow to different agencies in a given state and, in turn, finance quite different providers and services at the community level. Because integration of such federal funding brings with it the possibility of a significant realignment of resources throughout the system, many who would be affected are moving towards integration with great caution.

It should also be noted that the use of illicit drugs—and, more specifically, arrest for drug-related crimes—may result in limitations on an individual's ability to receive important federal benefits such as SSI or to qualify for housing under many public housing programs. Because of the high prevalence of co-occurring substance abuse and mental health disorders, many of those who come into contact with the criminal justice system are people whose past activities have left them unable to access various federal benefit programs. This circumstance places an additional strain on state systems and local agencies seeking reimbursement for integrated services provided to people with co-occurring disorders.

38

Housing

POLICY STATEMENT #38

Develop and enhance housing resources that are linked to appropriate levels of mental health supports and services.

As public mental health policy has moved away from reliance on institutions and toward community integration, policymakers, providers, and advocates have been forced to confront the many obstacles facing persons with mental illness who seek safe and affordable places to live. While some of the difficulties encountered by this population are common to all who live on low or moderate incomes, other challenges are more directly related to the experience of mental illness. In any case, in order to consider steps a community might take to improve housing options, it is first necessary to understand the existing obstacles.

The price of housing stock, particularly in major cities, has risen well beyond the ability of people with low or moderate incomes to pay for it. Since people in the public mental health system are among the poorest in the nation, they are hard hit by this crisis in affordable housing. In 2000, there was no housing market in the country where a person with a disability receiving SSI benefits could afford to rent a one-bedroom or efficiency unit.¹⁸

Federal housing subsidies for individuals with mental illness do not adequately compensate for the inflated private housing market. In 1992 and 1996,

Congress passed laws permitting public and assisted-housing providers to designate housing as “elderly only.” This resulted in many “non-elderly” adults disabled by mental illness no longer having access to a major portion of the affordable rental units in this country. Unfortunately, U.S. Department of Housing and Urban Development (HUD) officials have also promoted policies in recent years that have failed to keep pace with the needs of low-income people with disabilities who wish to rent affordable apartments. The Section 811 Supportive Housing for Persons with Disabilities Program has had its funding reduced from \$346 million in 1991 to \$217 million in the most recent budget.¹⁹

Federal housing policy makes it especially difficult for ex-offenders with mental illness to secure public housing assistance. At the most basic level, housing subsidies such as Section 8 are available only for the working poor—applicants must have federal income tax forms to be eligible. Because the large majority of individuals with mental illness are unemployed (70 percent to 90 percent) most do not qualify for such programs.²⁰ In addition, public housing authorities, Section 8 providers, and other federally assisted housing programs are permitted,

18. “Priced Out in 2000: The Crisis Continues,” Technical Assistance Collaborative, Inc., Boston, MA and Consortium for Citizens with Disabilities Housing Task Force, Washington, D.C., June 2001.

19. NAMI, Housing Position Paper, available at: www.nami.org/update/unitedhousing.html

20. Most reports agree on the statistic that between 70-90% of individuals with

and in some cases required, to deny housing to individuals with certain criminal histories.²¹ For example, if an individual is evicted from public housing for drug-related criminal activity, he or she is barred from reapplying to live there for three years. Because many people with mental illnesses have co-occurring substance use disorders, these restrictions affect this population disproportionately. People with mental illness who have histories of any kind of criminal justice involvement also frequently find themselves “jumped over” by others without such histories on waiting lists for assisted housing.

Even without the barriers to receiving federal assistance, the majority of individuals involved in the criminal justice system—regardless of whether they have a mental illness—have limited resources to secure adequate housing. For example, most ex-offenders leave prison without enough money for a security deposit on an apartment.²² Furthermore, private landlords may require prospective tenants to disclose employment, financial, and criminal histories, as well as mental health information, and may exclude individuals based on these characteristics.

Families and friends are an important housing resource for individuals with mental illness. When these individuals become involved in the criminal justice system their relationships with families and friends are often strained. Families living in public housing may be concerned that allowing an ex-offender to resume residency there will compromise their own housing eligibility (see federal restrictions above). More generally, family and friends may feel

incapable of or uninterested in helping an individual who has decompensated sufficiently to become involved in the criminal justice system.

Even if individuals with mental illness who have been involved in the criminal justice system are able to tap family or friends as a housing resource, their reintegrating into the community can be problematic. If an individual with mental illness is simply returning to the environment that fostered his or her involvement with the criminal justice system in the first place, there is a good chance that this reintroduction will result in a rapid return to the behavior that originally caused them to offend.

Individuals with mental illness who are able to locate housing often have difficulty sustaining residency. Sustained residency is usually predicated on the provision of support services (mental health, substance abuse, employment, etc.) in conjunction with housing. Housing and support services can be linked in a variety of ways.

Responses to the housing shortage for people with mental illness differ according to numerous variables: location (group vs. single-occupancy), level of supervision, funding source, intensity of integration with support services, intensity of case management, and others. It is difficult to identify discrete housing “models”; each approach tends to be unique to the community where the housing is provided. The recommendations below are an attempt to identify some of the common characteristics of successful efforts to develop housing options for individuals with mental illness.

RECOMMENDATIONS FOR IMPLEMENTATION

a

Form community-based partnerships to develop comprehensive solutions to housing for persons with mental illness.

Lack of affordable housing is a community problem. Just as there is no one cause for the shortage of housing, no one agency can possibly assume responsi-

mental illness are unemployed. See www.gladnet.org/marrone.htm

21. Travis et al., *From Prison to Home*, pp. 35-6.

22. *Ibid.*, pp. 35-6.

bility for addressing the problem. Effective solutions require partnership of the most inclusive kind. Local, community-based agencies are almost always the most effective at joining together to access housing funding available from state, federal, and, sometimes, private sources. Local agencies are also best positioned to understand the community's particular need and, most important, to create partnerships that can provide necessary housing and supports for people with mental illnesses.

In every community, collaboration among service providers, housing developers, lenders, and elected or appointed officials is critical to successful development of housing for people with mental illness, especially those with histories of criminal justice involvement. Local mental health service providers should actively seek and form partnerships to meet this most pressing of needs.

Example: Community Mental Health Centers, Vermont

In Vermont, every Community Mental Health Center (CMHC) has hired a housing coordinator. These coordinators work with staff from state housing agencies, public housing authorities, nonprofit developers, and others to develop cross-system, collaborative efforts to provide housing for individuals with mental illness. CMHC housing coordinators also work with private landlords, nonprofit developers, case managers and others to ensure that clients are on Section 8 waiting lists, tenant/landlord disputes are settled amicably, and housing development efforts consider the needs of the mentally ill population.²³

"People with [mental illness and addiction who are] on the street...see acutely the need for housing, for a place to feel safe and secure, before they're even ready to consider treatment. Recovery starts when you have something you care about, a place where you can go."

DR. SAM TSEMBERIS

*Executive Director,
Pathways to Housing, NY*

Source: Christina McCarroll, "Pathways to Housing the Homeless," *The Christian Science Monitor* May 1, 2002 edition, available at: www.csmonitor.com/2002/0501/p11s02-lihc.html

b

Establish leadership and coordination at the state level to provide technical assistance and ensure access to resources.

State mental health agencies should examine their role in housing development. Depending on the structure of state mental health systems, state mental health agencies may be able to require provider agencies to participate in local housing collaborations. More likely, it is through force of leadership and, especially, provision of incentives that state mental health agencies can assume a role in meeting this critical need. A relatively small matching grant or provision of technical assistance in completing often complicated applications can be crucial contributions to local housing initiatives.

Although solutions to the housing shortage for people with mental illness ultimately must be locally based, state agencies should encourage local providers to address this issue, and they should facilitate such projects with assistance and funding. Creation of a state-level office that concentrates on housing for persons with mental illness indicates the centrality of housing in the service array.

23. Elizabeth Edgar, and Anne D. Lezak, *Preventing Homelessness Among People with Serious Mental Illness: A Guide for States*, National Resource Center on Homelessness and Mental Illness, April 1996, pp. 31-34.

24. *Ibid.*, pp.26-28.

25. Dennis P. Culhane, Stephen Metraux, and Trevor Hadley, "The Impact of Supportive Housing for Homeless

Development of housing for individuals with serious mental illness is a complex challenge for local communities. By providing centralized expertise, state offices can help local agencies learn to negotiate regulations and requirements related to zoning, property acquisition, licensing, federal funding mechanisms, and the many other issues that arise in housing development.

Similarly, state housing offices can locate disparate funding sources and assist local communities in accessing them.

Example: Office of Housing and Service Environments, Ohio Department of Mental Health

The Ohio Department of Mental Health has created an Office of Housing and Service Environments. In 1989, this office, which has since been sub-divided into three offices, began to redirect some funds, formerly used in the development and renovation of hospitals, to housing development. The DMH Office of Housing also provides technical assistance to local community health boards to create independent corporations to develop housing for individuals with serious mental illnesses.²⁴

C

Institute linkages between housing options and service availability.

Almost all successful housing initiatives for individuals with mental illness are integrated with the provision of other services, including mental health, employment, crisis management, and substance abuse. This model of “supportive housing” recognizes that housing issues must not be viewed as isolated from the other needs of this population; housing should be viewed as part of a broader model of integrated treatment for individuals with mental illnesses (see Policy Statement 36: Integration of Services). Research has shown repeatedly that retention rates for housing with services are considerably higher (often twice as high) than for housing that is not linked to services.²⁵

The issue of whether services should be a mandatory condition of receiving housing is contentious. Some housing developers favor agreements that require individuals with mental illness to have their adherence to treatment closely monitored by case managers as a condition of receiving housing. Some service providers and mental health advocates hold strong philosophical positions against requiring acceptance of services as a condition of housing. This issue remains difficult and divisive.

In all cases, availability and use of service models such as Assertive Community Treatment can go a long way toward meeting the needs of both tenant and landlord in most housing situations.

People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems,” *Housing Policy Debate* 12, 2001.

26. See www.omh.state.ny.us/omhweb/omhq/q0901/Pathways.html

Example: Pathways to Housing, New York City (NY)

In 1992 the New York State Office of Mental Health established the Pathways to Housing program, which seeks to relocate individuals from shelters and the streets into permanent housing. Crucial to the Pathways mission is the integration of intensive services, based on the ACT model.²⁶ Pathways to Housing favors the eradication of all restrictions for housing clients; employment, substance abuse treatment, life skills, and other services are aggressively offered, but not required of program participants.

Example: Corporation for Supportive Housing (CA)

The California branch of the Corporation for Supportive Housing has established the Health, Housing, and Integrated Services Network. This initiative brings together four county public health departments with more than 20 different nonprofit service providers (mental health, substance abuse, HIV/AIDS, employment, and others) to link a broad array of services to housing.²⁷

Many programs that provide housing to individuals with mental illness are linked to case management services. These services may be provided by community mental health providers, the housing providers themselves, or other nonprofit agencies. The intensity of case management, i.e., the volume of cases each case manager handles, varies widely. Case management is often crucial in linking a client to the services that are integrated with housing providers. Many individuals with mental illness who have been involved in the criminal justice system have had bad experiences with treatment programs, and without a dedicated case manager they may not successfully reach out to these services, even if these services are provided in conjunction with housing. Case managers are also extremely important in helping consumers deal with crisis situations. (See Policy Statement 13: Intake at County / Municipal Detention Facility for discussion of the Thresholds Jail Program and Policy Statement 14: Adjudication for discussion of the Nathaniel Project; both programs provide case management and help connect to supportive housing individuals with mental illness who have been involved with the criminal justice system.)

d Blend funding for development and operation of stable, affordable housing.

The most successful housing partnerships are those that identify several funding sources that will allow them to make housing affordable for people with disabilities such as mental illness. Since funding sources frequently impose restrictions on the use of their available funds, this blending of funding sources may be the only way to gain access to funds for both development and operation of properties. When considering funding for housing this population,

27. See www.csg.org/whohhis.html

28. A recent study of more than 3,500 formerly homeless individuals with mental illness involved in a New York City supportive housing program showed that the per annum costs of the housing program were only slightly higher than

the service costs typically accrued by the individuals. The supportive housing model cost \$13,750 per placement per year and resulted in a cost reduction of \$12,145 per placement per year. Dennis Culhane et al., "The Impact of Supportive Housing."

it is important to remember that supportive housing for individuals with mental illness has proven very cost effective when compared with the cost of services (shelter, criminal justice, hospitals, etc.) typically provided to individuals who are homeless and have a mental illness.²⁸

Example: Common Ground (NY)

Common Ground, a New York City nonprofit organization that develops and manages large, congregate, supported housing properties, receives funding from more than 30 different sources. Their funders include foundations, private sector corporations, the New York City Departments of Housing, Human Resources, and Homeless Services, and the New York State Office of Mental Health, among others.²⁹

There are many federal programs that can be used for people with mental illness. These include: HOME, Community Development Block Grant, Section 8 rental assistance (including Section 8 Mainstream Housing Opportunities for Persons with Disabilities), McKinney/Vento Homeless Assistance, Section 811 Supportive Housing for Persons with Disabilities, and Housing Opportunities for People with AIDS (HOPWA). Each program comes with its own requirements and restrictions, but those interested in developing housing in their communities should become familiar with these options.³⁰

Example: Connecticut Local Housing Authorities

During the 1990s, local housing authorities in Connecticut received more than \$40 million from HUD, primarily from the McKinney grants program, to support the provision of housing and services for individuals with mental illness. The state aggressively educated local housing authorities on how to apply for the grants, and fostered collaboration between state mental health service providers and local housing authorities.³¹ The federal Shelter Plus Care Program offers substantial funds specifically targeted to individuals who are homeless and disabled, including those with serious mental illness. Title VII of the National Affordable Housing Act of 1990 amended the McKinney Act to create this grant program. The program provides rental assistance but requires a local match of an equal or greater amount of services.

Some states have found ways to make funds available for development of housing for people with low incomes, including those with disabilities. Bond issues, trust funds, and one-time appropriations have been used for these purposes in different states. For example, Oregon recently negotiated the sale of its former Dammash State Hospital. A 1999 statute establishes a trust fund with the sale proceeds; 70 percent of the trust fund interest will be used to finance community-based housing options for individuals with mental illness.³² Agencies such as Housing and Mortgage Finance Corporations may also have state-specific programs that encourage housing developers to tap various funding sources.

29. See www.commonground.org/docs/Overview/funders.html.

30. See www.hud.gov.

31. Robert J. Burns, *Strengthening the Mental Health Safety Net: Issues and Innovations*, NGA Center for Best Practices, p. 7.

32. *Ibid.*, p. 7.

e **Develop an array of housing to meet the varied needs of individuals with mental illness.**

Typically, community response is most favorable to development of housing that mixes people with mental illness with others who may require no support and/or who will rent at market rates. Most of the programs mentioned above are predicated on development of such “integrated” (also known as “scattered-site”) housing. A building with eight units, for example, may include just one or two units for persons with mental illness. Developers and most community mental health agencies frown on development of properties with many units, all of which are to be occupied by people with mental illness. Such “congregate” housing is a target for community opposition and is seen by many advocates as inimical to the concepts of community integration and recovery. Just the same, it should be pointed out that some communities have seen opportunities arise for development or redevelopment projects that are targeted exclusively to people with mental illness. Still, such projects are growing less common.³³

Example: Project Renewal (NY)

Project Renewal, a New York City based nonprofit, has facilitated the construction of both “integrated” and “congregate” housing throughout the city. One of its several congregate housing facilities, Renewal at Clinton Residence, opened in 1990 and houses and provides services for 57 individuals with mental illness who were formerly homeless. Project Renewal also maintains more than 90 units of “scattered-site housing,” some of which are occupied by graduates from Project Renewal-run treatment programs. Rent subsidies are provided by HUD and federal section 8 programs, among other funding sources.

It should be remembered that people with mental illness fall at different points on a continuum. For some, independent housing with only occasional supports is appropriate. For others, intensely supervised housing is necessary to ensure their safety and success in the community. It would be a mistake for a community to institute a housing plan that doesn’t account for this range of needs. To ensure appropriate housing development, a community should assess the housing options available as well as indications of need, such as waiting lists for section 8 housing or the numbers of people with mental illness found to be inadequately housed in shelters, with relatives, or, indeed, in jails or prisons.

33. Another reason for the decline in popularity of congregate housing is that, compared with some integrated housing models, congregate housing can be more expensive. This is due in large part to the extensive in-house

services available, especially having 24-hour trained mental health staff on-hand. Yves Ades, director, the Nathaniel Project, Center for Alternative Sentencing and Employment Services (CASES), interview, December 20001.

39

Consumer and Family Member Involvement

POLICY STATEMENT #39

Involve consumers and families in mental health planning and service delivery.

People whose lives have been affected by mental illness develop a vast reservoir of experience that can be put to constructive use to meet their immediate needs, those of their peers, and, ultimately, those of the mental health system. In still too many places, this reservoir remains untapped, and consumers and families have little meaningful involvement in determining the direction of services and a system that are meant to meet their needs.

In the 1980s, Congress recognized the value of including consumers and families in mental health

services planning when it created the precursors to today's statewide mental health planning and advisory councils. A major requirement for the composition of the councils is that no more than 50 percent of their membership be drawn from the ranks of professionals or state administrators. The intention is to make councils hospitable to consumers and family members and, in fact, consumers and family members serve on these federally mandated councils in every state.

RECOMMENDATIONS FOR IMPLEMENTATION

a Build consumer and family participation into all levels of the service delivery system.

Inclusion of consumers and family members at the county and/or local level is more variable than at the state level. County boards, for example, may or may not require participation by consumers and family members. Many local agencies include consumers and families on their governing boards or on agency planning committees, and such inclusion is encouraged by national associations. Still, consumers and family members in many areas report their frustration with what they view as a lukewarm commitment to this principle, espe-

cially in instances where they feel their inclusion reflects tokenism rather than an openness to their experience or perceptions of the system.

Example: National Council for Community Behavioral Healthcare

The National Council for Community Behavioral Healthcare (NCCBH) includes the following among the principles of governance it suggests to its members: "Governing boards should include members of or access to the views and input of individuals who are consumers and/or family members of consumers of the organization's services."³⁴

"Peer provided supports and services are a vast untapped resource for recovery when it comes to community based resources for diversion from the criminal justice system. And those supports and services are equally valuable for persons transitioning back into the community."

b

Include consumers and family members in service delivery.

Consumers and family members can also make important contributions to service delivery. Evidence is mounting to demonstrate the effectiveness of consumer-operated support services, for example. Systems that employ people with mental illness to help others gain insight into their illness and build strategies that can help them cope with it report success as measured by lowered use of crisis services. Services such as "warmlines," which make it possible for a person needing support to prevent an exacerbation of symptoms by talking with someone who has had direct experience with mental illness him-or herself, have been shown to succeed in a variety of settings. "Drop-in centers" are consumer-operated sites where people with serious mental illness can meet others and participate in social, vocational, and educational activities.

Similarly, some programs employ consumers to act as "peer educators" who provide generalized information about coping with mental illness in a manner that is authenticated by their own experiences. Peer educators frequently run groups for consumers at mental health service agencies in which they discuss issues of common concern. By removing the experience of mental illness from a wholly clinical approach, peer educator programs often allow people to make connections with one another and understand how to deal with their illness in a more individualized way. Consumer-operated services such as these are seen as part of the continuum of services that also includes professional services; they are not to be seen as a replacement for the professional system.

Example: Harbor Inn Residential Facility, Boston (MA)

In Boston peer educators every week visit Harbor Inn, a residential facility on Long Island in Boston Harbor. They meet with residents who are in transition from hospitals to community settings. Many residents have histories of involvement with the criminal justice system. Educators, who themselves are in treatment for mental illness, show videotapes or share written materials that provoke group discussions of issues such as housing, basic living skills, and tobacco use that are relevant to the lives of those in the residence.

TOM LANE

*Consumer Activist/
Advocate, Director,
Forest Park Drop In
Center at South Florida
State Hospital, FL*

34. *Principles for Behavioral Healthcare Delivery*, National Council for Community Behavioral Healthcare, Rockville, MD, 2001.

Example: Assertive Community Treatment Programs

Assertive Community Treatment programs in many locations around the country have recently added positions on their professional teams that are intended to be filled by consumers of services. Sometimes known as “peer counselors” or “peer advocates,” the consumers who fill these positions provide insight into the experience of mental illness and recovery that professionals without a consumer background are unable to offer.

C**Ensure that people with mental illness are accessing the full range of entitlements for which they are eligible (e.g., SSI, SSDI).**

For many people, access to appropriate services is determined by their ability to access the health benefits and other entitlements for which they are eligible. People with mental illness who are found to be disabled by their illness or who have little or no income as a result of their disability are eligible for an array of income and reimbursement benefits. Many mental health and addiction services provided by community agencies are reimbursable through Medicaid and Medicare, which are generally available to people who qualify for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Qualification for income support also can lead to eligibility for housing supports. In any case, income support through SSI and SSDI provides funds with which an individual can pay rent and meet other basic needs. Other valuable benefits programs for which persons with mental illness may be eligible include Temporary Assistance for Needy Families (TANF), food stamps, and benefits available to veterans through the Veterans Administration.

Rules and procedures for accessing disability entitlement programs are difficult for many with mental illness to understand. There is also a shortage of staff at community mental health agencies who are trained to provide assistance to clients who may qualify for either entitlement program. It is more common than not for first-time applications for entitlements to be denied, at a minimum causing a delay in benefits for qualified applicants. Because these entitlements are frequently the only legitimate source of income for many with mental illness, such delays can lead to homelessness and such “survival crimes” as shoplifting and bill evasion.

The issue of accessing government benefits is also examined in the sections of this report that look at the release of people with mental illness from jails and their reentry to the community from prison (see Policy Statement 13: Intake at County / Municipal Detention Facility and Policy Statement 21: Development of Transition Plan). Because many people with mental illness coming out of jail or prison have no other means of support, linkage with appropriate government benefits in a timely manner can make the difference between success and failure in the community. As discussed elsewhere in the report,

mental health provider agencies must work with partners in jails and prisons to establish protocols that will result in people with mental illness gaining speedy access to appropriate benefits.

Mental health agencies must train staff to provide assistance with applications for SSI and SSDI and the follow-up that is so often needed to secure these benefits. Further, they must ensure that case managers, employment counselors, rehabilitation therapists, and others who may be working with clients to secure employment are familiar with the each client's benefits profile. An increase in income can mean an end to benefits. When clients are working, especially when they are doing so through "transitional employment" or "supported employment" programs, staff should make sure that their transition does not leave them without health insurance or sufficient funds for housing and food. The rules and regulations applied by the Social Security Administration to these programs can create challenges for staff to provide guidance to clients on entitlement and benefit matters. It can also be time-consuming. Training and prioritization of this service are necessary if clients are to access supports intended to help them at a difficult time in their lives.

Example: International Center for Clubhouse Development

The International Center for Clubhouse Development (ICCD) publishes standards for programs that receive its certification. Among its most firmly held principles is the importance of employment in the recovery of clubhouse "members." In the ICCD standards are two that are meant to encourage training and consistency in maintaining the benefits of members who are working in transitional or more competitive employment. Clubhouses receiving ICCD certification are expected to provide sufficient training to ensure appropriate access to benefits by clubhouse members.

40

Cultural Competency

POLICY STATEMENT #40

Ensure that racial, cultural, and ethnic minorities receive mental health services that are appropriate for their needs.

Among the many barriers to appropriate treatment that people with mental illness must negotiate, those arising from cultural differences can make a profound difference in the quality of care a person receives. To supplement the groundbreaking 1999 report on mental health, the U.S. Surgeon General in 2001 issued *Mental Health: Culture, Race, and Ethnicity*, in which the disparities in mental health treatment are documented and discussed. The main message of the supplemental report is: “culture counts.” It states, “The cultures that patients come from shape their mental health and affect the kinds of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services. Cultural and social influences are not the only influences on mental health and service delivery, but they have been historically underestimated—and they do count. Cultural differences must be *accounted for* to ensure that minorities, like all Americans, receive mental healthcare tailored to their needs.”³⁵ Failure to provide mental health services in a culturally sensitive context al-

most certainly results in higher numbers of people with mental illness from racial, cultural, and ethnic minorities in our nation’s jails and prisons.

The Surgeon General’s supplemental report collects many of the studies that have demonstrated both the particular needs of different cultural and ethnic groups, and the availability, utilization, and effectiveness of mental health services for the different groups. It is clear that African Americans, Native Americans and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans may all present symptoms of distress or mental illness according to certain idioms of distress that are particular to their cultures. Members of each of these groups may also be more likely to seek and accept alternative therapies than are their white counterparts. In many cases, these alternative therapies are seen as much more acceptable or consistent with cultural norms than the dominant modes of treatment practiced in the mental health system might be. Within each of these broad groups there exist narrower cultural subgroups, making it difficult for outsiders to approach a person showing symptoms

35. Office of the Surgeon General, *Mental Health: Culture, Race, and Ethnicity – A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human

Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental

of mental illness with any certainty about how offers of treatment, for example, will be understood or accepted.

There is a great deal of data that demonstrate the unevenness with which mental illness falls on members of the cultural minority groups. The public system has, to date, been guilty of undertreatment of some mental illnesses in some cultures and what might be called overtreatment of

others. The thrust of the Surgeon General's supplemental report and of much that has been published about mental health care for members of different cultures is that policymakers and practitioners must take the time to understand mental illness and treatment in cultural terms so that suffering within various cultural groups that goes either undetected or improperly treated can be abated.

RECOMMENDATIONS FOR IMPLEMENTATION

a Recruit members of minority communities for clinical and administrative positions in which there is regular client contact.

The quest for cultural competency has been under way in the public mental health field for some time, but the results to date are mixed. With so many different cultural groups now living side by side in our society, it would be difficult for mental health practitioners or agencies to develop expertise in each one. It is reasonable, however, for agencies to approach the challenge in a manner similar to the approach suggested by the Surgeon General's office in compiling its supplemental report. That is, it makes sense for each agency to identify practitioners with the cultural understanding and, if applicable, the language skills to communicate effectively with the cultures most highly represented in the community. The underrepresentation of minorities among mental health providers, administrators, policymakers, and consumer and family organizations only helps to perpetuate the system's disparities. Agencies should be encouraged to recruit members of minority communities to fill clinical and contact positions.

Example: North Carolina Area Health Education Centers

Since 1985, the North Carolina Area Health Education Center (AHEC) Program has received special state funding to bring its educational services, training programs, and information services to the community mental health facilities in the state. Recognizing that a significant percentage of mental health clients in the public system are from minority groups, yet that the majority of mental health professionals are not minorities, AHECs promote the recruitment of racial and ethnic minority students into mental health professions through special regional programs.

b Provide training in cultural issues to all staff members in contact with clients.

At the same time, each agency should make sure that every staff member who comes in contact with clients has training that will allow him or her to recognize cultural clues in a person's presentation and response to offered services. Cultural competency training itself is evolving, but it is clear that for the mental health system to meet its responsibilities to all in the communities it serves, mental health professionals must develop an understanding of the roles of age, gender, race, ethnicity, and culture in the manifestation of mental illness and its research and treatment. A culturally informed training curriculum is essential if the system is to advance in this area.

Example: Pacific Clinics (CA)

Pacific Clinics, a provider of behavioral health care services in Los Angeles, Orange, Riverside, and San Bernardino counties in California, has made a priority of establishing services to meet the needs of different cultural groups. Many of their 50 sites include staff from Spanish-speaking cultures who can provide culturally sensitive services to Latino clients. Pacific Clinics also has developed services that are sensitive to the needs of the multiple Asian populations living in that part of California. Services at the clinics include links to culture-specific family and consumer groups, as well.

c Develop targeted outreach programs to make services available to members of minority communities.

Members of cultural and linguistic minority groups not only have a more difficult time than others accessing services, many simply fail to consider seeking help when they need it. To many in minority communities, the system is remote and frightening, especially when no one working in it appears to share their language or experience. Deep-seated values can also result in even greater stigma within some cultural groups than exist in the general population.

It is therefore very important for local agencies and the public mental health system in general to seek innovative ways to reach out to cultural minorities in their service areas. Outreach can and should take into account the cultural and linguistic barriers that may be standing between people in need and the services that could help them. One effective way to do this is to tailor outreach approaches to specific groups by using their language and by forming partnerships with cultural institutions that traditionally serve specific communities. In many parts of the country, for instance, mental health agencies have sought to improve outreach to African-American populations by forming collaborative relationships with churches in their communities.

Example: Mental Health Association of New York City (NY)

In 1998, the Mental Health Association of New York City extended its LifeNet help line service to the city's Hispanic community by creating *Ayudese*, a Spanish-language 24-hour referral and education toll-free telephone service. In 2000, the help line service became available to members of New York's largest Asian communities when a new number was created to provide information and referrals in Mandarin and Cantonese. The service is advertised on posters in different languages that are carried in the city's subway cars. In a recent pilot project, police in eight of the city's police precincts carried LifeNet referral cards in different languages to give to people they perceived to be in need of services.

Example: Haitian Mental Health Clinic, Cambridge (MA)

Operated through Cambridge Hospital, the Haitian Mental Health Clinic provides culturally and linguistically appropriate ambulatory mental health care for first- and second-generation immigrants of the Haitian community of metropolitan Boston, including individual and family treatment for adults and children, long-term and short-term therapy, crisis intervention, psychological testing, and psychopharmacology within a managed care framework, encouraging preventive and primary care.

41

Workforce

POLICY STATEMENT #41

Determine the adequacy of the current mental health workforce to meet the needs of the system's clients.

Like other segments of the human services field, the public mental health system is experiencing significant difficulty in attracting and retaining qualified personnel to provide appropriate services and to effectively manage the myriad agencies on which it relies at the community level. Constrained state budgets and tightly capped reimbursement rates result in salaries for line staff and other professionals that are barely competitive with fields requiring far less professional commitment and responsibility. Mental health officials in many states report difficulty in filling positions at the service provision level. Some positions remain vacant for long periods of time. Officials also report high rates of turnover in sensitive line positions in both hospitals and community agencies. In many agencies, ironically, the pathways for career advancement lead only to management positions where clinical skills and experience may take a back seat to other attributes. As a result, mental health agencies can find themselves with few experienced clinicians meeting clients and poorly prepared managers dealing with increasingly complex reimbursement, staffing, and planning issues.

Case managers are, arguably, the most important link in an individualized, community-based system. Theoretically, they should be the most constant face of the system to consumers and their immediate families. However, most consumers who have received services in community mental health centers for any length of time report that they have seen their case managers turn over steadily. More-

over, many complain that their case managers are almost universally young, inexperienced, minimally trained, and paid on a par with people working at McDonald's. Many consumers report that they—the consumers—know far more about the mental health system and how it works than do the case managers they are meant to rely on.

At the same time, mental health workers with the ability to provide services with particular sensitivity to cultural, language, or age-related needs are in especially short supply in many areas. At a time when awareness of the need for culturally sensitive services has grown, it is a sad truth that providers in many communities simply cannot attract the workers needed to implement those services.

It is evident that there are any number of reasons for high vacancy and turnover rates. The jobs entail stressful workloads and conditions, while commanding little public respect or compensation. Reality may not jibe with expectations or training, and paperwork and other bureaucratic imperatives place an additional set of burdens on workers who may have a genuine desire to serve people in need. Moreover, staff currently entering the field may find themselves in agencies oriented only toward survival and not toward achieving the high expectations that should be the hallmark of the community mental health system. Services researchers must thoroughly examine the factors involved in workforce recruitment and retention, and steps must be taken to address the gaps evident in the field. Without significant improvement in this area, many

of the important recommendations in this report will not be implemented, simply because competent staff will not be available to do the necessary work.

Example: California State Task Force

A California statute created a task force led by the Department of Mental Health to identify options for meet-

ing the staffing needs of state and county health, human services, and criminal justice agencies. Also in California, the Center for Health Professions at the University of California, San Francisco, has created the California Workforce Initiative to look broadly at needs in the health care workforce, including the behavioral health care field.³⁶

RECOMMENDATIONS FOR IMPLEMENTATION

a Plan to increase the supply of skilled and experienced mental health providers.

Using data from research, policymakers and state legislators should consider steps that will ensure availability of sufficient resources to attract qualified workers to the mental health field and to make work in the mental health field an attractive career choice for those with an aptitude for provision of supportive services. At the same time, state mental health officials should undertake efforts designed to raise the professional standing of mental health field workers and others involved in providing mental health services. Working in concert with universities and other entities outside the public mental health system, officials should develop degree or certificate programs that recognize and reward life experience that can be converted to credentials acceptable to regulatory, licensing, and reimbursement bodies. Efforts should also be made to provide financial or other incentives that will attract workers to the mental health field. For example, tuition loan forgiveness or support programs should be implemented. Innovative opportunities for professional development and advancement should be increased.

Example: Ohio Residency/Traineeship Program, Ohio Department of Mental Health

Since 1947, the Ohio Department of Mental Health (ODMH) has funded the training of psychiatric residents, psychology students, graduate-level nurses, and social workers to provide services to persons in Ohio's public mental health system. This program is seen as critical in the development of high-quality and high-performance mental health clinicians. Recruitment and retention is closely linked to experience gained and expertise fostered in this program. ODMH works in partnership with local mental health systems and institutions of higher education to implement this initiative.

Example: Mental Health Worker Certificate Program, Walnut (CA)

A new project at Mt. San Antonio College/Regional Health Occupations Center in Walnut, California, will create a competency-based certificate program for entry-level mental health workers. The program expects to contribute to a more prepared mental health workforce. The curriculum includes 64 hours classroom study and 6 months' clinical practice experience. It expects to train between 20 and 50 workers over a six-month period.

Health, 2001.

36. Little Hoover Commission, *Young Hearts and Minds: Making a Commitment to Children's Mental Health*, Sacra-

b Promote the employment of current and former clients in the provision of mental health services.

The mental health system's own clients may represent a ready reservoir of talent that can supply workers for many positions in the field. An expanding body of research shows that consumers of mental health services bring skills and compassion to such frontline positions. Training programs should be developed to maintain high standards of care and full integration of consumers into the workforce. Programs that ensure appropriate support for consumers working in mental health services should be developed at local agencies. Agencies should also come to consensus on the ethical issues raised by the inclusion of consumers in the mental health workforce; seeing a possible compromise to patient confidentiality, some agencies prohibit their clients from taking on provider positions, while others have found ways to minimize the issue. Finally, state systems and provider agencies must find ways to substitute experience for education in qualifications for case management and other frontline positions. This may require negotiations with a state Medicaid authority so that providers can bill for experienced peer counselor activities, thus eliminating a major obstacle to consumer employment.

Example: New Jersey Division of Mental Health Services, Department of Human Services

The New Jersey Division of Mental Health Services, Department of Human Services, wanted to open the way for employment of consumers as peer counselors in Assertive Community Treatment programs operated in many of the state's counties. While the benefits of this initiative seemed obvious to the division, Medicaid reimbursement regulations were a barrier. The state Medicaid agency's willingness to defer to state mental health agency guidelines made it possible for this plan to move forward.

c Provide training that specifically addresses the consumer and family experience of mental illness.

While ongoing training of all mental health workers is necessary to ensure familiarity with developments in the field and to address deficits in training received prior to employment, specific training by consumers and family members can help mental health workers better understand the needs of those they serve. Exposure to the experiences of primary consumers of mental health services and their families can provide insights that do not come from much of the training received in classroom or credentialing situations.

Example: NAMI Training Courses

State NAMI affiliates in fourteen states have presented a comprehensive course for providers that is taught by mixed teams of consumers and family members. Classes are presented throughout the year and with significant state mental health agency support in Vermont, Connecticut, Missouri, and Utah. The purpose of the course is to acquaint providers with the firsthand experience of mental illness. Evaluations of early classes indicate that staff have changed clinical practice as a result of what they have learned in the course.

The need for training and cross-training of professionals is addressed elsewhere in this report but must be mentioned here again for emphasis (see Chapter VI: Training Practitioners and Policymakers and Educating the Community). With workforce issues, including job frustration and burnout, looming as large problems in the mental health field, staff training is a tremendously important function. A workforce in which individuals have a firm grasp of their role and of the options open to them in the performance of their duties will provide a more professional response to the challenges faced in the field.

d

Plan to increase the supply of skilled and experienced mental health providers in rural areas.

A separate but very much related issue is the acute shortage of mental health workers in many rural areas. Particularly in the rural West, where population density is low, recruitment of psychiatrists and other skilled professionals presents an enormous challenge. Many counties report vacancies in key positions lasting several years. Community mental health therefore takes on a different look in rural areas, especially in the West. Care may be delivered by whatever professionals are available. Primary care physicians often take on the role of psychiatrist in rural communities, and telemedicine and other techniques that allow few professionals to cover vast areas are widely employed. Wide distances distort the meaning of “community” mental health, and institutional care at state hospitals many hours’ drive from home can be more common. Practices that have proven effective in more densely populated districts are often simply impractical in rural areas.

The unique needs of people with mental illness in rural states have been explored in detail by the Mental Health Program of the Western Interstate Commission for Higher Education (WICHE), in Boulder, Colorado. By collecting and analyzing data on mental health services in frontier counties (fewer than seven persons per square mile), WICHE has identified the greater challenges in service provision. At the same time, policymakers and providers in states with large rural areas have worked to identify services that are effective in such settings.³⁷

Another organization that focuses on the issues in rural mental health is the National Association for Rural Mental Health (NARMH). Founded in 1977 in order to develop and enhance rural mental health and substance abuse services and to support mental health providers in rural areas, NARMH has added the goal of developing and supporting initiatives that will strengthen the voices of rural consumers and their families.

Both WICHE and NARMH address recruitment and retention issues in the rural mental health workforce.³⁸ NARMH maintains a job bank on its Web site and provides information on recruitment through its annual conference.

mento, CA, October 2001, pp. 63-66.

www.wiche.edu/mentalhealth/Frontier/index.htm

37. Examples can be found at the WICHE Web site:

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Accountability

POLICY STATEMENT #42

Establish and utilize performance measures to promote accountability among systems administrators, funders, and providers.

The purpose of performance measures is to evaluate and monitor how well a system responsible for providing mental health care is performing: to report the information in quantitative terms and to direct the system's efforts and resources toward desirable goals. The fundamental problem with defining such a set of indicators is the lack of consensus on these goals and, therefore, the lack of definition of what constitutes "good" performance.

The various stakeholders of the mental health system—consumers, family members, advocates, providers, purchasers, and policymakers—often have different expectations of the system. A purchaser may emphasize efficiency and cost, while a

consumer may consider outcomes more important. One stakeholder may define a good system as one that contains costs and increases consumer satisfaction; another stakeholder may consider a system successful when it helps a consumer to participate productively in the life of the community. These different values and expectations of stakeholders in a system help to shape the character of the performance measurement system. They also shape the goals and objectives of the system, which, in turn, determine selection and ranking of performance indicators and the criteria by which performance is judged to be adequate. (See Chapter VIII: Measuring and Evaluating Outcomes.)

RECOMMENDATIONS FOR IMPLEMENTATION

a Utilize performance measures in budgeting, contracting, and managing mental health services.

Different stakeholders also have different uses for performance measures. Payers, for instance, need performance indicators to make purchasing decisions and to ensure that contract provisions are met. Consumers may use information on performance to make enrollment decisions, choose providers, and track quality and responsiveness of the different systems of care available to

them. Providers need performance measures for quality management and improvement purposes. Accreditation agencies are incorporating performance measures to monitor adherence to regulations and standards and to guide accreditation and program-review decisions. Finally, governmental entities need performance measures for policymaking, purchasing decisions, budget formulation, and monitoring accountability.

Performance measures are one set of tools in the arsenal of efforts intended to improve quality, management, and accountability. Often, they are used as a key component of ongoing management functions such as planning, quality improvement/management, contract management, and accountability. The focus of management is to monitor and improve (or maintain) levels of performance: performance measures are quantitative, measurable ways to do so. Performance measures can be used effectively in planning/budget systems, quality improvement/management systems, and in contracts management.

Example: New York State Office of Mental Health Center for Performance Evaluation and Outcomes Management

The New York State Office of Mental Health has created the Center for Performance Evaluation and Outcomes Management to develop performance measures and associated performance targets for each priority initiative and major sector of the public mental health system and to evaluate the outcomes associated with each initiative.

b

Involve consumers and families in mental health service evaluation.

Evaluation of mental health services by those who use them is an extremely valuable gauge of the system's effectiveness. One way to tap the energy, commitment, and hard-earned knowledge of mental health consumers and family members is to engage them in the independent evaluation of services. Consumers and family members can help design surveys and "report cards" on services. With consumer and family participation, it is more likely that report cards will reflect real-life experiences of consumers: Did they get help applying for benefits? Did they receive help in finding housing and/or employment? Were they treated with respect?

Consumers and families generally respond to such surveys if they feel the results will be made known to them and will lead to any corrective measures indicated. In some places, consumers and family members have gone beyond these efforts to form consumer satisfaction teams, which work with the system to formally evaluate services through site visits, surveys, and interviews with clients. When efforts of this nature are paired with a commitment by providers to make improvements in services based on the team's findings, significant progress can be made.

Example: Consumer Surveys, Mental Health Statistics Improvement Program

Under the auspices of the Center for Mental Health Services and its Mental Health Statistics Improvement Program, consumers and professionals have worked together to develop consumer surveys that are now in use in a number of states. These surveys, which in some states have been translated into Spanish, Cambodian, traditional Chinese, Portuguese, Russian, and Vietnamese, among other languages, provide an opportunity for consumers to indicate how well services do or do not work for them.

Example: Consumer Satisfaction Team, Philadelphia (PA)

In 1990, a Consumer Satisfaction Team (CST) was developed in Philadelphia. At the time, a state hospital was closing and patients from the hospital were being transferred to community services. Family members and consumers, skeptical of the system's commitment to provide adequate services, coalesced to form the CST. The consumers and family members won support of local authorities for incorporation of the CST's findings in the overall evaluation of the system's ability to provide services in the community. Relying primarily on multiple interviews with consumers at different agencies, the CST was able to document consumer views on provided services. The Philadelphia CST has served as a model for a number of state and local systems wishing to formalize methods for obtaining consumer feedback.

C Attach funding to outcomes.

States and other government entities responsible for funding the public mental health system should employ budgeting and contracting mechanisms that emphasize improved outcomes. Performance based budgeting and other mechanisms that allow for costs in one system to be balanced against offsets in another – spending in the mental health system versus fewer costs in corrections, for example – should be considered by legislatures of states wishing to better understand the full implications of the policies they establish.

Similarly, state mental health agencies that contract with provider agencies for services in communities should attach funding to the outcomes to be achieved. For example, contracts can include incentives for lower rates of arrest among the population served by an agency, along with safeguards that ensure the agency is not “creaming” or finding ways to provide services only to clients at lower risk for involvement in the criminal justice system.

By their nature, performance-based budgeting and contracting mechanisms promote provision of a full spectrum of services that meet all needs experienced by people with mental illness. Strategic placement of both incentives and accountability can lead to development of a system that stresses collaboration and outcomes and allows those making service decisions to make specific spending decisions, as well.

Example: Performance-based budgeting, Various states

Performance-based budgeting and contracting initiatives are under way in many states across the country. While it is too early in this wave of activity to identify states that are leading the field, it is possible for states and counties to begin to learn lessons from the experiences of their counterparts in other jurisdictions. Florida, Texas, Virginia, Missouri, and South Carolina are among the states that have examined or implemented performance-based budgeting in state government. In addition, the federal government is developing methods to convert existing block grants, such as the Mental Health Block Grant, to “performance partnership” grants. Regulations for this effort will be issued some time in 2002.

43

Advocacy

POLICY STATEMENT #43

Build awareness of the need for high quality, comprehensive services and of the impact of stigma and discriminatory policies on access to them.

The stigma of mental illness is a persistent and pernicious force against which people with mental illness, their families, and those who provide services to them must continually struggle. As noted in the Surgeon General’s report on mental health, stigma manifests itself in distrust, bias, fear, stereotyping, embarrassment, anger, and/or avoidance. Stigma derives in part from poor or incomplete understanding of causes and treatment for mental disorders.

Stigma translates into problems that must be addressed by the public mental health system if it is to provide needed services to people with mental illness. Among the most major problems is the reluctance of nearly two-thirds of all people with diagnosable mental illness to seek treatment. Stigma is not the only issue that discourages people in need from seeking treatment, but among many populations, including rural populations and members of many distinct cultural groups, it clearly keeps many away from needed services and supports.³⁹

Stigma also manifests itself in negative public attitudes towards payment for mental health services. Even with passage of mental health insurance “parity” laws in nearly two-thirds of the states, private insurance coverage for mental illness often re-

mains inequitable in terms of co-payments and dollar or durational limits on coverage. At the same time, support for public funding of mental health programs remains soft relative to public willingness to pay for highways, prisons, or even other health services.

In recent years, a common approach by the mental health community to the problem of stigma has been to point out that mental illnesses are illnesses like any other. Much faith has been placed in the promise of research to clarify the etiology of mental illness and to further improve treatments that already can demonstrate effectiveness comparable to treatments for “accepted” diagnoses such as heart disease, cancer, and diabetes. While this approach to stigma and discrimination can be shown to have had some effect, it is clear that public support for greater expenditure on mental health services has simply not materialized.

Recent years have also seen a rise in greater awareness of other problems associated with mental illness, particularly within the law enforcement, judicial, and corrections fields. Low public investment in mental health services has resulted in a system that often cannot adequately meet the complex needs of the people it is meant to serve. A stark

38. See: www.narmh.org/

39. Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, p. 454.

symptom of this undervalued and underfunded system is the increase in criminal justice contact for people with mental illness. Without adequate ser-

vices, many commit the petty crimes that bring them to the attention of law enforcement and the courts and that may result in stays in jail or prison.

RECOMMENDATIONS FOR IMPLEMENTATION

a

Create public support for the investment necessary to make high-quality, comprehensive mental health services available to those who need them.

A significant effect of stigma is that it allows many in society to distance themselves from people with mental illness and the real, if complicated, social issues associated with their condition. People with mental illness, especially those in trouble with the law, are easy to dismiss as unworthy of public notice. At a minimum, they may be seen as inconsequential in the broad political calculus by which limited resources are allocated. Even harsher attitudes prevail when offenders with mental illness are seen exclusively as authors of their own problems or when they become involved in high-profile, often tragic, encounters with the law.

The challenge to public mental health policymakers, providers, consumers, and family members is to find ways to make the public aware of the experience and costs of untreated mental illness. Having found that their own voices alone are ineffective in changing public attitudes, these advocates must search for new allies who can help to carry the message, making support for effective services a public priority.

b

Present a common front to advocate for greater investment in improved mental health services.

In the face of stigmatizing attitudes, increased efforts by law enforcement officials, judges, prosecutors, and corrections administrators to understand and address the causes for their increased contact with individuals with mental illness hold the potential to increase awareness of the costs borne by society when appropriate mental health services are not delivered. By highlighting the burdens placed on their systems by people overlooked or underserved by the public mental health system, members of the criminal justice system have an unprecedented opportunity to help shape public opinion and public policy. Increased public awareness of the inefficiency stemming from the current allocation of resources will help to create the political will necessary to direct resources toward development and maintenance of comprehensive, high-quality public mental health programs. Improvement in public mental health programs will result not only in fewer criminal justice contacts by people with mental illness but, more basically, in more opportunities for people with mental illness to participate fully in society. (See Policy Statement 32: Educating the Community and Building Community Awareness.)

Measuring and Evaluating Outcomes

When agents of change go to extraordinary lengths to facilitate collaboration among mental health and criminal justice stakeholders, which leads to the development of new and exciting initiatives to improve the systems' response to people with mental illness, it is essential that they measure and evaluate the impact of these efforts. Too often, policymakers exhaust time and resources planning and implementing a new program, policy, or statute without taking the steps to ensure that they will know the results of the initiative. By then, administrators need additional resources to sustain the initiative, yet administrators are insisting upon some evidence describing the impact of the program before authorizing the expenditure of additional funds.

Indeed, policymakers and organization executives are right to demand such information. It often rewards the initial decision to authorize the allocation of resources to a particular initiative with

data illustrating the benefits of a new program. The results of an objective, thoughtful evaluation also signal how an initiative can be improved. Furthermore, the evaluation process itself facilitates quality control; not every good idea is implemented well. Sometimes the results of a study reveal that a new program, policy, or legislation has had a negligible impact on a problem, or occasionally even exacerbated it.

The section of the Introduction to this report entitled "Getting Started" explains that an essential first step for any jurisdiction interested in improving the response to people with mental illness is to identify the problem (or problems) that leaders in the criminal justice and mental health community can agree to address. This chapter assumes the existence of such an agreement about the problem; the first policy statement underscores the importance of establishing practical measures of success, which will allow program *funders* and program *administrators* to determine whether they have ad-

1. The subsequent policy statements do not review the elements of validating instruments to identify a mental illness or to assess the potential of a person with mental illness to be violent. Although extremely important, and certainly needed,

the validation of various diagnostic instruments is complex and beyond the purview of this report.

dressed the problem.¹ The second policy statement in this chapter reviews the elements of a program or policy that will support the data collection needed to measure the outcomes identified. The last policy statement in the chapter assumes the change agent has helped analyze an initiative's successes and failures and discusses disseminating the findings.

Evaluations can be extraordinarily complex and expensive undertakings. The policy statements in this chapter suggest how policymakers and practitioners can measure the impact of an initiative practically and efficiently. That said, any effort to obtain reliable and useful information describing an initiative's outcomes requires some resource allocation. Examples cited elsewhere in this report sometimes include a provision requiring state or local government officials to use a portion of the funds allocated to evaluate the impact of the program.² Partnering with local universities is one way to conduct an evaluation and maximize the use of existing resources.

The value and usefulness of a program evaluation often corresponds to the degree to which various stakeholder groups are involved in identifying outcome measures, developing a data collection process, and disseminating the findings. Extensive collaboration inevitably enhances the quality and efficiency of the evaluation. Equally important, it vastly improves the likelihood that significant segments of the community will accept the findings that the evaluation yields. That said, this chapter does not address the oversight of the evaluation. (For a discussion about how to collaborate effectively and establish and institutionalize partnerships, see the section of the report Introduction entitled "Getting Started" and Chapter V: Improving Collaboration.)

2. See, for example, The California Mentally Ill Offender Crime Reduction Grant Program. California Board of Corrections, *Mentally Ill Offender Crime Reduction*

Grant Program: Annual Report, June 2000. Available at www.bdcorr.ca.gov/cppd/miocrg/miocrg_publications/miocrg_publications.htm.

44

Identifying Outcome Measures

POLICY STATEMENT # 44

Identify outcome measures that will enable policymakers and the public to assess the value and efficacy of the initiative.

Change agents who have nurtured a new program, policy, or statute should, before the initiative is implemented, determine how they will measure its success. The outcome measures identified should correlate to the specific goals of a program and the problem it was designed to address. Program administrators and policymakers are sometimes prone to pinning the success of an effort to types of outcomes that their program could never guarantee.

Selecting outcome measures that are particularly difficult, time-consuming, or expensive to measure also undermines the value of an evaluation. For example, while determining the overall cost savings that a program generates can be very valuable in persuading the legislature to maintain or increase funding for a project, isolating such data can be extremely complex. Empirical data linking a program's impact on criminal behavior to a pilot project can be equally elusive. Longitudinal studies with random assignment and control groups are not only an enormous undertaking, they also may not yield conclusive findings.

Law enforcement, court, corrections, and mental health system officials each measure success differently, and they have developed (or are in the process of developing) performance-based measures unique to their professions.³ The recommendations below describe outcome measures that can be tailored to law enforcement, court, corrections, or mental health programs. In addition, these measures can provide useful information without requiring an evaluation process that is particularly time-consuming or expensive to conduct.

3. See, for example, Larry Hoover, ed., *Police Program Evaluation*, Police Executive Research Forum, 1997; Larry Hoover, ed., *Quantifying Quality in Policing*, Police Executive Research Forum, 1997.

RECOMMENDATIONS FOR IMPLEMENTATION

a Establish process measures to assess how well the program activities have been implemented.

Project funders and the public will want to know exactly what project support bought. The following list describes the process outputs that program administrators should count both before and after program implementation.

Number of people served

Program administrators should know the total number of people served over a specified period of time. These numbers will indicate the size of the target population served and the extent of each person's involvement in the program, enabling administrators to compare these figures with numbers projected at the beginning of the effort and to understand better the makeup and needs of the target population.

Each program will identify different process measures depending on the program design and the point of intervention on the criminal justice continuum. For example, administrators of a Crisis Intervention Team should capture at least the following data: the number of calls referred to the team; the number of individuals referred to community-based services; the number of individuals hospitalized; and the number of referrals to community-based services who received follow-up services. A pretrial services program would track the following numbers regarding the number of people served: the number of defendants interviewed; the number of defendants referred for a mental health assessment; the number of defendants recommended for pretrial release; the number of defendants approved for pretrial release; and the number of defendants who successfully comply with the conditions of release.

Example: Jail Addiction Services, Clinical Assessment and Triage Services (CATS), Montgomery County (MD)

The Montgomery County Clinical Assessment and Triage Services (CATS) is a team of mental health professionals at the county jail who assess new inmates suspected of having a mental illness at intake and assist in determining whether it would be appropriate for some of these inmates to be diverted to community-based mental health treatment. The team uses the following measures to gauge their impact: 1) number of inmates assessed for behavioral health problems; 2) number of inmates recommended for diversion; 3) number of inmates with mental health symptoms diverted into community treatment; and 4) number of inmates who are eligible for the public mental health system.

Units of Services

Whereas the figures discussed above will indicate the extent of the target population's penetration of the layers of the program, units of service indicates the target population's access to substance abuse and mental health services. For each person served, it is important to know the number of contacts that he or she has had with mental health and/or substance abuse treatment providers. A "contact" could include a weekly counseling session or participation in an Alcoholics Anonymous meeting. Researchers should continue to tally the number of contacts an individual has after he or she has completed a sentence or after referral. Such information will be extremely useful in determining whether a new program has made services accessible to the target population and whether a new program has successfully engaged people with mental illness in treatment and/or facilitated access to services.⁴

Efforts should be made to determine when there are repeated contacts with the same individual (identifiers need not be used) and whether contacts are increased or reduced before and after the project's start.

Timeliness of Service

Program administrators should consider using the timeliness of the service delivered as one way to measure empirically the quality of service provided. For instance, jail administrators should determine how long it takes for detainees referred for a mental health assessment following the screening to in fact receive an assessment. Similarly, it is helpful to know how much time passes after a person is released from prison before he or she makes contact with the mental health system.

Example: Montgomery County (MD) Police Department

The Montgomery County Police Department uses the timeliness of service and the distribution of trained officers as several factors to help measure quality of service. The program measures the average length of time between the call to the CIT officers the Department of Health and Human Services crisis center specialist. In addition, the police department calculates both the percentage of the patrol force that is CIT certified and the percentage of police districts that have at least one trained CIT officer assigned to each shift.

b

Establish outcome measures that indicate the impact of the initiative on the person's involvement with the criminal justice system and mental health system.

Confirming a connection between a new program and some desired outcomes, such as improved public safety and providing better, or more, services

4. Subsequent contacts with (or calls for service to) law enforcement, even when they do not end in arrest, are also important indicators of the extent to which the mental health system has effectively engaged the individual. These contacts and other contacts with the criminal justice

system are addressed in the subheading under the next recommendation regarding public safety.

5. The National GAINS Center for People with Co-occurring Disorders in the Justice System has provided technical

with limited resources, can be extremely difficult. Nevertheless, such outcome measures are compelling and key to maintaining support from policymakers and the public.

Accordingly, program administrators should identify *aspects* of public safety, quality of life, and cost efficiency that can be realistically measured without being irresponsible or misleading about the impact of the program on these issues. For example, tracking whether (and how often) program participants are re-arrested, violate a condition of release, are reincarcerated, or are re-hospitalized provides important indicators of the program's impact on the justice system and a person's involvement with it. Such data, however, need responsible analysis to determine when the program correlates to particular results or when it causes change.

Public Safety

Measures of public safety include numbers describing the following:

- calls for service to law enforcement
- calls for transportation / referral
- re-arrest
- jail admissions
- jail days
- jail or prison-based disciplinary infractions
- revocations of community-supervised release

Other measures, although more difficult to track than the numbers above, include assaults involving people with mental illness and uses of force involving a person with mental illness.

Quality of life

Changes in personal functioning measures, such as the following, enable researchers to assess how or whether an individual's quality of life has improved or worsened:

- drug/alcohol abuse
- employment
- housing situation
- family reunification
- job skills
- education level
- suicidal ideation/attempts
- demonstrable improvement in functioning (using the scale provided in the DSM IV)⁶

The federal government (particularly through the US Department of Justice and the US Department of Health and Human Services) plays an essential role in generating knowledge about what programs have demonstrated promise or have proven effective in improving responses to people with mental illness. Although not every new initiative can benefit from a federally-sponsored evaluation, policymakers and practitioners across the country can learn from program evaluations that the federal government has conducted—especially when data sets and outcome measures are congruent across jurisdictions. The Substance Abuse and Mental Health Services Administration (SAMHSA), through the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) has initiated a three-year Jail Diversion Knowledge Development and Application project to study programs that divert some individuals with mental illness and co-occurring substance abuse disorders from jail in nine sites. The purpose of the study is to determine when jail diversion works, for whom, and under what circumstances. This evaluation effort will capture and analyze data both within and across jurisdictions and should provide important information for the field.⁵

assistance for the jail diversion programs and the Research Triangle Institute is responsible for overall program integration, data management, and data analyses. See: [http://gainscenter.samhsa.gov/html/tapa/jail diversion/background.asp](http://gainscenter.samhsa.gov/html/tapa/jail%20diversion/background.asp)

6. See the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV), American Psychiatric Association, Washington D.C., 1994.

Cost

Project funders will be especially interested in the costs associated with an initiative:

- requests for law enforcement for service
- jail days
- mental health crisis facility admissions
- psychiatric inpatient admissions and total days
- substance abuse crisis facility admissions and total days
- involuntary treatment costs
- prison days

To capture the true criminal justice cost reductions that a new initiative realizes, jail and corrections administrators should attempt to calculate the real cost of incarcerating a person with mental illness. Existing prison and jail per diem costs reflect the expense of incarcerating an average inmate. Inmates with mental illness, however, typically absorb a disproportionately high amount of correctional resources. Although no correctional system has effectively isolated the cost, providing mental health services (especially when taking into account the cost of escort and transportation costs) in a prison or jail is expensive. The bedspace for a person with mental illness in prison or jail (recall that many are assigned to high-security cells) may also be more expensive than the average inmate

Corrections administrators also should attempt to capture some of the costs associated with inadequately treating mental illness in prison or jail. These situations can lead to inmate-on-staff assaults, inmate-on-inmate assaults, and other use-of-force incidents, which translate into missed work days, lawsuits, and injuries to officers and inmates—physically and emotionally. Such incidents also often increase the length of inmates' stay.

Law enforcement officials should use similar measures to gauge the fiscal impact of an initiative. Reducing the time it takes for a police officer to clear a call involving a person with mental illness (while also reducing the likelihood that there will be a subsequent call for service) has significant cost implications. Lowering rates of injuries among line staff or members of the community who have a mental illness is also a significant outcome.

Quality of Service

The preceding recommendation included as an important outcome measure the timeliness of service. This performance indicator can be a useful element to consider when measuring the quality of service. Satisfaction with service, although considerably more subjective than the timeliness of service, is also an important measure of the quality of service.

C**Monitor the gross numbers of people with mental illness in contact with—or under the supervision of—the criminal justice system**

Improving the effectiveness and the accessibility of mental health services should reduce the number of people with mental illness who are in contact with the criminal justice system. (See Policy Statement 1: Involvement with the Mental Health System.) Indeed, the overrepresentation of people with mental illness in the criminal justice system is, in part, what prompted the *Criminal Justice / Mental Health Consensus Project*. Accordingly, assuming state and local government officials have provided criminal justice officials with sufficient tools and guidance to identify people with mental illness, they should track the gross numbers of people with mental illness (or, in the case of law enforcement's contact with a person with mental illness, those individuals who exhibit signs of potential mental illness) at each stage on the criminal justice continuum (i.e., arrest, detention, probation, etc.). Such data should also include demographic information (e.g., age, race, gender) regarding this population.

45

Collecting Data

POLICY STATEMENT #45

Ensure mechanisms are in place to capture data consistent with the process and outcome measures identified.

Once officials have determined the criteria they will use to measure the impact of the program, they need to be sure they will capture the relevant data. In addition, they need to establish a baseline, which serves as a benchmark against which progress can be measured.

Implementing many of the policy statements in this report should facilitate the collection of data that would accomplish both these goals. For instance, Policy Statement 2: Request for Police Service explains the value of tagging calls for assistance that appear to involve a person with mental illness.

Policy Statement 11: Pretrial Release / Detention Hearing addresses the importance of screening a pretrial defendant for mental illness. Policy Statement 13: Intake at County / Municipal Detention Facility and Policy Statement 17: Receiving and Intake of Sentenced Inmates provides for screening people with mental illness when they enter a jail or prison. The recommendations below suggest how state and local government officials can capitalize on these and other opportunities to assemble valuable data.

RECOMMENDATIONS FOR IMPLEMENTATION

- a** Agree upon common definitions of mental illness and the characteristics of the general target population.

Researchers studying various initiatives that target people with mental illness have cited inconsistent definitions of mental illness and uneven qualities of documentation as a major obstacle to evaluating effectively the impact of a program.⁷

7. Polly Phipps and Gregg Gagliardi, Implementation of Washington's Dangerous Mentally Ill Offender Law: Preliminary

Findings, Washington State Institute for Public Policy, March 2002.

Although mental illness diagnoses are complex, and insisting upon a precise diagnosis is problematic, it is reasonable and wise to ensure partners use common definitions.

Example: Dangerous Mentally Ill Offender (DMIO) Program (WA)

When the Washington State Institute for Public Policy conducted a preliminary review of the DMIO program, it recommended that the agencies charged with implementing the program needed “to come to an agreement about which objective criteria (diagnosis, functional impairment) will qualify a candidate as mentally ill for the purposes of the DMIO program.” Department of Corrections officials, while noting that agencies already were using a “working definition” for “major mental disorder,” concurred that reviewing and resolving differences in the definitions adopted by the committee and definitions already employed by DOC would be useful.⁸

For the data to be particularly useful, it is important that the target population share other common denominators, such as the age of the group (juveniles or adults) and the presence of a co-occurring disorder (e.g., mental illness only or mental illness and a co-occurring substance abuse disorder).

Of course, detailed definitions of the target population alone will not ensure that evaluators are analyzing data for a population that shares similar mental health status and/or criminal history. Training staff on the application of this definition to the client population is essential.

b

Capitalize on existing management information systems to facilitate data collection and analysis.

Automated management information systems reduce paperwork, maintain data in an organized fashion, and provide quick access to information. Data collections that can easily draw from these systems can reduce the time it takes to capture data, ensure the information is collected in a consistent format, and enable quick analysis of the information. For example, law enforcement officials could add a field to police record management systems, which would enable law enforcement to record information, after a call is cleared, about successful referrals to community-based services.

Example: Mentally Ill Offender Crime Reduction Grant Program (CA)

The state law that established the Mentally Ill Offender Crime Reduction Grant Program requires counties receiving a grant to conduct an evaluation of their project that includes outcome and performance measures. To assist counties in assembling data needed for the evaluation, the Board of Corrections (which oversees the grant program) tapped three existing databases: 1) the State Department of Mental Health’s Client and Services Information (CSI) System, which captures various data regarding diagnoses, demographic information, and lifestyle information; 2) the Medi-Cal/CSI Billing systems, which net data regarding the health and support services that each client uses; and 3) the State’s Adult Performance Outcome System, which captures

8. Ibid, Appendix G, p. 67.

data for each client regarding the results of two of three mental health instruments administered at the beginning of mental health treatment and at regular intervals thereafter.⁹

Example: Dangerous Mentally Ill Offender (DMIO) Program (WA)

In evaluating the quality and quantity of pre-release and post-release services that the target population received, the Washington Public Policy Institute relied in part on detailed notes that community corrections officers entered into the state Department of Correction's Offender Based Tracking System (OBTS) electronic database.

C Solicit comments and opinions from staff, crime victims, family members, and program participants.

Program staff, crime victims and program participants and their family members can be extremely helpful in informing policymakers how a new program or initiative has affected lives and systems. To that end, policymakers should encourage administrators to collect anecdotal data from these stakeholder groups. Indeed, information about their satisfaction with a new policy or program is often as important as empirical data regarding the impact of the program.

Program administrators should survey crime victims, asking them whether they felt that they had been sufficiently informed about developments in the case and whether they had been adequately consulted, given the requirements of the existing state law. Obtaining feedback from practitioners is also essential.

Example: Jail Diversion Program, Connecticut Department of Mental Health and Addiction Services (DMHAS)

DMHAS officials conducted a written survey of judges, prosecutors, public defenders, and other court officials, asking them to what extent they agreed with statements regarding the jail diversion program, such as the following: 1) it saves the court time; 2) it gives unfair advantage to the defendants; 3) it protects the rights of the defendant; 4) it saves the state money; and 5) it reduces risks to the community. They included the results in a report submitted to the General Assembly. This report helped to convince the Connecticut State Legislature to expand funding for the Jail Diversion Project to create diversion programs statewide.

Example: Mobile Crisis Team (MCT), Montgomery County (MD)

The MCT provides emergency mental health services to individuals at any location in the jurisdiction to attempt to stabilize the situation at the least restrictive level possible. Clients who requested the MCT are surveyed regarding their level of satisfaction with the response.

In surveying people with mental illness who participated in the program, interviewers should ask about the individual's level of satisfaction with his or her housing situation, employment status, or relationships with loved ones.

9. California Board of Corrections, *Mentally Ill Offender Crime Reduction Grant Program*, p. 7.

Some jurisdictions have taken additional steps to collect empirical data regarding the qualitative impact of the initiative.

Example: Mentally Ill Offender Crime Reduction Grant Program (CA)

The Board of Corrections, which oversees the grant program, developed a methodology to evaluate the program. Thirteen of the 15 counties that are grant sites are employing this experimental design. Randomly selected treatment and comparison groups are assessed at least twice (before and after the intervention) with the same instruments over the same period of time. Records are kept for every project participant (in both the comparison and treatment groups) and must include any services or interventions received and a definition those services.¹⁰

d

Establish procedures early in the process to share information that will facilitate the data collection of people served by both the criminal justice and mental health systems.

Criminal justice and mental health officials sometimes let laws and regulations protecting the privacy of people served by the mental health system serves prevent efforts to collect data and conduct evaluations. There are ways, however, for researchers to respect these mandates and still obtain data that will inform an evaluation. For example, to determine whether an initiative has been effective in maintaining contact between a community mental health provider and a person referred by the police, courts, or corrections, criminal justice officials do not necessarily need records regarding a particular person's attendance at a clinic. Instead, information in the aggregate would serve the same purpose. In addition, researchers do not necessarily need to have access to a mental health provider's records to determine the units of service provided to a particular individual. Requesting that the provider simply check its records for a particular person would accomplish the same goals.

Example: Crisis and Engagement Services, Mental Health, Chemical Abuse and Dependency Services Division, Dept. of Community and Human Services, King County (WA)

The King County Department of Community and Human Services conducted a cross-system examination of the costs of providing services to a group of "high utilizers of drug and alcohol acute services." This evaluation included costs associated with jail time, inpatient psychiatric services, substance abuse crisis services, involuntary treatment costs, and emergency room admissions. To minimize information-sharing obstacles, the Mental Health, Chemical Abuse and Dependency Services Division first collected information concerning the use of mental health and substance abuse services under their supervision. The division then asked the jail and local emergency room to provide information that was cross-referenced with the initial list to determine which individuals were utilizing multiple services during a one-year period.

10. Ibid.

46

Disseminating Findings

POLICY STATEMENT # 46

Publicize program successes as appropriate to the media, public, and appropriators

Once agents of change have completed an evaluation, they should share the results of their findings with various audiences. In most cases, disseminating information about the impact of the program

is essential to build support for a new initiative, to facilitate the replication of a pilot project, or to engage additional partners. This policy statement suggests three ways to accomplish these goals.

RECOMMENDATIONS FOR IMPLEMENTATION

a Capitalize on existing networks of advocacy groups to publicize program results

By tapping its national network, an advocacy group, such as a local Mental Health Association or affiliate of NAMI (Alliance for the Mentally Ill), can be extraordinarily effective in spreading the word about a new and promising initiative.

Example: Crisis Intervention Team, Memphis (TN)

The Memphis CIT was established as a result of a collaborative effort among the Memphis Police Department and various leaders in the community, including members of the NAMI. Training is an important component of the CIT initiative, and NAMI members play a key role in administering the training program for police officers. NAMI hosts an annual awards dinner for officers serving on the CIT and has also been helpful in trumpeting the results that Professor Randolph Dupont has documented: the response time for a CIT officer on a crisis call averages 5 to 10 minutes, as compared with other models where police take 30 to 50 minutes. NAMI's promotion of these and other data at its conventions and on its website has facilitated replication of the CIT model in communities across the country.

b Advertise positive program results in local media outlets

When the results of an evaluation confirm the value of a new initiative, policymakers and practitioners should publicize the data. In this regard, press

kits that briefly highlight the findings and provide contact information for program spokespersons can be extremely effective.

It is important to identify spokespersons who the media or the public might not immediately associate with the issue. For example, a mental health advocate or provider might be expected to talk about the value of an effective community-based mental health program. On the other hand, law enforcement officials, corrections administrators, or other criminal justice practitioners who explain how effective mental health services have improved public safety can be particularly compelling.

Example: Trauma, Addictions Mental Health and Recovery (TAMAR) Program (MD)

Preliminary research regarding rearrest rates among women participating in TAMAR has been impressive. Wardens and other correctional administrators of facilities in county jails where the TAMAR program has been established have made presentations for county commissioners and state legislators citing these data to help explain the value of the initiative. Elected officials have responded by promoting the replication of the program and publicizing its value to the state and counties in public hearings.

Example: Partners in Crisis (FL)

Linda Gregory, the widow of a deputy sheriff shot and killed by Alan Singletary (a person with a history of untreated mental illness) and Alice Petree, Alan Singletary's sister, are members of Partners in Crisis, a coalition of leaders in the criminal justice and mental health system in Florida. Partners in Crisis conducted public service announcements across Florida featuring Ms. Gregory and Ms. Petree who explained the value of access to effective mental health services.

"We need to better demonstrate the effectiveness of the kinds of programs discussed in this report—do empirical studies, figure out what works, and then institutionalize these practices."

WILLIAM SONDERVAN
*Commissioner, Maryland
Division of Correction*

C

Create clearinghouses at the state and local level that provide information regarding the availability of services people with mental illness coming into contact with the criminal justice system.

Clearinghouses can help to advertise new initiatives that are promising and spread the word about valuable lessons learned in other communities.

Example: Texas Council on Offenders with Mental Impairments

The Texas Council on Offenders with Mental Impairments is statutorily responsible for providing technical assistance and information to local and state criminal justice entities regarding alternatives to incarceration for those with special needs. The council comprises individuals from throughout the state who represent every facet of local and state criminal justice systems. These board members are responsible for collecting information from the field and bringing it to the council for review and response.

Establishing for one jurisdiction an organization that will serve as a clearinghouse around criminal justice and mental health issues exclusively may be unrealistic, but adding this function to an existing entity is often feasible. For example, the mental health agency funding community programs or an entity or person reporting to the court (e.g., pretrial services, probation, mental health court staff) regarding the availability of community-based services could become a locus of information.

Appendices

Glossary¹

adjudication — The disposition or resolution of a criminal case.

advanced directive — Documents written while a person is competent specifying how decisions about treatment should be made if the person becomes incompetent.²

alternative therapies — Treatment toward mental health through programs other than the traditional hospitalization and institutional care options for patients. These programs include various community-implemented treatment programs and facilities.

arraignment — The first appearance in court of an individual after arrest at which the individual is informed of the charges and a pretrial release/detention decision is made.

assertive case management — An intensive form of case management intended to help patients to increase daily-task functioning, residential stability, and independence, and to reduce their hospitalizations. Assertive case management substantially reduces inpatient service use, promotes continuity of outpatient care, and increases community tenure and residence stability for people with serious mental illness.³

Assertive Community Treatment (ACT) — Sometimes referred to as Program of Assertive Community Treatment (PACT). A team-based approach to the provision of treatment, rehabilita-

tion, and support services. ACT/PACT models of treatment are built around a self-contained multidisciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of patients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all patient services using a highly integrated approach to care.⁴

assessment — An examination, more comprehensive than a screening, performed on each newly admitted detainee (or inmate) soon after arrival at an institution. It usually includes a review of the medical screening, behavior observations, an inquiry into any mental health history, and an assessment of suicide potential.

atypical antipsychotics — Also known as second-generation antipsychotics, they include these chemical classes: dibenzoxazepine (e.g., Clozapine), thienobenzodiazepine (e.g., Olanzapine), and benzisoxazole (e.g., Risperidone). These medications are known as “atypical” because they are generally more effective in symptom reduction than the earlier generation of antipsychotic medications, without the side-effect profile typical of those medications.⁵

bail — A condition of pretrial release in which an individual who has been arrested must pay a specified amount to obtain

1. Many terms used in this report (e.g., assessment) have multiple meanings depending on the context in which they are used. The definitions listed in this glossary address the context in which the words appear in this report.

2. Appelbaum, “Advanced Directives,” p. 983.

3. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 286-287.

4. Proposed New HCPCS Procedure Codes for Mental Health Services, 4.

5. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 69.

release. The purpose of bail is to assure the appearance of the accused at all court proceedings.

behavioral health care — An encompassing term including assessment and treatment of mental and/or psychoactive substance abuse disorders.⁶

blood levels of medication — The amount of a medication present at any given time within the inmate’s blood system—used to determine whether a correct, or optimal, dosing regimen is being used in order to achieve therapeutic effects.

Brief Psychiatric Rating Scale (BPRS) — The BPRS is an 18-item rating scale used for evaluating psychiatric symptom change. Developed by John Overall, Ph.D., and D. R. Gorham, Ph.D., the BPRS provides an efficient, clinician-based means to assess a large number of psychiatric symptom constructs. The BPRS generates valid patient information covering the full spectrum of psychiatric diagnoses (e.g., bipolar disorder, major depression, schizophrenia, psychosis, and anxiety).

call for service — When police are called to respond to some event; does not necessarily indicate that a crime has been committed. Typically, when police respond to calls, they are referred to as “out of service.”

case management — A range of services provided to assist and support patients in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services; linkages and training for patient served in the use of basic community resources; and monitoring of overall service delivery. This service is generally provided by staff whose primary function is case management.⁷

case-rated funding — Payment to the provider based on one global fee for the patient case, regardless of the actual services rendered.⁸

character disorder — Personality disorder.⁹

classification — A system within each correctional facility/agency for determining and reviewing the level of security required by each inmate, based upon history, current charges, behavior, and perceived risk of violence or elopement.

clinical informatics — The use of information technology and standardized protocols (e.g., algorithms or decision trees) to evaluate and treat inmates for mental health or health problems.

clubhouse model — Based on a model developed at Fountain House in New York, a clubhouse provides support services through a comprehensive self-help community-based center. Staff

and members work as teams to perform the tasks necessary for the operation of the clubhouse.

Cognitive Behavioral Therapy (CBT) — A manual-driven course of structured counseling aimed toward increasing awareness of one’s thoughts, behaviors and actions, and the consequences of them. CBT is often used to address specific problem areas such as anger management, moral reasoning, criminal thinking, addiction, relapse prevention, and relationships.

command staff — Manages the daily operations and future planning of a police department, (e.g., chief, deputy chiefs, and majors).

Commission on Accreditation for Law Enforcement Agencies (CALEA) — The Commission on Accreditation for Law Enforcement Agencies, Inc., was established as an independent accrediting authority in 1979 by the four major law enforcement membership associations: International Association of Chiefs of Police (IACP); National Organization of Black Law Enforcement Executives (NOBLE); National Sheriffs’ Association (NSA); and Police Executive Research Forum (PERF). The purpose of CALEA is to improve delivery of law enforcement service by offering a body of standards, developed by law enforcement practitioners, covering a wide range of up-to-date law enforcement topics. The CALEA accreditation process is voluntary.

community-based treatment — A concept of treatment that focuses on the community services offered to an individual through a system of community support. Individuals with mental illness can remain citizens of their community if given support and access to mainstream resources such as housing and vocational opportunities.¹⁰

community corrections — The provision of corrections services to offenders under supervision, in a low-security-level facility located within a community or neighborhood, rather than in an institution; includes probation/parole, electronic monitoring, and other arrangements where offenders may have access to paid or volunteer work and/or be living within their own homes.

community mental health system — The system intended to provide public mental health services directly to those in need of assistance in the communities where they reside. Development of the community mental health system can be traced to enactment of the Community Mental Health Centers Act of 1964. Intended to provide a community-based alternative to institutional care for many people with mental illness, implementation of the community mental health system rested on expansion of outpatient services in the community, particularly in federally funded community mental health centers. In many jurisdictions, the community mental health system has yet to meet the expect-

6. Logical Health Care Solutions, *Glossary*, p. 14.

7. Proposed New HCPCS Procedure Codes for Mental Health Services, p. 3.

8. Logical Health Care Solutions, *Glossary*, p. 21.

9. Proposed New HCPCS Procedure Codes for Mental Health Services, p. 10.

10. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 80.

tations of its designers or those who work within it, primarily because funding did not materialize to provide needed services.¹¹

community policing — Philosophy of law enforcement that includes prevention, partnering and collaboration, and problem solving. See below for definitions of these elements.

Community Policing Consortium — The Community Policing Consortium, which is funded by the Office of Community Oriented Policing Services, is composed of the International Association of Chiefs of Police (IACP), National Sheriffs' Association (NSA), National Organization of Black Law Enforcement Executives (NOBLE), Police Executive Research Forum (PERF), and Police Foundation. The consortium's primary mission is to deliver community policing training and technical assistance to police departments and sheriff's offices.

computer-aided dispatch (CAD) — Systems that fully automate call taking and dispatching functions, and have the capability to provide an agency with sophisticated record keeping and analysis functions. CAD systems work by recording caller information such as phone number and address, prioritizing calls for service, and matching those calls to available police resources, which are also monitored by the system using vehicle locator systems. This enables the system to quickly reference information about call types, location, disposition, responding officer, and many other identifiers that inform dispatchers and officers about appropriate responses.

consumer — In the mental health system, "consumer" is the term most frequently applied to a person who receives mental health services. The term is sometimes used more generically to refer to anyone who has a diagnosis of mental illness. Not all persons with mental illness accept this terminology, however. Some may prefer to be known simply as clients of the facilities where they receive services. People who feel they have been abused by the system or who reject traditional mental health services may prefer a term such as "survivor."

co-occurring disorder — Refers to two or more disorders occurring simultaneously. Generally refers to mental health and substance abuse disorders but can refer to mental health, physical health, developmental, or other disorders.¹²

Crisis Intervention Team (CIT) — Police program developed in Memphis, Tennessee. A CIT is comprised of designated officers who are called upon to respond to mental disturbance calls and crises, such as attempted suicides. These officers participate in specialized training under the instructional supervision of mental health providers, family advocates, and mental

health consumer groups. Officers trained under this program are skilled in de-escalating potentially volatile situations, gathering relevant history, and assessing medication information and the individual's social support system. The CIT is recognized as a national program and has been replicated in communities such as Portland, Oregon; Albuquerque, New Mexico; Seattle, Washington; San Jose, California; and Waterloo, Iowa.

cross-training — The implementation of a training program to educate individuals from both the criminal justice and the mental health communities on the issues and concerns each confronts, cross-training attempts to build awareness in both communities to help develop a more coordinated approach to the needs of people with mental illness involved with the criminal justice system.

cultural competence — Recognition of and response to cultural concerns of ethnic and racial groups, including their histories, traditions, beliefs, and value systems. Cultural competence is one approach to helping mental health service systems and professionals create better services and ensure their adequate utilization by diverse populations. Cultural competence entails a set of behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables that system, or agency or those professionals to work effectively in cross-cultural situations.¹³

current situational stressors — Circumstances and environmental realities that create significant pressure on, or greatly limit, an individual's ability to function in a healthy, productive manner.

custodial transport — The transportation of an individual when he or she is under arrest and is not free to leave. A suspect may be in handcuffs during custodial transport to a police station.

decompensation — Temporary return to a lower level of psychological adaptation or functioning, often occurring when an individual is under considerable stress or has discontinued psychiatric medication against medical advice.

de-escalation techniques — Verbal and nonverbal interpersonal skills that enable an officer to recognize and defuse violent behavior, preferably without using force, thus preserving the suspect's safety and dignity.

defendant — An individual who has been charged with but not yet convicted of a criminal charge.

11. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 79.

12. Little Hoover Commission, *Being There*, p. 107.

13. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 90.

14. www.webmd.com.

defense attorney or counsel — The official who represents the defendant in a criminal case.

developmental disability — A substantial handicap in mental or physical functioning, with onset before the age of 18 and of indefinite duration. Examples are autism, cerebral palsy, uncontrolled epilepsy, certain other neuropathies, and mental retardation.¹⁴

diagnostic profile — The symptoms exhibited by a person that allow a clinician to arrive at a specific diagnosis.

discharge plan — A written plan that provides an inmate with guidance to help him/her make a successful transition from institution to community. Typically includes concrete plans in several areas such as housing, employment or education, transportation, continued counseling or social services, required supervision (i.e., probation/parole), and the like.

dispatch function — Dispatch answers phone calls and sends patrol cars to respond to those calls. From simple service calls, such as helping someone locked out of his/her car, to true emergency calls, such as a domestic violence call, nearly every police response is generated from dispatch. Depending on the circumstances, every call is given a “priority” or ranking and then dispatched to the appropriate beat officers in a specific order. Dispatch composition can differ greatly from one jurisdiction to the next. In some jurisdictions, dispatch is located in the police department and is responsible only for police emergencies. Dispatch can also be contracted with the county. The same dispatchers can be responsible for fire and ambulance emergencies and housed separately from the police department.

dispatchers — The individuals who serve as the communications link between citizens and public safety agencies. Upon receiving emergency calls for services, they assess the public safety response needs, dispatch the appropriate personnel and equipment, and enable continued communication between public safety agencies.

dispositional alternative — A dispositional option in which the judge defers or withholds adjudication of the criminal case for a specified period with the charges dismissed or reduced upon successful completion of the deferral period.

diversion — [A] dispositional practice is considered diversion if: (1) it offers persons charged with criminal offenses alternatives to traditional criminal justice or juvenile justice proceedings; and (2) it permits participation by the accused only on a voluntary basis; and (3) it occurs no sooner than the filing of

formal charges and no later than a final adjudication of guilt; and (4) it results in a dismissal of charges, or its equivalent, if the divertee successfully completes the diversion process.¹⁵

diversion program — A treatment program that addresses the specific needs of a person with mental illness who has been “diverted” from the criminal justice system either before arrest or before trial.

drop-in centers — An integral component of psychosocial rehabilitation that typically occurs in nonclinical settings with minimal, if any, professional facilitation. Drop-in centers usually focus on normalization and empowerment of people with severe and persistent mental illness.¹⁶

emergency evaluation — In many states, a police officer has the authority to detain an individual who exhibits predefined characteristics of mental illness or appears to be an imminent danger to him/herself or to others. The officer may transport the individual to a local hospital to receive an emergency mental health evaluation. In some instances, after an emergency mental health evaluation police are legally required to continue detention of the individual.

Emotionally Disturbed Person (EDP) — Term commonly used by police to refer to people with mental illness.

entitlement — Benefits provided by the federal government for individuals with disabilities (disability is defined as “the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months”). Entitlements available to people with mental illness include income support through the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs, and health coverage under Medicaid and Medicare.¹⁷

evaluation — A face-to-face interview of the patient and a review of all reasonably available health care records and collateral information. Evaluation includes a diagnostic formulation and, at minimum, an initial treatment plan.

Comprehensive Mental Health Evaluation — A face-to-face interview of the patient and a review of all reasonably available health care records and collateral information. It includes a diagnostic formulation and, at least, an initial treatment plan.¹⁸

15. National Association of Pretrial Services Agencies, *Performance Standards*: p. 1.

16. Barton, “Psychosocial Rehabilitation,” p. 526.

17. On Our Own, Inc., *Disability, Entitlements and Employment*, p. 3; Bazelon Center, *Finding the Key*, p. 1.

18. APA, *Psychiatric Services in Jails and Prisons*.

evidence-based practices — Interventions and treatment approaches that have been proven effective through a rigorous scientific process.

face validity — Extent to which a measure seems to evaluate a phenomenon on face value, or intuition. For example, a screening instrument that proposes to measure the likelihood that an individual will commit suicide has face validity if, based on the opinion of knowledgeable psychiatric professionals, the screening instrument seems likely to identify individuals who are at a risk for suicide.

family psychoeducation — Activities to provide information and education to families and significant others regarding mental disorders and their treatment. This activity acknowledges the importance of involving significant others who may be essential in assisting a client to maintain treatment and to recover. Family psychoeducation models include courses taught by mental health professionals as well as those taught by family members themselves.

felony — An offense for which there is a sentence of death or a term of imprisonment for one year or more.

Field Training Officer (FTO) — A new recruit generally goes through the Field Training Officer program after finishing academy training. The purpose of the FTO program is to prepare officers in training to perform the essential duties of a police officer and enhance the professionalism of future patrol divisions through continuous quality improvement. Not all police departments have FTO programs.

formularies — A standard list of the most commonly used medications and preparations used within an institution and stored at the facility in sufficient quantities to meet demand.

functional assessment — An evaluation of an inmate's ability to function in society (e.g., socially, employment, personal care, etc.).

gatekeeper functions — The functions performed by law enforcement personnel and Crisis Intervention Team members for people with mental illness. Refers to the fact that these personnel often make the initial contact with persons exhibiting characteristics of mental illness or are the first responders to mental health emergencies and are often responsible for referring individuals to adequate mental health services.

Health Insurance Portability and Accountability Act (HIPAA) — Legislation intended to provide portability of employer-sponsored insurance from one job to another in order to

prevent what has become known as “job lock” or the inability to change jobs because of the fear of losing health insurance. This act also makes it illegal to exclude people from coverage because of preexisting conditions and offers some tax deductions to self-employed people who pay their own health insurance premiums. The act also directs the federal government to standardize billing codes and to develop privacy standards related to individually identifiable health care information.

holding cell — Any room or cell that is used to hold incarcerated subjects until the booking process is completed. In the holding cell, a detainee typically awaits his/her initial court appearance, after which (s)he will stay in the holding cell until (s)he is either able to pay bail or sent to another facility.

illness self-management — A growing trend within the mental health field in which clients educate themselves to recognize symptoms of their illness as well as factors that exacerbate or ameliorate them. By managing those factors and taking remedial steps when symptoms become acute, some find they are able to avoid more intrusive interventions by professionals. Those consumers who are successful in managing their illness gain confidence in their ability to achieve recovery.

inmate — An individual remanded to the custody of a local/county, state, or federal correctional facility, including jails and prisons.

inmate self-reporting — Obtaining personal information directly from inmates, a practice that often lacks reliability.

inpatient facility — Any medical facility—usually a hospital—where patients stay for a period of time to receive treatment. Most mental health systems differentiate between acute care (short-term) facilities and long-term care facilities.

institutional care — Refers not only to hospital-based treatment given to a patient, usually within a state mental health facility, on a long-term basis, but also to the more restrictive, less normalized aspects of such treatment.

instrument/instrumentation — Forms or other written tools used to obtain information in a standardized manner to ensure consistency and thorough data collection; usually refers to questionnaires or surveys that have been field-tested for validity and reliability to maximize the likelihood that they measure what they are intended to measure and are likely to do so consistently.

intake — A set of procedures for accepting an offender into a correctional facility as an inmate. Includes obtaining personal

19. Little Hoover Commission, *Being There*, p. 107.

history and information, searching personal belongings, and assigning housing, among other procedures.

integrated services — Generally refers to providing an array of services through a single agency or entity. Often requires discretionary or blended funding to cover the cost of multiple services. A term most frequently used in the mental health field when referring to services for co-occurring mental illness and substance abuse disorders.¹⁹

jail — A correctional facility designed to detain individuals pending judicial hearings or to provide brief periods of incarceration, generally less than one year, for sentenced inmates. Jails are typically operated by local or county jurisdictions.

Law Enforcement Steering Committee (LESC) — The Law Enforcement Steering Committee is a coalition of national police labor, management, and research organizations representing more than 550,000 law enforcement professionals. The LESL consists of the Federal Law Enforcement Officers' Association (FLEOA), Fraternal Order of Police (FOP), International Brotherhood of Police Officers (IBPO), Major Cities Chiefs (MCC), National Association of Police Organizations (NAPO), National Organization of Black Law Enforcement Executives (NOBLE), National Troopers Coalition (NTC), Police Executive Research Forum (PERF), and Police Foundation.

less-than-lethal (LTL) force — Force that is not likely to cause death or serious bodily harm. Examples of nonlethal weapons include pepper spray, stun guns, and bean bag “bullets.”

leveraged treatment — An approach to ensure an individual receives treatment he or she may not otherwise accept. Both conditional treatment and mandated treatment may be considered leveraged treatment.

mainstreaming — The integration of individuals with mental illness back into their communities and a functional life within the community with the assistance of community treatment programs.

maladaptive thinking — Thought patterns and decision-making processes that, rather than promoting productive and healthy solutions, result in further negative consequences for the individual and do not necessarily solve the problem.

managed care — Managed care represents an approach to funding health care services. Generally, managed care provides a specific level of funding to serve a population of people. Managed care programs often restrict clients to seeing providers from an approved list and may limit available services.²⁰

Medicaid — Medicaid is a jointly funded, federal/state health insurance program for low-income and disabled people who meet needs-based eligibility requirements. Nationally, it covers approximately 36 million individuals including children, the aged, the blind, and/or disabled and people who are eligible to receive federally assisted income maintenance payments.²¹

Medicare — Federal health insurance program primarily for older Americans and people who retired early due to disability.²²

memorandum of understanding — Interagency agreement that serves as a guideline for shared activities.

mental illness — Term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.²³

Serious mental illness — A term defined by federal regulations that generally applies to mental disorders that interfere with some area of social functioning.²⁴

Severe mental illness — A term that applies to more seriously affected individuals. This category includes schizophrenia, bipolar disorder, other severe forms of depression, panic disorder, and obsessive-compulsive disorder.

Severe and persistent mental illness — A term that incorporates the concepts of chronicity or recurrence with the definition above, often used to describe clients with a high level of need.

Mobile Crisis Team (MCT) — Teams composed of mental health service professionals who provide on-scene responses in mental health emergencies.

noncustodial transport — Transport of an individual by the police who is not under arrest and may leave at any time. Examples of noncustodial transport may include shelter relocation for a person who is homeless or transport to a hospital for a person who has a mental illness.

non-sworn personnel — Includes dispatchers, clerks, technicians, and employees who are sworn for correctional or civil purposes but do not possess sworn powers outside of these departments. Also known as civilian employees.

offender — An individual who has been convicted of a criminal charge.

20. Little Hoover Commission, *Young Hearts & Minds*, p. 128.

21. *Ibid.*, p. 128.

22. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 74.

23. *Ibid.*, p. 4.

24. *Ibid.*, p. 46.

outpatient treatment — Any treatment that takes place on an outpatient (as opposed to inpatient or residential) basis.

outstanding warrants — Warrants that indicate that an individual has not properly resolved a police or court order, or that the individual has eluded the service of an arrest warrant.

parity laws — Federal and state laws that remove limits imposed by insurance providers on access to mental health care that are more restrictive than limits imposed on access to physical health care. Legislation requiring insurers to cover access to mental and physical health care under equivalent terms and conditions is referred to as parity legislation.²⁵

parole — A process whereby inmates can be released from incarceration and transferred to community supervision prior to the end of their sentence, given exceptional behavior and rehabilitation during incarceration and a comprehensive review by a parole board. Parole has been abolished in a number of states in recent years.

partnering and collaboration — The processes by which several individuals or agencies make formal, sustained commitments to work together to accomplish a common mission. For police officers in particular, partnering and collaboration involve working with community members, sometimes called stakeholders, who have a vested interest in the problem and who are willing to commit time, talents, and resources toward its solution. (See community policing.)

Peace Officer Standards and Training (POST) — State POSTs set standards for police training and education for officers in all departments located in that state. All states set such standards, however not all use the term POST.

peer educators — Usually refers to mental health consumers who work with their “peers” on a volunteer or paid basis to help them understand and more effectively manage their mental illness. Can also refer to family members who conduct family education courses or any group in which shared experience forms the basis for the trainer-trainee relationship.

pharmacotherapeutic protocols — Standardized methodologies for the use of medical or psychiatric medications (e.g., dosing patterns and instructions, monitoring blood levels, observing both clinical impact and side effects, reviewing the need for continuation or discontinuation, etc.).

plea — A defendant’s answer to the criminal charges made against him or her. The defendant may plead guilty, not guilty,

no contest, among others.

plea discussion — A discussion between the prosecutor and the defense attorney about an agreeable way to resolve a criminal case.

plea offer — An offer presented by the prosecutor to the defense attorney for the resolution of a criminal case.

post-acute withdrawal — A cluster of symptoms that typically manifest following the initial period of physical withdrawal from the use of addictive drugs or medications (e.g., agitation, or depression, and the like).

prebooking diversion — Response strategy through which a police officer can avoid detaining and filing criminal charges against a person with a possible mental illness by making an immediate referral to community mental health services or directly transporting the individual to a designated hospital or drop-off center.

presentence investigation report — A report prepared by a probation officer to provide the sentencing judge with thorough background information on the offender to be sentenced.

pretrial detention — Holding a defendant in custody while the criminal case is pending adjudication.

pretrial diversion — A dispositional option in which the prosecutor offers a person charged with a criminal offense an alternative to having the case prosecuted in the traditional criminal proceedings, with the charges dismissed or reduced upon successful completion of the diversion period.

pretrial release/detention hearing — The hearing at which the judge considers whether to release or detain a defendant.

pretrial services program — A program that provides background information about a defendant to the judge at the pretrial release/detention hearing, and that supervises conditions of pretrial release imposed by the court.

prevention — A policing strategy that focuses on reducing crime and the opportunity for crime. Prevention encompasses but goes far beyond the concepts of home security and personal safety and extends to the whole community and its engagement with public safety. (See community policing.)

prison — A correctional facility that houses inmates generally sentenced to a period of incarceration exceeding one year. Pris-

25. Little Hoover Commission, *Being There*, p. 107.

ons are typically operated by state corrections agencies, although private companies also operate prisons in some states.

probation — A sentence imposed by the court on an offender that requires the offender to abide by specified conditions, under supervision in the community by a probation officer, for a specified period of time.

problem solving — Strategy of policing, also known as problem-oriented policing, that challenges officers to analyze the reasons for repeated incidents of a particular crime(s) and to address the underlying problems, factors, or issues that might be responsible for these repeated incidents. Many credit Herman Goldstein, a University of Wisconsin law professor, as the father of problem-oriented policing. (See community policing.)

Program of Assertive Community Treatment (PACT) — See Assertive Community Treatment.

prosecution — The pursuit of criminal charges against an individual in court.

prosecutor — The official who brings charges in court and represents the government in prosecuting those charges.

protective order — Order of the court that is issued to provide immediate, short-term protection of a person or property.

psychiatric symptomatology — The array of symptoms that an individual with mental illness may display.

psychosocial difficulty — Problems an individual may have relating to people as a result of a psychiatric disorder.

psychosocial rehabilitation — Professional mental health services that bring together approaches from the rehabilitation and the mental health fields. These services combine pharmacological treatment, skills training, and psychological and social support to clients and families in order to improve their lives and functional capacities.²⁶

psychotic symptoms/episodes — Hallucinations and delusions are the most common types of psychotic symptoms demonstrated. However, other symptoms of schizophrenia are divided into two classes: positive symptoms and negative symptoms. Positive symptoms generally involve the experience of something in consciousness that would not normally be present, such as hallucinations and delusions. Negative symptoms reflect the absence of thoughts and behaviors that would otherwise be expected. Psychotic symptoms may occur in a wide variety of

mental disorders. They are most characteristically associated with schizophrenia but psychotic symptoms can also occur in severe mood disorders.²⁷

psychotropic medications — Prescription drugs that address psychiatric symptoms, usually given to reduce anxiety, depression, or other consequences of mental illness such as hallucinations, delusions, or bizarre thinking. (See atypical antipsychotics.)

quality of life crimes — Minor illegal behaviors (generally misdemeanors) that jeopardize the community's sense of well-being and safety, e.g., loitering, aggressive panhandling, vandalism, littering, public urination, graffiti, and noise violations. Also known as nuisance crimes.

recidivism/recidivate — The return of a released ex-inmate to custody in a correctional facility. Typically results from either an arrest for a new crime or from a technical violation such as failure to meet conditions of release (probation/parole).

recovery — Most people with mental illness see recovery as a process tied closely to the experience of gaining a new and valued sense of self and purpose, although some may see it as the end state of that process. Many treatment approaches today are defined as “recovery-oriented,” meaning that they provide consumers with tools that will enable them to gain a combination of self-esteem and self-reliance, in turn allowing them to become increasingly or fully independent of the mental health system.

referral — The process by which inmates who appear to be in need of mental health treatment receive targeted assessment or evaluation so that they can be assigned to appropriate services.

relapse prevention — The steps taken in mental health and/or substance abuse treatment to avert relapse.

risk-sharing arrangements — Contractual arrangement to share in financial risks and rewards associated with various health care management techniques.²⁸

roll call — Brief period at beginning of every police officer's tour of duty. During this time, assignments are given out and officers are alerted to any special situations requiring their attention. Roll call is also a useful time to provide short 15-to-20 minute training sessions on timely topics. For example, roll call can be an appropriate time to show a short video or explain how a new law or court case affects the department.

Scan Analysis Response Assessment (SARA) — Problem-solving model developed by police officers and researchers

26. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 98.

27. Little Hoover Commission, *Being There*, p. 107.

28. Logical Health Care Solutions, *Glossary*, p. 103.

in Newport News, Virginia, in the early to mid-1980s. SARA model consists of scanning, analysis, response, and assessment, and is a helpful framework for those engaged in crime control and crime reduction.

schizophrenia — A disorder of the prefrontal cortex and its ability to perform the essential cognitive function of working memory. Schizophrenia is characterized by profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect, and sense of self. The array of symptoms, while wide ranging, frequently includes psychotic manifestations, such as hearing internal voices or experiencing other sensations not connected to an obvious source (hallucinations) and assigning unusual significance or meaning to normal events or holding fixed false personal beliefs (delusions).²⁹

screening

receiving mental health screening — Mental health information and observations gathered for every new admitted inmate during the intake procedures as part of the normal reception and classification process by using standard forms and following standard procedures.³⁰

intake mental health screening — A more comprehensive examination performed on each newly admitted inmate within 14 days of arrival at an institution. It usually includes a review of the medical screening, behavior observations, an inquiry into any mental health history, and an assessment of suicide potential.³¹

sedative hypnotics — Sedative-hypnotic drugs depress central nervous system function. Used both as tranquilizers and sleeping pills, these prescribed medications decrease anxiety, produce calm, and promote sleep; in addition, they are used as anticonvulsants and muscle relaxants.

Selective Serotonin Reuptake Inhibitors (SSRIs) — A class of antidepressants that primarily blocks the action of the transporter protein for a neurotransmitter, serotonin, thus leaving more serotonin to remain at the synapse. These medications appear to be effective because serotonin is directly involved in the body's ability to regulate moods. Examples of these medications include such brands as Prozac, Paxil, Celexa, and Zoloft.³²

sentence of time served — A sentence imposed by the court upon an offender that provides that the time the offender already spent in custody while the case was pending adjudication is sufficient punishment.

sentencing hearing — The hearing at which the judge imposes a sentence on an offender.

sheriff — The chief law enforcement officer of the county, whose general duties include keeping the peace within the county, apprehending persons who break the peace, serving as custodian to the county jail, and performing services to the county's courts.

Social Security Disability Income (SSDI) — Individuals who worked are "insured" by the Social Security taxes (F.I.C.A.) that are withheld from their earnings to replace part of a person's earnings upon retirement, disability, or for survivors when a worker dies. If insured workers (and, in some cases, their dependents or survivors) become disabled, they may become eligible for SSDI benefits. The amount received is dependent upon how many years an individual has worked and the individual must apply to determine if (s)he is eligible for benefits.³³ (See also entitlements.)

somatic disorders — Disorders affecting the body, as distinguished from mental disorders.

Special Weapons and Tactics (SWAT) Unit — Special police units that respond to high-risk incidents involving hostages, barricaded suspects, sniper situations, terrorism, and riot control.

substance abuse — Substance abuse stands alone as a disorder contributing annually to the deaths of 120,000 Americans. As many as half of people with mental illness develop alcohol or other drug abuse problems at some point in their lives. Theories to explain this co-morbidity range from genetic to psychosocial, but empirical support for any one theory is inconclusive. Co-morbidity worsens clinical course and outcomes for individuals with mental disorders. It is associated with symptom exacerbation, treatment noncompliance, more frequent hospitalization, greater depression and likelihood of suicide, incarceration, family friction, and high services, use, and cost. In light of the extent of mental disorder and substance abuse co-morbidity, substance abuse treatment is a critical element of treatment for people with mental disorders.³⁴

suicidality — A term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.³⁵

suicide screen — An interview or questionnaire designed to determine whether an individual is currently experiencing thoughts, feelings, impulses, or actual plans to commit suicide.

29. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 269-70

30. Ibid.

31. APA, *Psychiatric Services in Jails and Prisons*.

32. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 68-9.

33. On Our Own of Maryland, Inc., *Disability, Entitlements and Employment*, p. 14.

34. U.S. Dept. of HHS, *Mental Health: A Report of the Surgeon General*, p. 288

Supplemental Security Income (SSI) — The SSI Program was established in 1974 as a mechanism for incorporating various state programs into one federal program. SSI is a program that provides direct federal payments to the aged, blind, and disabled people who have limited income and resources.³⁶ (See also entitlements.)

support services — Rehabilitative services that are not strictly medical but are nonetheless considered to be necessary to the recovery process for many clients. Such services are designed to develop and/or restore a patient's functional capacities and may include support to enable clients to maintain independent housing, education, employment, or other activities associated with community integration.

supported employment — An evidence-based service that matches and trains persons with severe developmental, mental, or physical disabilities to jobs where their specific skills and abilities make them valuable assets to employers.

supportive housing — A system of professional and/or peer supports that allows a person with mental illness to live independently in the community. Such supports may include regular staff contact and assistance as needed with household chores, as well as the availability of crisis services or other services designed to prevent relapse, such as mental health, substance abuse, and employment. Also known as supported housing.

sworn personnel — All law enforcement officers with full arrest powers who take an oath to uphold the United States Constitution and the constitutions of their respective states, e.g., chiefs, sheriffs, supervisors of line officers, and line officers active in the field.

symptom acuity — The severity of symptoms experienced by a patient, usually requiring self-reporting, and rated on a scale of 1 to 10.

telemedicine/telepsychiatry — Provision of health care or psychiatry via telecommunications, typically utilizing medical computer sciences. A qualified mental health professional is able to interview and examine the detainee through the use of closed-circuit television or telephone.³⁷

training

in-service — Annual training required by most jurisdictions of all officers. Training topics can include: orientation to the agency's role, purpose, goals, policies, and procedures; working conditions and regulations, firearms qualifications; any new department policies or procedures;

and relevant legal updates. In-service requirements differ in every state and requirements can change yearly depending on state and/or local guidelines.

recruit/preservice — Training required by police and sheriffs' departments for new recruits at academy. Recruit training involves curriculum ranging from criminal law, defensive tactics, conflict management/crisis intervention training, community policing, investigative procedures to motor vehicle law and patrol procedures. Content and length of training offered varies in every jurisdiction depending on state local guidelines.

transitional employment — A key component of psychosocial rehabilitation in which consumers set their own vocational goals, which form the basis for motivation toward recovery of vocational roles.³⁸

traumatic brain injury — An often devastating condition characterized by changes that occur when a particular area of the brain is struck, penetrated, or pierced. Symptoms of traumatic brain injury such as poor judgment or poor impulse control can mimic symptoms of some mental illnesses.³⁹

Uniform Crime Reports (UCR) — Federal reporting system that provides data on crime based on police statistics submitted by city, county, and state law enforcement agencies across the nation. The Crime Index total is the sum of selected offenses used to gauge fluctuations in the overall volume and rate of crime reported to law enforcement. The offenses included in the Crime Index total are the violent crimes of murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault, and the property crimes of burglary, larceny-theft, and motor vehicle theft.

uniformed patrol — Police division responsible for the immediate response to calls for service. The members of this unit are all distinctively uniformed.

vocational rehabilitation (VR) — This term covers a wide range of services designed to assist individuals with disabilities in regaining skills needed to function in the workplace. It is generally delivered under the auspices of a state department of vocational rehabilitation and supported by state and federal appropriations. Eligibility for VR programs is established under the federal Rehabilitation Act. Programs offered by state VR agencies may include supported employment, Ticket to Work, Pathways to Independence, and work-readiness programs.

35. National Strategy for Suicide Prevention, p. 203.

36. On Our Own of Maryland, Inc., *Disability, Entitlements and Employment*, p. 12.

37. Logical Health Care Solutions, *Glossary*, p. 110.

38. Barton, "Psychosocial Rehabilitation," p. 526.

39. www.webmd.com.

Program Examples Cited in Report

STATE: **Alabama**

AGENCY/ORGANIZATION:

Birmingham Police Department

PROGRAM TITLE:

Community Service Officer Unit

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene Response

YEAR ESTABLISHED: **1976**

Overview

The Community Service Officer Unit responds to calls involving individuals in crisis, including people with mental illness, survivors of violent crimes, and missing persons.

Description

In 1976, the Crisis Intervention Taskforce in Birmingham decided to increase training and develop a Community Service Officer (CSO) unit in the Birmingham Police Department. The unit responds to every problem along the social work spectrum, including elder abuse, child endangerment, domestic violence, and mental illness. It was initially formed as a pilot program and was funded by the state of Alabama Community Education Training Act (CETA). The unit is now fully funded by the city of Birmingham.

When a patrol officer responds to a call for service involving a person with mental illness, the officer decides if a Community Service Officer (CSO) should provide secondary response. The CSO unit is staffed by six social workers that are housed within the department and report to the chief. The CSO unit can facilitate certain direct services that officers are not fully trained to provide (e.g., crisis intervention), make referrals, and transport consumers to the primary mental health-care facility.

Currently, University Hospital has been designated as the primary emergency health care facility for people with mental illness. Police officers can bring people who are in a mental

Birmingham Police Department
continued

health crisis to this location. This centralized location prevents confusion in coordinating follow-up services. The police department has developed a positive relationship with the psychiatric nurses who facilitate emergency care in the ER.

The CSO unit has developed a policy manual/ reference guide for sergeants. New recruits to the police force attend a 12-hour block of instruction in the academy on people with mental illness and crisis intervention. In 2001 the CSO unit also provided training to sergeants with a workshop/ training session about the unit's capabilities and resources.

Challenges/Areas for Improvement

The CSO unit would like to survey people who use the program's resources so that the department can evaluate its success in responding to community needs. Birmingham is also attempting to develop a CSO program for its Sheriff's Department, but its progress has been delayed due to funding considerations.

Contact Information

Senior Community Service Officer
Birmingham Police Department
1710 First Avenue North
Birmingham, AL 35203
Phone: (205) 254-2793
Fax: (205) 254-1703

STATE: **Alabama**

AGENCY/ORGANIZATION

Florence Police Department

PROGRAM TITLE

Community Mental Health Officer

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene Response

YEAR ESTABLISHED: **1997**

Overview

The Florence Police Department uses a modified Crisis Intervention Team approach, in which one officer serves as a “Community Mental Health Officer” and is the second responder to all calls involving people with mental illness. The officer in this position receives approximately 100 hours of mental health training.

Description

The Community Mental Health Officer (CMHO) responds 24 hours a day, seven days a week to pages and/or calls from officers who encounter a situation involving a person with mental illness who is in crisis or who appears dangerous or threatening. Upon responding, the officer determines whether the person requires immediate psychiatric evaluation. In Florence, the CMHO has the same authority as a probate court judge to make an involuntary commitment for 48 hours, but she can also file a petition with the judge for a longer period. It is not necessary for the CMHO to wait for a petition from the judge to bring the person in for evaluation and, consequently, responding patrol officers feel less inclined to find a “petty” complaint under which to take the person into custody.

The Community Mental Health Officer also reviews arrest reports weekly to check the status of arrestees who have been identified as having a mental illness that requires treatment, and determines whether arrestees are compliant with their medication or if their condition is worsening and emergency treatment is needed. The officer also maintains a log of arrestees and maintains contact with a liaison at the partnering mental health agency for follow-up.

The Community Mental Health Officer maintains a close relationship with the local hospital emergency room for responding to injuries or other medical conditions. The emergency room has developed a “fast track” procedure, in which the officer calls ahead to ensure that the arrestee will receive prompt service at the hospital.

In 2001, the CMHO and the Alabama State Department of Mental Health collaborated on the development of a statewide, 40-hour, post-academy training. This training will be provided for all officers in the state and will include role plays and lectures from doctors to teach basics in addressing issues related to mental illness and substance abuse.

Florence Police Department

continued

Challenges/Areas for Improvement

The Florence Police Department is developing methods for connecting people with substance abuse treatment, while avoiding unnecessary interactions with the corrections system. (Currently, the only way people with mental illness can access substance abuse treatment is through the jail.) The department also intends to address the perceived lack of adequate responses to people with mental illness who are adjudicated through the Drug Court.

Contact Information

Florence Police Department
701 South Court Street
Florence, AL 35630
Phone: (256) 760-6603

STATE: **Alaska**

AGENCY/ORGANIZATION:

Alaska Department of Corrections

PROGRAM TITLE:

Mental Health Management System

POLICY STATEMENT(S):

Receiving and Intake of Sentenced InmatesYEAR ESTABLISHED: **N/A****Overview**

The Alaska Department of Corrections has developed a screening tool that can be administered by trained, non-medical staff. The tool can be downloaded, administered, and immediately sent to the department's central office using handheld personal desk assistants or Palm Pilots. Mental health professionals in the central office can then make assessments and recommend or initiate appropriate interventions, if needed.

Description

There are 13 correctional and pretrial facilities within the state of Alaska, where geography and low population density present particular challenges. To ensure consistent, comprehensive inmate mental health screening, the Department of Corrections has developed the mental health management system.

The software for Alaska's program was written by Department of Correction's staff and has been copyrighted. The Palm Pilot serves not only as an electronic means of keeping medical records, but as a platform for the entire management information system. The platform-interactive database provides for a standardized assessment system. All clinicians perform the same, standardized exam on the Palm Pilot. It is structured as a psychiatric interview and produces comprehensive psychological diagnosis and treatment planning. The information is then uploaded to a statewide computer network and becomes available for printing for medical files. The system makes it possible to generate information in summary and/or aggregate form, thereby facilitating quality assurance and research. For example, information and reports can be generated by facility, by activity levels within a facility, or by diagnostic or prescription trends at a facility.

Contact Information

Alaska Department of Corrections
Mental Health Services
4500 Diplomacy Drive
Suite 211
Anchorage, AK 99508
Phone: (907) 269-7316

STATE: **Arizona**

AGENCY/ORGANIZATION:

Maricopa County Adult Probation Department

PROGRAM TITLE:

Conditional Community Release Program

POLICY STATEMENT(S):

Intake at County / Municipal Detention FacilityYEAR ESTABLISHED: **2000****Overview**

The Conditional Community Release Program provides community-based supervision for offenders with mental illness and helps to ensure that program participants receive appropriate treatment.

Description

The Conditional Community Release Program employs a contract psychiatrist, probation officer, surveillance officer, and intake specialist to identify, diagnose, and supervise offenders with mental illness. Once referred, the inmate is evaluated within 72 hours by an intake specialist. If appropriate, the inmate is admitted to the program and jail-release planning is undertaken. The psychiatrist will see the person in jail in order to ensure continuity of care once released, and the probation officer will see the client to complete all necessary paperwork.

Once released, the probationer may be placed in a housing facility funded by adult probation, or released to his or her home if appropriate. While in the community, the probation officer and surveillance officer supervise the client. The psychiatrist provides follow-up treatment if the client is not enrolled in community treatment. Using contracts with a local medical services agency, the program provides medication at a reduced cost and ensures that the clients receive necessary psychological testing.

The program is 45 days in length, at which time the client is transferred back to his or her original probation officer or referred to a specialized mental health caseload. In the event the client is not stabilized, the county will continue to serve the client until this is accomplished.

Contact Information

Maricopa County Adult Probation Department
111 S. Third Avenue, 3rd Floor
P.O. Box 3407
Phoenix, AZ 85030
Phone: (602) 506-7249
Web site: www.superiorcourt.maricopa.gov/adultPro/index.asp

STATE: **Arizona**

AGENCY/ORGANIZATION:

Maricopa County Sheriff's Office

PROGRAM TITLE:

Data Link Project

POLICY STATEMENT(S):

Intake at County / Municipal Detention Facility

YEAR ESTABLISHED: **1999**

Overview

The Data Link Project allows the Maricopa County Sheriff's Office to cross-reference names of detainees with the records of the local behavioral health provider in order to identify individuals who may be eligible for diversion from the criminal justice system.

Description

When individuals are booked into the county jail, their name, date of birth, social security number, and gender are entered into the Data Link Program database. The system electronically and simultaneously cross-references the individual's name with the database of the local behavioral health authority, which includes names and information for more than 12,000 clients who receive mental health services in the area. The data link provides for continued identification of clients throughout the day, regardless of booking charge, time of booking, or current mental status. The information flows only one-way—from the jail to the mental health provider.

Clients that match all categories are considered a full match and their names are immediately sent electronically to the jail diversion staff computer as well as the client's case manager. Full match screens contain the client's booking number, a maximum of three booking charges, court jurisdiction(s), and general demographic information. Clients that match at least one of the categories, with the exception of gender, are considered a partial match and are only sent to the jail diversion staff. The jail diversion staff further investigates partial matches, which are either converted to full matches or deleted from the system. If converted to a full match, the case manager then electronically receives notification of the client's admission to jail.

After full matches are determined, the jail diversion staff use various criteria to select candidates for the jail diversion program. The criteria include, but are not limited to:

- nature of the current offense(s)
- history of incarceration
- current mental status
- availability of community mental health resources
- public safety factors
- past performance in treatment settings.

Maricopa County Sheriff's Office

continued

The jail mental health diversion program consists of three types of intervention: Clients may be released from jail with conditions that include treatment; clients may be placed on summary (unsupervised) probation, which includes mandatory treatment; or clients may be given the opportunity for deferred prosecution in an intervention that includes increased judicial participation and supervision, and required treatment participation over a specified period of time. Successful completion of all requirements results in dropping criminal charges. All three types of diversion programs require mandatory group therapy sessions, including integrated treatment group for co-occurring disorders, which accounts for about 70 percent of the diversion population.

For individuals who are eligible for diversion, case managers are required to send pertinent clinical and care information to the jail diversion staff within 24 hours. They also must visit the client in the jail within 72 hours of incarceration, and at least once every 14 days thereafter until the inmate is released from jail.

Challenges/Areas for Improvement

One of the risks of the system is jeopardizing the offender's right to privacy by the automatic sharing of information that occurs. However, advocacy groups were involved with the formation of the program so as to try to eliminate many of these concerns from the outset.

Contact Information

Maricopa County Sheriff's Office

102 W. Madison Avenue

Phoenix, AZ 85003

Phone: (602) 256-1801

Web Site: www.mcso.org

STATE: **Arizona**

AGENCY/ORGANIZATION:

Pima County Pretrial Services

PROGRAM TITLE:

Mental Health Diversion Program

POLICY STATEMENT(S):

Prosecutorial Review of ChargesYEAR ESTABLISHED: **1997****Overview**

The Mental Health Diversion Program provides the court with an alternative to incarceration for defendants with mental illness who are charged with city court misdemeanors.

Description

The prosecutor, in conjunction with the case manager, determines eligibility for the Mental Health Diversion Program. Prosecution is deferred for eligible defendants, who are granted conditional release with certain requirements, including behavioral health treatment. Compliance with these conditions is monitored by pretrial services. If the defendant successfully completes the program, which lasts 180 days, charges are dismissed. If they fail to comply with program conditions, prosecution resumes.

Since the implementation of the Mental Health Diversion Program, there have been no filings for Rule 11 (competency to stand trial) hearings in the city court. This has resulted in great savings to the community. The number of misdemeanor defendants detained beyond their initial appearance has decreased significantly each year, and, just as significantly, the number of misdemeanor defendants remaining in custody more than 30 days has decreased to a negligible number (fewer than five in each jail population reviewed during the first quarter of 2000).

Contact Information

Pima County Pretrial Services

110 W. Congress, 9th Floor

Tucson, AZ 85701-1317

Phone: (520) 740-3322

Fax: (520) 620-0536

Web site: www.sc.co.pima.az.us/Pretrial/STATE: **California**

AGENCY/ORGANIZATION:

Board of Corrections

PROGRAM TITLE:

Mentally Ill Offender Crime Reduction Grant (MIOCRG) Program

POLICY STATEMENT(S):

Obtaining and Sharing Resources, Collecting DataYEAR ESTABLISHED: **1998****Overview**

The MIOCRG was initiated in 1998 by the California State Sheriff's Association and the Mental Health Association in an effort to reduce crime, jail crowding, and criminal justice costs associated with offenders with mental illness. The California State Legislature first authorized the program in 1998 and reauthorized the program in 2000-2001. The program is overseen by the California Board of Corrections and has provided over \$104 million in grants for 30 projects in 26 counties.

Description

To be eligible for a grant, the program required counties to establish a Strategy Committee that included key leaders from the criminal justice and mental health communities (e.g., sheriff, superior court judge, county mental health director). The authorizing statute required the Strategy Committees to develop a Local Plan that described the county's existing response to offenders with mental illness, service gaps that had been identified, and proposed strategies for improving service to offenders with mental illness. The legislature earmarked \$2 million for noncompetitive planning grants to assist counties in developing these plans.

The grants were awarded in multiple phases based on the three separate legislative appropriations. The first set of appropriations was made in May 1999 and totaled \$22.9 million to seven counties. The 1999/2000 State Budget appropriated an additional \$27.7 million to the grant program; these funds were distributed to six counties. The Board of Corrections refers to the grantees from 1999 and 2000 as MIOCRG I. The 2000/2001 State Budget included an additional \$50 million for the grant program. In May 2001, 15 counties received grants totaling approximately \$45.7 million. The Board of Corrections refers to these fifteen counties as MIOCRG II.

The MIOCRG requires the Board of Corrections to develop a plan to evaluate the efficacy of the program in reaching its stated goals of reducing crime, jail crowding, and criminal justice costs associated with offenders with mental illness. The board staff developed a research design in conjunction with funded counties. This research plan requires counties to collect com-

Board of Corrections
continued

mon data elements concerning the population served, the services provided, and the efficacy of the programs. The counties submit data to the board every six months. In addition, the program requires counties to evaluate their project by establishing outcome and performance measures and conducting a process assessment. This two-tiered evaluation allows the board to focus on cross-site evaluations while the counties can concentrate on the unique aspects of their program.

Contact Information

California State Board of Corrections
600 Bercut Drive
Sacramento, CA 95814
Phone: (916) 445-5073
Fax: (916) 327-3317
Web site: www.bdcorr.ca.gov/cppd/miocrg/miocrg.htm

STATE: **California**

AGENCY/ORGANIZATION:
Department of Mental Health

PROGRAM TITLE:
California State Task Force

POLICY STATEMENT(S):
Workforce

YEAR ESTABLISHED: **2000**

Overview

In California, a state law directed a task force led by the Department of Mental Health to identify options for meeting the mental health staffing needs of state and county health, human services, and criminal justice agencies.

Description

In 2000, the California State Assembly passed a bill in response to the shortage of mental health professionals throughout the state of California. The bill directed the representatives of the task force funded by the Budget Act of 2000 to address and identify options for meeting the staffing needs of state and county health, human services, and criminal justice agencies. The task force has representatives from the Department of Mental Health, the California State University, the California Community Colleges, and a number of other educational and mental health stakeholders. The bill also instructed the task force to establish regional training centers and to develop a grant program for students in California colleges and universities that offer certain degrees in order to attract students to employment in publicly funded mental health services. The task force will report its findings to the Legislature by May 1, 2002.

Also in California, the Center for Health Professions at the University of California, San Francisco, has created the California Workforce Initiative to look broadly at needs in the health care workforce, including the behavioral health care field.

The programs have begun implementing several areas of development on the issue of staffing shortages. However, data has yet to be examined concerning the outcome of these programs.

Contact Information

California Department of Mental Health
1600 9th Street, Rm. 151
Sacramento, CA 95814
Phone: (916) 654-3565
Fax: (916) 654-3198
Email: dmh@dmhhq.state.ca.us
Web site: www.dmh.cahwnet.gov/default.asp

STATE: **California**

AGENCY/ORGANIZATION:

Long Beach Police Department

PROGRAM TITLE:

Mental Evaluation Team

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene ResponseYEAR ESTABLISHED: **1996****Overview**

The Mental Evaluation Team (MET) pairs a police officer and clinician to respond to calls for service involving people with mental illness.

Description

The MET program was designed with the following goals: to prevent unnecessary incarceration and/or hospitalization of individuals with mental illness; to prevent duplication of mental health services; to protect the community and individuals who may be a danger to themselves or others; and to enable police patrol units to return quickly to service.

MET units can be dispatched either directly to calls involving mental health issues or in support of a request for assistance from patrol units. In the latter case, the MET takes over the call, allowing the patrol unit to respond to other calls. The MET unit focuses on calm, supportive, and respectful interactions with individuals with mental illness and only uses force as a last resort. Currently, the MET program provides response to calls for service during 10 hours a day, seven days a week.

The MET has led to cost-savings for the county because officers can assess which individuals have private insurance, Medi Cal (which allows individuals to use private hospitals), or no insurance. If a person with MediCal is sent to the county hospital, the county pays twice for the person. Additionally, the MET is able to direct patients away from an already overburdened County Hospital.

One of the core strengths of the MET program is the training for participating officers.

The Long Beach Police Department mandates both academy and in-service training on issues related to responding to people with mental illness. New recruits must attend a six-hour course on issues involving people with disabilities. This portion of the training is mandated by the state. Additionally, recruits are required to attend a class called Field Contacts with People with Mental Illnesses. This training is not state-mandated. The Field Contacts course is also part of the in-service training.

The Los Angeles County Mental Health Department funds the MET team and its additional training. During its first three years of operation, the MET team handled 1,810 calls for service,

Long Beach Police Department

continued

hospitalizing 838 people, (46 percent). Of the persons hospitalized, 357 (43 percent) were hospitalized privately, for a cost-savings of \$785,400. During this same time period there were less than ten uses of force.

Challenges/Areas for Improvement

With additional funding, Long Beach would like to extend this program to provide 24- hour-a-day/seven-days-a-week response.

Contact Information

Long Beach Police Department

400 W. Broadway

Long Beach, CA 90802

Phone: (949) 770-6501

Fax: (562) 570-7114

Web site: www.ci.long-beach.ca.us/lbpd/

STATE: **California**

AGENCY/ORGANIZATION:

**Pacific Clinics: Los Angeles, Orange, Riverside,
and San Bernardino Counties**

PROGRAM TITLE:

Pacific Clinics

POLICY STATEMENT(S):

Cultural Competency

YEAR ESTABLISHED: **1987**

Overview

The Pacific Clinics provide mental health treatment in a community environment to individuals in Southern California, with a special focus on cultural sensitivity to members of Latino and Asian populations.

Description

Pacific Clinics, a provider of behavioral health care services in Los Angeles, Orange, Riverside, and San Bernardino counties in California, has made a priority of establishing services to meet the needs of different cultural groups. Many of their 65 sites include staff from Spanish-speaking cultures that can provide culturally sensitive services to Latino clients. Pacific Clinics has also developed services that are sensitive to the needs of the multiple Asian populations living in that part of California. Services at the clinics include links to culture-specific family and consumer groups, as well.

Pacific Clinics has a budget of over \$52 million and a staff of more than 800 professionals. Among its many services, Pacific Clinics provides training and education to a variety of audiences, including consumers, families, and professionals.

Contact Information

Pacific Clinics

800 S. Santa Anita Avenue

Arcadia, CA 91006

Phone: (626) 254-5000

909 S. Fair Oaks Avenue

Pasadena, CA 91105

Phone: (626) 795-8471

Email: CallCenter@pacificclinics.org

Web site: www.pacificclinics.org/

STATE: **California**

AGENCY/ORGANIZATION:

Orange County Probation Department

PROGRAM TITLE:

Project IMPACT

POLICY STATEMENT(S):

Sentencing

YEAR ESTABLISHED: **1999**

Overview

Project IMPACT facilitates the transfer of offenders with mental illness from jails to community-based mental health services.

Description

Participants for Project IMPACT receive an individualized service plan, along with linkages to alcohol and drug abuse services, social services, housing, and medication. Specialized probation officers are assigned to a small number of cases and they coordinate the care of their clients. The program also provides a county-wide education and training program, a liaison and training with law enforcement, a Community Resource Center for offenders with mental illness, and an informational video for families and friends of offenders with mental illness.

Contact Information

Project IMPACT

Orange County Probation Department

909 N. Main Street

Santa Ana, CA 92701

Phone: (714) 480-6778

Web site: www.oc.ca.gov/Probation

STATE: **California**

AGENCY/ORGANIZATION:

Pasadena Police Department

PROGRAM TITLE:

Mental Illness Law Enforcement System

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene ResponseYEAR ESTABLISHED: **2001****Overview**

The Pasadena Police Department is involved in community partnerships that improve law enforcement's response to people with mental illness.

Description

The Pasadena Police Department works closely with Genesis, a social service provider that deals with issues affecting the elderly (specifically mental illness), to serve individuals with mental illness better. Genesis staff provide training and are on call 24 hours a day, 7 days a week to respond to police situations involving people with mental illness. Genesis offers this service free of charge.

The Pasadena Police Department also participates in the San Gabriel Valley Task Force, which addresses the law enforcement response to people with mental illness. The task force was initiated by the mental health community and began in 1998. The task force meets monthly and is comprised of mental health care service providers and representatives of the Pasadena Police Department and the Monterey Police Department. The name of the program is MILES (Mental Illness Law Enforcement System). This task force is also responsible for the annual MILES conference during which speakers discuss various issues involving people with mental illness.

The director of Pacific Clinics, a local mental health care agency, has also collaborated with the Training Division of the Pasadena Police Department to develop a roll-call training program on mental illness-related issues for each of the patrol teams.

Contact Information

Training Sergeant

Pasadena Police Department

207 N. Garfield Avenue

Pasadena, CA 91101

Phone: (626) 744-4573

Fax: (626) 744-3959

Web site: www.ci.pasadena.ca.us/police/STATE: **California**

AGENCY/ORGANIZATION:

PERT, Inc

PROGRAM TITLE:

Psychiatric Emergency Response Team (PERT)

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene ResponseYEAR ESTABLISHED: **1996****Overview**

The Psychiatric Emergency Response Team (PERT) program in San Diego County is a partnership among eight county-wide law enforcement agencies, San Diego County Mental Health Services, and PERT, Inc., a non-profit organization formed to organize, supervise, and manage the operations of the program. Each PERT consists of a specially-trained officer/deputy and a licensed mental health clinician and responds to calls that may involve mental illness throughout San Diego County.

Description

The San Diego County PERT teams comprise specially trained officers or deputies who are paired with mental health professionals; together, they respond on-scene to situations involving people with mental illness. The 24 PERT teams represent a partnership between the Sheriff's Office and the eight law enforcement departments in the county.

Participating officers, deputies, and mental health professionals are specially selected and complete an 80-hour block of training. The training includes modules about on-scene assessment, payer systems, community-based organizations, and available hospitals. The goal of the program is appropriate placement for people with mental illness in the least restrictive environment possible.

The PERT model is funded by both county and state grants (which are actually pass-through federal SAMHSA funds). Partners determined that the most efficient way to manage these funds was to form a separate organization, known as "PERT, Inc." The board for PERT, Inc. is made up in part of NAMI board members and board members from the Community Research Foundation, which is the largest private, nonprofit mental health service provider in the county. PERT, Inc. supervises the PERT staff and coordinates billing for services rendered (a funding stream that provides considerable support for the program). The executive director of PERT, Inc. developed training and is viewed by the police and mental health professionals as a neutral liaison.

Important to the success of this program are the committees that meet to discuss the program and solve problems. The first committee is the coordinating council, which meets quarterly to examine policies. The coordinating council is made up of a captain or assistant chief from all nine departments and the

PERT, Inc
continued

director of the county department of mental health. The second group comprises supervisors from the divisions where PERT teams are active, who meet to discuss logistics and operations. The third group is an advisory board of 15 mental health stakeholders from around the county and two police coordinators. This group meets to provide oversight of the program and to establish accountability measures.

The Community Research Foundation has prepared a report on the operations of the PERT teams for the period from July 1, 1998, through June 30, 1999. This report details the incidents the teams responded to, including client information, how long the calls took, and what the outcome of each encounter was.

Contact Information

San Diego County Sheriff's Department
Commander of Law Enforcement Services Bureau
P.O. Box 429000
San Diego, CA 92142
Phone: (858) 974-2319

STATE: **California**

AGENCY/ORGANIZATION:
San Bernardino County

PROGRAM TITLE:
San Bernardino Partners Aftercare Network (SPAN)

POLICY STATEMENT(S):
Development of Transition Plan

YEAR ESTABLISHED: **1998**

Overview

The San Bernardino Partners Aftercare Network (SPAN) connects individuals with mental illness to appropriate mental health services at the time of their release from jail.

Description

The San Bernardino Partners Aftercare Network (SPAN) was one of many programs to receive funding from California's the Mentally Ill Offender Crime Reduction Grant Program (MIOCRG). (See description of the MIOCRG above.)

SPAN is housed on the grounds of the San Bernardino County's West Valley Detention Center. The aftercare management team serves as a "bridge" between the offender's release from state custody and his or her reintegration in the community. SPAN provides a number of services such as early discharge planning so that the mental health needs of inmates' can be assessed early on. In addition, released inmates receive a 14-day supply of medication at the time of their release to cover the period until they can meet with a mental health service worker. Identification cards are provided to inform law enforcement personnel and treatment providers that the person with mental illness is part of the program.

The coordination of terms and conditions of probation is handled by a sub-program, STAR-LITE (Supervised Treatment After Release—Less Intense Treatment Expectations). STAR-LITE provides extensive front end case management to inmates who are at high risk of recidivism. This includes housing, financial support, and substance abuse counseling.

Contact Information

California Board of Corrections
600 Bercut Drive
Sacramento, CA 95814
Phone: (916) 445-5073
Fax: (916) 327-3317
Web site: www.bdcorr.ca.gov

STATE: **California**

AGENCY/ORGANIZATION:

San Diego County Public Defender's Office

PROGRAM TITLE:

San Diego Homeless Court

POLICY STATEMENT(S):

AdjudicationYEAR ESTABLISHED: **1999****Overview**

The San Diego Homeless Court conducts court proceedings in homeless shelters to facilitate the fulfillment of court orders and reduce subsequent contact with the criminal justice system for program participants.

Description

Many homeless individuals are charged with crimes and have outstanding warrants, usually for misdemeanors such as illegal lodging. These individuals may be wary of attending court proceedings or, due to their lack of a permanent address, do not receive notices to appear. Most studies estimate that at least 20-25 percent of the adult homeless population has a mental illness.

The San Diego Homeless Court is a program run by the San Diego Public Defender's Office that brings court proceedings into shelters, where legal issues are disposed of through progressive pleabargaining and alternative sentencing measures. The Homeless Court does not resolve felony cases. Prosecutors and defense attorneys work together to hold court sessions once-a-month. The program works on a four-week schedule.

- **week one:** participants sign up for a court proceeding
- **week two:** the court and prosecution prepare cases for the next scheduled hearing
- **week three:** the defense attorney meets with the participants to review and prepare for the cases
- **week four:** the court personnel arrive at the shelter and hear the cases

Sentences often involve participation in programs at local shelters or other community services instead of fines or jail-time. Also, shelters can then provide drug counseling, job placement, and access to additional public services (e.g. mental health care).

The Criminal Justice Research Division of The San Diego Association of Governments (SANDAG) conducted a project evaluation of the San Diego Homeless Court. The evaluation is available by contacting SANDAG at (619) 595-5383.

Contact Information

San Diego Public Defender's Office
233 A Street, Suite 800
San Diego, CA 92101
Phone: (619) 236-2523

STATE: **California**

AGENCY/ORGANIZATION:

Village Integrated Service Agency, Long Beach

PROGRAM TITLE:

Village Integrated Service Agency

POLICY STATEMENT(S):

Integration of ServicesYEAR ESTABLISHED: **1987****Overview**

The Village Integrated Service Agency provides comprehensive mental health services to individuals in Los Angeles County.

Description

The Village Integrated Service Agency in Long Beach, California, was initially developed through state legislation (1989) that attempted to remove administrative and funding barriers from the delivery of comprehensive, individualized mental health services. The three basic elements of the Village's program design are collaborative case management teams, case-rated funding, and a psychosocial rehabilitation/recovery philosophy. As in the ACT model, services at the Village are delivered to the client wherever he or she is. Teams of clinicians work with each client and bring complementary skills to the process. Case-rated funding is an important principle because it focuses on outcomes rather than on delivery of units of service. The overarching recovery philosophy encourages staff and clients to seek the rewards that come with higher risks, knowing that support will be available when needed. The Village offers a clear, single point of responsibility for everyone it serves and provides coverage 24 hours a day, seven days a week.

In 1987 a group of concerned parents, consumers, business people, and professionals, prompted the lieutenant governor to help form a task force to make recommendations for creating a better mental health system. Two years later, after 14 statewide community hearings, the task force's recommendations were incorporated into a bipartisan legislative bill, which was passed in 1989. The statute provided funding for three years, directly out of the state general funds, for three Integrated Service Agency (ISA) demonstration projects in three different settings—countywide, urban, and rural. The mission of the Village Integrated Service Agency is to support and teach adults with psychiatric disabilities to recognize their strengths and power to successfully live, socialize, and work in the community. In addition, the organization also seeks to stimulate and promote the system-wide changes necessary so that these individuals may achieve these goals.

Village Integrated Service Agency, Long Beach
continued

Challenges/Areas for Improvement

The Village has struggled with the difficulty presented in treating individuals with co-occurring mental health and substance abuse disorders. The division of funding sources for these different problems makes facilitating treatment especially difficult.

Contact Information

Village Integrated Service Agency
456 Elm Avenue
Long Beach, CA 90802
Phone: (562) 437-6717
Fax: (562) 437-5072
Email: mailbox@village-isa.org
Web site: www.village-isa.org/

STATE: **Connecticut**

AGENCY/ORGANIZATION:

Department of Mental Health and Addiction Services

PROGRAM TITLE:

Jail Diversion Program

POLICY STATEMENT(S):

Pretrial Release/Detention Hearing

YEAR ESTABLISHED: **1994**

Overview

The Connecticut Department of Mental Health and Addiction Services (DMHAS) has instituted jail diversion programs in all 22 geographical area courts across the state. These programs work with the courts to link to treatment services people with mental health and co-occurring substance abuse disorders arrested on minor offenses.

Description

In 1994 DMHAS developed in Hartford the first jail diversion program in the state for defendants with mental illness. The program was the outcome of interagency discussion about the frequent rearrest of people with serious mental illness. Prior to this program, the courts were helping defendants with mental illness to obtain mental health services by finding them incompetent to stand trial and admitting them to psychiatric hospitals. This approach, geared towards enabling the defendants to become competent to stand trial, generally did not focus on their long-term needs.

The goals of the diversion program include the following:

- reduce recidivism of people with mental illness by providing access to treatment
- reduce incarceration of individuals with mental illness for minor offenses
- free jail beds for violent offenders; provide judges with additional sentencing options
- increase the cost-effectiveness of the courts, Department of Corrections, and DMHAS

The jail diversion program allows the courts and community mental health centers to work together for the benefit of the defendant. The clinicians who operate the diversion programs work out of the local community mental health centers. When those centers are run by DMHAS, the clinicians are DMHAS staff; when the centers are not run by DMHAS, they receive funding and supervision from DMHAS. All of the clinicians are licensed practitioners (social workers, nurses, psychologists) who receive training from DMHAS Division of Forensic Services. The diversion programs also offer training to the local police departments to enhance police understanding of mental illness and the alternatives to arrest for certain individuals.

Department of Mental Health and Addiction Services
continued

The diversion staff conduct assessments of individuals who may be eligible for diversion, generally prior to arraignment. The diversion staff then propose a treatment plan as an alternative to incarceration, and work with the court and the treatment providers to ensure that the defendant complies with the diversion conditions. The only information that diversion staff provide to the court is a treatment plan and what options are available to the client. The nature of the illness and any diagnoses are kept confidential. The diversion team does not make the decision to divert; it simply offers options to the judges. If the client agrees to allow the clinician to share more information with the court it is easier to prepare a treatment plan that can be followed up by the court.

If the court does offer diversion to the defendant, possible outcomes include deferred prosecution with the condition of treatment, dismissal of charges, or probation with special condition of treatment. When possible, diversion staff follow-up on program participants to assess their success in the program.

In 1997, Connecticut's jail diversion program was selected as part of the SAMHSA study of the impact of jail diversion. Using initial data from that study, DMHAS prepared a report to the Connecticut General Assembly Joint Committee on the Judiciary, Public Health, and Appropriations. DMHAS's ability to demonstrate that individuals who participated in the programs spent significantly fewer days in jails and psychiatric hospitals helped convince the General Assembly to appropriate funding for an expansion of the program to all 22 geographical area courts in the state. Beginning in 1998, researchers in Connecticut have collected data comparing the experiences of two groups of defendants with mental illness—one group from courts with diversion programs and one group from courts without diversion programs.

The data collection period is complete and the study is currently in the data analysis phase. The researchers will look to compare the costs of serving the two groups, including costs associated with criminal justice services and mental health services.

Contact Information

Jail Diversion Program
Department of Mental Health and Addiction Services
410 Capital Avenue
Hartford, CT 06134
Phone: (860) 418-6914
Web site: www.dmhas.state.ct.us/pdf/jaildiversion.pdf

STATE: **Florida**

AGENCY/ORGANIZATION:

Broward County District Court

PROGRAM TITLE:

Broward County Mental Health Court

POLICY STATEMENT(S):

**Pretrial Release/Detention Hearing;
Adjudication**

YEAR ESTABLISHED: **1997**

Overview

The Broward County Mental Health Court seeks to link defendants with mental illness to appropriate diagnostic and treatment services. Only defendants who have been charged with misdemeanors are eligible for the court, excluding those charged with domestic violence, driving under the influence, or battery, unless the victim consents to the transfer of the defendant.

Description

Defendants can be referred for participation in the mental health court in a variety of ways including by the magistrate who presides at the bond hearing, the defense attorney, the defendant's family, the police, or a mental health caseworker, among others.

Defendants may either be in custody or out-of-custody (e.g., on pretrial release) when they are referred. For defendants who are in custody, clinicians from Nova Southeastern University assigned to the public defender's office screen defendants prior to the initial probable cause/bail hearing. When defendants exhibit symptoms of mental illness, the defender informs the court during the hearing, which is generally conducted via closed circuit television. Depending on the time of arrest, the magistrate presiding at the bond hearing will refer the individual to the mental health court either for the same day or the next day. Individuals who are deemed to be in crisis or a danger to themselves are referred to a crisis center until they are stabilized, at which point they may be eligible to again participate in the court.

Defendants who are referred to the court have a probable cause hearing in the court to review the charges. Those individuals whom the judge determines are eligible for the court are offered, after consulting with an attorney and mental health professionals, the opportunity to participate in treatment under the supervision of the court. For those defendants who agree to this arrangement, the state's attorney holds their charges in abeyance, pending the progress of the treatment.

After being selected for participation in the program, defendants are further assessed and then assigned to a case manager. The case manager is responsible for preparing a service plan, which is coordinated in conjunction with the defendant, family members, a treatment provider, and the mental health court. The court then holds a series of status hearings, as needed,

Broward County District Court
continued

to monitor the progress of the defendant. Defendants report to the court regularly, usually at two, three, or four-week intervals (intervals increase after continued satisfactory progress).

Challenges/Areas for Improvement

One of the key problems that the mental health court faces has been the lack of community placement options. Accordingly, the court appealed to the legislature and received funding for a three-year program to develop a residential treatment facility, more intensive case management, and independent housing options

Contact Information

Broward County Mental Health Court
Broward County Courthouse
201 S.E. 6th Street, Rm. 905
Ft. Lauderdale, Florida 33301
Phone: (954) 831-7805

STATE: **Florida**

AGENCY/ORGANIZATION:
Florida Bar

PROGRAM TITLE:
Florida Bar Continuing Legal Education Requirements

POLICY STATEMENT(S):
Training for Court Personnel

YEAR ESTABLISHED: **2001**

Overview

On February 8, 2001, the Florida Bar added mental illness awareness as a mandatory category of continuing legal education requirements.

Description

Continuing Legal Education Requirement (CLER) was adopted by the Supreme Court of Florida in 1988 and requires all Florida Bar members to further their legal education. The Florida Bar requires each member to complete 30 hours of CLE over a three-year period. Five of those hours of education must be obtained in one of four mandatory categories—ethics, professionalism, substance abuse, and mental illness awareness. Adding mental illness awareness as a mandatory category demonstrates the Florida Bar's appreciation of the importance of attorney's gaining education in this area. The Board of Governors of the Florida Bar voted 50 to 0 in support of mandatory CLE in mental illness awareness.

Challenges/Areas for Improvement

According to Angela Vickers, an attorney and mental health advocate who was a leading proponent of the inclusion of mental illness awareness as a mandatory category in the Florida CLER, there is a shortage of educational opportunities for attorneys in this area.

Contact Information

The Florida Bar
650 Apalachee Parkway
Tallahassee, FL 32399-2300
Phone: (850) 561-5600
Web site: www.flabar.org/

STATE: **Florida**

AGENCY/ORGANIZATION:

Seminole County Sheriff's Office

PROGRAM TITLE:

**Crisis Intervention Team /
Medical Bracelet Program**

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene ResponseYEAR ESTABLISHED: **1999****Overview**

A task force consisting of key stakeholders from the mental health care, substance abuse treatment, and criminal justice systems helped the Seminole County Sheriff's Office form a Crisis Intervention Team (CIT) in 1999. The goal of the team is to respond appropriately to people with mental illness who are the subject of calls for service.

Description

The Sheriff's Office funds all CIT training. When the program was first initiated, all CIT officers were required to complete a 40-hour block of training. The Crisis Intervention Team assigns one trained officer to every shift. This deputy is expected to respond to calls for service involving people with mental illness. If this officer is unavailable, any deputy can respond to the call. However, it is expected that the responding deputy will speak with the CIT officer to gain insight and develop a strategy to effectively manage the call. In order to better prepare and respond to the needs of people with mental illness, CIT staff create and maintain a file of information about each individual with whom they have contact, including the nature of the illness, family relations, the layout of the person's home, the availability of weapons, and any other relevant information. The Sheriff's Office collects these data from the Forensic Diagnosis team at the jail, the Crisis Intervention Team files, and the Medical Bracelet Program.

The Sheriff's Office also participates in the Seminole County Mental Health and Substance Abuse Task Force. The task force (which includes representatives from the State Attorney's Office, Public Defender's Office, Seminole Community Mental Health Center, NAMI, and the Coalition for the Homeless) meets monthly to discuss issues related to each agency's response and the collaborative initiatives developing among the agencies.

The Sheriff's Office has contracted with the Mental Health Association of Central Florida (MHACF) to set up the Medical Bracelet Program. The MHACF is a nonprofit organization and the project is funded entirely by the Sheriff's Office. The program offers free voluntary registration to people with mental illness. They can get a bracelet or an identification card that alerts law enforcement to a particular condition. Accordingly, if a citi-

Seminole County Sheriff's Office

continued

zen with mental illness fails to comply with medication or encounters the police, the responding officer will be aware that the person is in need of specific assistance. This information is stored in the department's communication center and is available 24 hours a day, seven days a week.

In 2000, the CIT responded to approximately 1200 calls for service involving people with mental illness. Also, participation in the task force has provided the Sheriff's Office with feedback on CIT program successes and barriers, and each participating agency's understanding of other agency's roles was significantly increased.

Challenges/Areas for Improvement

Since the initial training, the sheriff's office has recognized the need to locate alternate training opportunities. One resource that the sheriff's office has identified is the Florida Regional Community Policing Institute at St. Petersburg, which offers a class entitled "Managing Encounters with the Mentally Ill."

Contact Information

Seminole County Sheriff's Office

100 Bush Blvd

Sanford, FL 32773

Phone: (407) 665-6986 or (407) 331-8231

Fax: (407) 665-6797

Web site: www.seminolesheriff.org/

STATE: **Florida**

AGENCY/ORGANIZATION:

Pinellas County Sheriff's Office

PROGRAM TITLE:

Crisis Intervention Training Program

POLICY STATEMENT(S):

Training for Law Enforcement Personnel

YEAR ESTABLISHED: **2001**

Overview

Pinellas County Sheriff's Office personnel receive training on using crisis intervention skills in interacting with people for whom mental illness was a factor in the call for service.

Description

The Mental Health Commission of Pinellas County provides a 40-hour training program at no charge to the Sheriff's Office. The Mental Health Commission of Pinellas County comprises mental health providers, mental health advocates (e.g., NAMI), and law enforcement executives. Nonpolice personnel, including people with mental illness and family members, teach the training course. 150 employees of the Pinellas County Sheriff's Office have been trained, including civilian staff, corrections, and law enforcement. Specifically, Pinellas County has made an effort to train its communications/dispatch staff.

The Pinellas County Crisis Intervention (CI) program is based on the Memphis, Tennessee, Police Department's Crisis Intervention Team model, in which specially trained officers respond to calls involving people with mental illness. The county has helped other Florida police departments implement their own Crisis Intervention programs.

As a result of the crisis intervention training, dispatchers are prepared to ask the necessary questions to provide deputies on-scene with as much information as possible, and sworn staff are better able to respond to calls involving people with mental illness.

Challenges/Areas for Improvement

The department hopes to increase the number of its CI-trained officers. Unfortunately, there are not enough trained officers to have a CI officer respond to every call involving a person with mental illness. Usually, only 10 to 12 people per shift have received CI training. As a result, there are many instances in which a CI officer is not available to respond to a call involving a person with a mental illness.

The department would also like to hire social workers to follow up with a person who has been admitted to a mental health care facility. The social worker would speak with family members and caseworkers or locate resources. This intervention

Pinellas County Sheriff's Office

continued

might increase the number of people with mental illness who can be helped by access to ongoing services.

Contact Information

Patrol Operations Administration

Pinellas County Sheriff's Office

10750 Ulmerton Rd.

Largo, FL 33778

Phone: (727) 582-6293

Fax: (727) 582-6769

STATE: **Georgia**

AGENCY/ORGANIZATION:

Athens-Clarke County Police Department

PROGRAM TITLE:

Crisis Intervention Program

POLICY STATEMENT(S):

Training for Law Enforcement PersonnelYEAR ESTABLISHED: **1997****Overview**

The Athens-Clarke Crisis Intervention Program (CIP) trains every officer in the Athens-Clarke police department to respond effectively to calls for service involving people with mental illness.

Description

The Athens-Clarke Crisis Intervention Program (CIP) is based on the Memphis CIT program, particularly with regard to the training requirements. Unlike the Memphis model, however, the county government in Athens-Clarke determined that special teams alone could not provide an adequate law enforcement response to people with mental illness in Athens-Clarke County. County government officials believed that every officer must be able to respond effectively to a call for service involving a person with mental illness.

All new recruits are required to attend post-academy training in mental health crisis intervention. Currently, about half of the 210 sworn officers have been trained in this subject area. Advantage Behavioral Health, a community-based health care provider, conducts the training. Local mental health professionals donate their expertise, teaching the crisis intervention class. As part of the course, officers visit a local hospital or mental health facility to interact with and learn from consumers.

The training provides officers with a well-structured method for handling on-scene response. When arriving on-scene, an officer must first assess whether the consumer is a danger to him/herself or others. Based on their crisis intervention training, the officer must then decide if the person is in need of professional evaluation. During regular business hours, an officer may transport a consumer to the local mental health care provider, Advantage Clinic, for evaluation. During off hours, or if the person is considered violent, the officer may bring the individual to the emergency room where an Advantage staff person will meet them.

As a result of the Crisis Intervention Program, the Athens-Clarke County Police Department has established close relationships with local advocacy groups, particularly NAMI and the Mental Health Association. In April 2001, the captain who serves as the informal liaison to the mental health care providers won the Mental Health Association's annual award for public services as a result of his work with the CIP.

Athens-Clarke County Police Department

continued

Challenges/Areas for Improvement

The Athens-Clarke County Police Department plans to continue providing crisis intervention training to its officers until all sworn personnel have received the training. Also, the department has encountered difficulties in finding appropriate care and placement for youth who have mental illness, and would like to develop specialized responses for this population.

Contact Information

Career Development Unit Administrator
Athens-Clarke County Police Department
3035 Lexington Road
Athens, GA 30605
Phone: (706) 613-3330 ext. 325
Fax: (706) 613-3348

STATE: **Georgia**

AGENCY/ORGANIZATION:
Georgia Indigent Defense Council

PROGRAM TITLE:
Mental Health Advocacy Division

POLICY STATEMENT(S):
Appointment of Counsel

YEAR ESTABLISHED: **1992**

Overview

The Georgia Indigent Defense Counsel (GIDC) serves as an information clearinghouse for defense attorneys throughout the state, including information regarding the representation of persons with mental illness. The Mental Health Advocacy Division of the council is responsible for providing aid to attorneys representing clients suffering from a mental illness.

Description

The GIDC was established in 1979 but was not funded by the state until 1989. The Mental Health Advocacy Division was created internally in 1992 and was legislated in 1996.

The mental health division provides assistance in one of three specific areas. It can directly represent those who are incarcerated indefinitely in state mental hospitals due to an insanity plea. The division also offers training seminars and manuals for defense attorneys who represent clients with mental illness and for the judges who sentence those defendants. Finally, the division works as a consultation service for lawyers representing clients who are confined to mental hospitals or whose mental illness has a bearing on the disposition of their pending charges.

Contact Information

Mental Health Advocacy Division
Georgia Indigent Defense Council
985 Ponce de Leon Avenue
Atlanta, GA 30306
Phone: (404) 894-2595
Web site: www.gidc.com

STATE: **Hawaii**

AGENCY/ORGANIZATION:
Honolulu

PROGRAM TITLE:
Honolulu Jail Diversion Project

POLICY STATEMENT(S):
Pretrial Release/Detention Hearing

YEAR ESTABLISHED: **1988**

Overview

Honolulu's jail diversion program is a court-based program that transfers misdemeanants with mental illness from the jail into some form of treatment while they are awaiting trial.

Description

The post-booking program in Honolulu begins when detainees are transported from holding cells in the local precincts to the courthouse in the early morning, where they are seen by a case coordinator who determines before arraignment whether diversion is appropriate. Participants in the program sign a voluntary release of information form for medical and mental health records. A plan for services is arranged, and participants are arraigned and released on their own recognizance. Clients are then taken directly to treatment centers, and their progress is monitored by a case coordinator. The case manager helps defendants gain whatever aid they need, even if it means picking them up and driving them to their hearing. This program is designed to ensure that less time is spent in jail during the pretrial phase, regardless of the disposition of the case, and it also decreases the rate of failures to appear.

Contact Information

Jail Diversion Project
Oahu Intake Service Center
2199 Kamehameha Center
Honolulu, HI 96819
Phone: (808) 586-4683

STATE: **Illinois**

AGENCY/ORGANIZATION:

**Cook County Department of Corrections,
Illinois Office of Mental Health**

PROGRAM TITLE:

**Cook County Jail Electronic Access to
Information**

POLICY STATEMENT(S):

Intake at County / Municipal Detention FacilityYEAR ESTABLISHED: **2001**

Overview

The goal of the program is to notify mental health clinics electronically when their members go to jail to immediately begin the process of aftercare planning.

Description

Through an automated information system, the Cook County Jail electronically transfers its jail census on a daily basis to mental health clinics in the Chicago area. Clinic staff review the lists to determine whether they can identify any of their clients. The goal is to notify these clinics when one of their clients is in custody to aid in the continuation of treatment while in custody.

Contact Information

Cook County Department of Corrections
2700 South California Avenue
Chicago, IL 60608
Phone: (773) 869-7100
Email: corrections@cookcountysheriff.org
Web site: www.cookcountysheriff.org

STATE: **Illinois**

AGENCY/ORGANIZATION:

Cook County Adult Probation Department

PROGRAM TITLE:

Mental Health Unit

POLICY STATEMENT(S):

SentencingYEAR ESTABLISHED: **1988**

Overview

The Mental Health Unit provides intensive supervision to probationers with serious mental illnesses and/or developmental disabilities. The unit, which is Medicaid certified, is funded by the Illinois Department of Mental Health and Developmental Disabilities.

Description

To be eligible for supervision in the mental health unit, probationers must have a diagnosis of mental illness and/or mental retardation. Pedophiles and those who have been found unfit to stand trial are not eligible for the program. Probationers are mandated to receive mental health services ranging from outpatient counseling to psychiatric hospitalization and nearly all are on psychotropic medication. The most common diagnoses are Axis I psychotic disorders (e.g., schizophrenia, severe mood disorders, and bipolar disorder).

Staff in the unit have mental health–related experience and training. Officers supervise reduced caseloads of approximately 50 probationers and work closely with treatment providers and a contracted clinical consultant to ensure comprehensive case management. Officers perform a number of duties including: conducting clinical assessments; making referrals; completing detailed supervision plans; monitoring compliance with probation conditions, medication requirements, and other treatment objectives; helping probationers to obtain disability benefits, Supplemental Security Income, and medical cards; and serving as advocates for probationers in their effort to obtain mental health services.

Contact standards are dictated by the three phases. Each phase lasts a minimum of three months. Prior to advancing to a less restrictive phase, probationers must meet strict criteria. Probationers may be returned to a previous phase if compliance problems arise. Upon successful completion of all three phases, cases may be transferred to standard probation supervision if the following criteria have been met:

- all needs have been adequately addressed by appropriate referrals;
- there have been no violations of probation or involuntary hospitalizations during any of the probation sentence;

Cook County Adult Probation Department
continued

- there have been no inpatient treatment or hospitalizations in the past eight months; and
- all special conditions ordered by the court have been met

Contact Information

Adult Probation Department
Cook County Administration Building
69 West Washington Street, Suite 2000
Chicago, IL 60602
Phone: (312) 603-0240
Web site: www.cookcountycourt.org/services/programs/adult-probation/probation.html#8

STATE: **Illinois**

AGENCY/ORGANIZATION:

Thresholds Psychiatric Rehabilitation Centers

PROGRAM TITLE:

Thresholds Jail Program

POLICY STATEMENT(S):

Intake at County / Municipal Detention Facility

YEAR ESTABLISHED: **1997**

Overview

The Thresholds Psychiatric Rehabilitation Centers Jail Program helps offenders with mental illness in the Cook County Jail transition from jail to the community and provides them with a broad array of support services to ensure their successful reintegration.

Description

Most Thresholds members (as the program's clients are called) have a history of state inpatient psychiatric hospitalization and incarceration—the average member has been hospitalized 112 times and arrested 35 times.

Thresholds relies on the Bridge Model of assertive community treatment, which uses an intensive team approach to provide long-term, comprehensive, and integrated services. The Thresholds Program marks the first time that the Bridge Model has been specifically applied to the jail population. Thresholds staff forge relationships with clients while they are still in jail, sometimes even securing early release into Thresholds custody. Once released from the jail, the members are expected to adhere to treatment regimens, to work with a psychiatrist, and to nominate Thresholds as a payee. Thresholds provides services for substance abuse, vocational training, education, and peer supports. Thresholds has developed relationships with housing providers and the police department to ensure community support and to enlist assistance in monitoring program members. Thresholds provides 24-hour services; if a member is missing, Thresholds staff will go into the streets to locate the member. Thresholds staff do not carry individual caseloads; instead, a multidisciplinary team shares responsibility for each member, with a psychiatrist overseeing the treatment program. Unlike many programs that provide services for a limited time, Thresholds provides services as long as the member needs them.

Thresholds has compiled impressive outcome data concerning the success of its program. Thresholds has recently completed a study comparing data for thirty program participants who have completed one-year of Thresholds service with data from the one year prior to their involvement with the program. Prior to becoming involved in Thresholds these individuals had spent a combined 2,741 days in jail; during one year in Thresholds they spent a total of 489 days in jail, a reduction of

Thresholds Psychiatric Rehabilitation Centers
continued

82 percent. Similarly, in the year prior to being involved in Thresholds the group had been arrested a total of 101 times, while during their year at Thresholds they were arrested 49 times for a reduction of 51 percent. The group experienced a similar reduction in hospital days (85 percent) and total hospitalizations (82 percent). The Thresholds program costs approximately \$26 per day per member, whereas jails cost approximately \$70 per day and hospitals cost \$500 per day. According to these per diem rates, the Thresholds program saved \$157,000 in jail costs and \$917,000 in hospitalization costs in the one year studied. In addition, Thresholds received the American Psychiatric Association's prestigious Gold Achievement Award in 2001, that organization's highest honor.

Contact Information

Thresholds Psychiatric Rehabilitation Centers Jail Program
4101 North Ravenswood Avenue
Chicago, IL 60613
Phone: 1-888-99 REHAB
Email: thresholds@thresholds.org
Web site: www.thresholds.org

STATE: **Iowa**

AGENCY/ORGANIZATION:

Community Corrections Improvement Association (of Iowa)

PROGRAM TITLE:

Commission on the Status of Mental Health of Iowa's Corrections Population

POLICY STATEMENT(S):

Educating the Community and Building Community Awareness

YEAR ESTABLISHED: **2001**

Overview

In November 2001, the Community Corrections Improvement Association (CCIA) and the Commission on the Status of Mental Health of Iowa's Corrections Population held eight public hearings intended to bring the issue of mental health in prisons to the attention of corrections professionals, mental health professionals, policymakers, and citizens.

Brief Description

The concept behind the public hearings was to impress upon the public that mental health is a local concern. The forums sought to accomplish this by both educating those who attended and gauging feelings about how Iowa is currently handling the issue of mental health. Part of the strategy included attracting media attention in statewide newspapers.

The 240 participants in the hearings each completed a questionnaire that was then analyzed by the State Public Policy Group (SPPG). The survey sought to assess varying groups' perceptions of how the state was addressing the mental health issues within corrections treatment programs.

In the surveys, 80.8 percent of those polled said that access to mental health and substance abuse treatment services was an urgent matter in the state of Iowa. Additionally, reports concluded that there is poor communication between mental health providers and corrections staff. When asked how to address this issue, respondents showed strong support for a "no closed doors" program, which would make it a uniform protocol in all parts of the community. In this system, agencies from the police department to the department of human services immediately refer people with mental illness to a mental health provider. The commission will publicize the findings by developing a video based upon clips from the public hearings and interviews with incarcerated persons who suffer from mental illness. The follow up is a conference in the spring of 2002 intended to draw attention to not just the problem but possible solutions, including ideas that have worked in other states.

Community Corrections Improvement Association (of Iowa)
continued

Iowa is experiencing budget cuts and system restructuring. The public hearings are an effort to hedge against this problem by raising public awareness.

Contact Information

Community Corrections Improvement Association
200 10th St., 5th Floor
Des Moines, IA 50309
Phone: (515) 243-2000

STATE: **Kentucky**

AGENCY/ORGANIZATION:

Louisville-Jefferson County Crime Commission

PROGRAM TITLE:

Mental Health Diversion Program

POLICY STATEMENT(S):

Prosecutorial Review of Charges

YEAR ESTABLISHED: **1992**

Overview

The Mental Health Diversion Program identifies nonviolent felony and misdemeanor defendants with serious mental illness and works with the court system to provide incentives for involvement with community-based treatment in lieu of incarceration. Following completion of the diversion program, charges against the participant are dismissed.

Description

The Louisville-Jefferson County Crime Commission developed the Mental Health Diversion Review Board and is responsible for determining appropriate admissions to the diversion program, approving individual treatment plans, and overseeing the jail diversion program in general. The Review Board consists of seven volunteer members including a psychiatrist, psychologist, registered nurse, clinical social worker, attorney, veteran member of probation/parole or other law enforcement, and a mental health advocate.

The jail diversion program employs, in addition to the review board, a court liaison, three Community Treatment Alternatives Program case managers, and mental health workers at the jail to refer individuals for jail diversion and coordinate community treatment upon entry to the program. Treatment consists of a six-month to one-year intensive portion, and two years, court-ordered treatment for misdemeanor offenders and five years, court-ordered treatment for felony offenders. During the intensive portion, participants attend weekly meetings with the community mental health facility, group therapy (including dual diagnosis group therapy, if appropriate), and a weekly legal issues group meeting.

Upon admission to the program, the defendant's court case is suspended for a period of six months to a year. Following successful completion of the intensive portion of the court order and dismissal of charge, the participant is obligated to remain in treatment under the terms of the original court order (two to five years). The State of Kentucky Criminal Justice Council and the Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnosis, are also currently establishing a joint subcommittee to address cross-systems issues at the state level.

Louisville-Jefferson County Crime Commission
continued

According to the executive director, the Mental Health Diversion Program has been successful in meeting its goals. In addition to the treatment, support, and rehabilitation services provided through the program, the program has helped reduce total jail days for program participants and in the process saved the county money.

Challenges/Areas for Improvement

Although from time to time there is difficulty maintaining a full review board, board members feel the program is reaching individuals in need of diversion services and treatment. One consistent problem, however, is a limited amount of money for additional services needed to treat this population effectively.

Contact Information

Louisville-Jefferson County Crime Commission
231 S. Fifth Street, Suite 300
Louisville, KY 40202
Phone: (502) 574-5088

STATE: **Maryland**

AGENCY/ORGANIZATION:

Anne Arundel County Police Department

PROGRAM TITLE:

Mobile Crisis Team

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene Response

YEAR ESTABLISHED: **1999**

Overview

The Anne Arundel County Mobile Crisis Team (MCT) comprises licensed mental health professionals—psychiatric social workers—to provide on-scene response to 911 calls at the request of the first responding officer.

Description

Anne Arundel County uses a Mobile Crisis Team modeled after a program implemented in Berkeley, California. The program is funded through grants from the federal government. The program was developed after representatives of law enforcement and the mental health representatives met and determined that the mental health professionals were better equipped than police to respond to the needs of people with mental illness. As a result, the county decided to expand funding for its crisis intervention teams. The specific plan was designed with the assistance of a focus group of officers and mental health professionals.

When the MCT responds to a call, the social worker helps the officer determine whether someone is a danger to themselves or others, assesses the need for intervention, and, if appropriate, assists the individual obtain access to mental health services. The team also coordinates follow-up to consumer cases and shares only essential, nonprivate information with the police after the initial call for service. A lieutenant on the police department serves as a liaison to the head of the county mental health agency.

The Mobile Crisis Team prompted the creation of a walk-in clinic, which serves as the base for the MCT, maintains a countywide bed registry, and provides counseling. An outreach team was also formed to provide community intervention and mental health services to people who are homeless.

Challenges/Areas for Improvement

The MCT on-scene response is available until late at night on the weekdays and weekends. Anne Arundel County would like to expand this service to make it available 24 hours a day, 7-days-a-week.

Contact Information

Commander of Management and Planning
Anne Arundel County Police Department
8495 Veterans Highway
Millersville, MD 21108
Phone: (410) 222-8651
Fax: (410) 222-8626

STATE: **Maryland**

AGENCY/ORGANIZATION:

Baltimore Crisis Response, Inc. (BCRI)

PROGRAM TITLE:

Mental health crisis beds

POLICY STATEMENT(S):

On-Scene Response

YEAR ESTABLISHED: **1992**

Overview

Baltimore Crisis Response, Inc. (BCRI) offers a variety of services for individuals experiencing a mental health crisis in Baltimore City. These services include an information hotline, a mobile crisis team, and residential crisis beds.

Description

BCRI is the result of collaboration among several local mental health agencies in an effort to better serve individuals in Baltimore City who are experiencing a mental health crisis. BCRI accepts referrals from any source, including the police, mental health agencies, members of the community, and professionals. BCRI works closely with the Baltimore City Police Department, providing a location to which police can refer individuals who do not fit the criteria for involuntary commitment and have not committed a crime that warrants arrest.

BCRI also has a mobile crisis team that can respond to situations in homes, shelters, or other community locations. When police respond to a call that involves a person with mental illness who is in crisis, BCRI provides an important resource—a location where the police can take the individual and be assured that he or she will be safe, housed, and provided with links to needed services. The ratio of BCRI mental health crisis bed case managers to clients is approximately 1:4, ensuring that BCRI staff will be able to provide needed attention to individuals in crisis.

Contact Information

Baltimore Crisis Response, Inc.
1105 Light Street, Second Floor
Baltimore, MD 21230
Phone: (410) 752-2272

STATE: **Maryland**

AGENCY/ORGANIZATION:

Department of Health and Mental Hygiene

PROGRAM TITLE:

Mental Hygiene Administration, Core Services Agencies (CSA's)

POLICY STATEMENT(S):

Access to Effective Mental Health Services

YEAR ESTABLISHED: **2002**

Overview

In Maryland, mental health and substance abuse services are organized through local “core service agencies,” positioned throughout the state. The core service agencies are responsible for maintaining relationships with local community providers, staying abreast of treatment needs, and communicating with the state mental health administration regarding the status of mental health and substance abuse treatment in their respective communities.

Description

The Core Service Agencies (CSA's) are the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level. CSA's exist under the authority of the secretary of the Department of Health and Mental Hygiene and also are agents of the county government, which approve their organizational structure.

The functions of core service agencies are to plan, develop, and manage a full range of treatment and rehabilitation services for persons with serious mental illness in their jurisdiction. Organizationally, the CSA can exist in a number of forms: as a unit of county government (e.g., health department), as a quasi-public authority, or as a private, nonprofit corporation. The CSA is an agent of county government; accordingly, the county determines the organizational structure of the CSA, which must be governmental or not-for-profit in nature.

The CSA must be able to link with other human service agencies to promote comprehensive services for individuals in MHA's priority population who have multiple human needs.

Contact Information

Maryland Department of Health and Mental Hygiene
Mental Hygiene Administration
Spring Grove Hospital Center
55 Wade Avenue
Dix Building
Catonsville, MD 21228
Phone: (410) 402-8300
Fax: (410) 402-8301
Web site: www.dhmh.state.md.us/mha/

STATE: **Maryland**

AGENCY/ORGANIZATION:

Montgomery County Department of Correction and Rehabilitation

PROGRAM TITLE:

Information-sharing with mental health providers

POLICY STATEMENT(S):

Incarceration at County / Municipal Detention FacilityYEAR ESTABLISHED: **2002**

Overview

The county detention center in Montgomery County ensures that local mental health providers are notified when their clients are incarcerated.

Description

The county detention center each day posts the names of detainees who have entered the facility in the previous 24 hours, makes this list available to local mental health providers. Providers recognizing names of current or past clients on the detention center list may then, without breaching confidentiality, contact mental health staff at the detention center with information, including diagnosis and medication, that might help the detention center provide appropriate services or make decisions regarding placement or diversion.

Contact Information

Montgomery County Department of Correction and Rehabilitation
51 Monroe Street
Rockville, MD 20850
Phone: (240) 777-9975
Web site: www.co.mo.md.us/services/docr/

STATE: **Maryland**

AGENCY/ORGANIZATION:

Montgomery County Department of Correction and Rehabilitation

PROGRAM TITLE:

Suicide Screening Initiative

POLICY STATEMENT(S):

Intake at County / Municipal Detention FacilityYEAR ESTABLISHED: **N/A**

Overview

In Montgomery County, staff use the same set of seven questions to screen inmates for suicide risk at three points of intake: at central processing, upon institutional intake, and as part of medical screening.

Description

The Suicide Screening Initiative is designed to maximize the likelihood of identifying inmates who are at risk of committing suicide. When an inmate is first processed through the Central Processing Unit, an officer completes the Suicide Screening Form, consisting of seven items relating to current suicidal ideation and past history of suicidal/self-destructive behavior. There are specific questions regarding mental health history and current psychiatric treatment (e.g., psychotropic intervention).

Inmates are then processed through intake, where the same form is completed a second time. The process is intentionally redundant and allows for the inmate to answer the same questions asked by different staff members. Third, inmates are screened at medical intake where nursing staff use the same Suicide Screening form. The document, initiated at Central Processing, follows the inmate throughout this process. If an inmate answers affirmatively to any of the questions at any point along this three-part process, a referral is generated to mental health services, at which point mental health staff conduct an assessment to determine the suicide risk of the detainee.

Procedures for accountability are in place to ensure that the form is completed correctly and that all inmates requiring an assessment are seen by mental health staff. Inmates who have a history of self-destructive behavior are put on a list and their institutional and medical records are placed in a special file. Facility staff monitor these inmates closely.

Contact Information

Montgomery County Department of Correction and Rehabilitation
51 Monroe Street
Rockville, MD 20850
Phone: (240) 777-9975
Web site: www.co.mo.md.us/services/docr/

STATE: **Maryland**

AGENCY/ORGANIZATION:

Montgomery County Police Department

PROGRAM TITLE:

Crisis Intervention Training

POLICY STATEMENT(S):

Training for Law Enforcement Personnel

YEAR ESTABLISHED: **N/A**

Overview

The Montgomery County Police Department provides a 40-hour certification course for Crisis Intervention Team officers regarding the proper response to individuals with mental illness. The course is also available to deputy sheriffs, corrections officers, non-sworn law enforcement personnel, fire rescue personnel, and mental health professionals.

Description

The Montgomery County Police Department covers a variety of topics in its CIT training course, including (but not limited to):

- Suicide prevention
- Methods of approach
- Interviewing techniques
- Co-occurring disorders
- Understanding and Assessing Mental Illness
- De-escalation techniques
- Psychotropic medications
- Post Traumatic Stress Disorder (PTSD)

The department uses a variety of training techniques in the course, including cassette tapes that simulate the experience of a person with mental illness who hears voices. Designed by someone who suffered from a psychiatric disability, the cassette tape series “Hearing Distressing Voices” simulates the experience of someone who hears voices. The program was developed in association with the Massachusetts based National Empowerment Center ([www. Power2u.org](http://www.Power2u.org)).

The curriculum calls for the participants to wear headphones that emit disturbing shuffling sounds, derogatory comments, and in some cases, racial slurs and profanity. The intent is to help trainees to understand the difficulties that people who hear voices experience. While listening to the tapes, participants are asked to complete forms or answer questions—tasks that inmates with mental illness must perform.

In addition, the department holds a portion of its training program in the physical space of a public mental health facility to familiarize officers with people with mental illnesses.

Montgomery County Police Department

continued

Contact Information

CIT Coordinator

Montgomery County Department of Police

Strategic Planning Division

2350 Research Blvd.

Rockville, MD 20850

Phone: (240) 773-5057

Fax: (240) 773-5007

Web site: [www: www.co.mo.md.us/services/police/](http://www.co.mo.md.us/services/police/)

STATE: **Maryland**

AGENCY/ORGANIZATION:

Mental Hygiene Administration, Division of Special Populations

PROGRAM TITLE:

Maryland Community Criminal Justice Treatment Program

POLICY STATEMENT(S):

Intake at County / Municipal Detention Facility

YEAR ESTABLISHED: **1994**

Overview

The Maryland Community Criminal Justice Treatment Program (MCCJTP) is a multiagency collaborative that provides shelter and treatment services to offenders with mental illness in their communities. Created to serve jail inmates with mental illness, the program now also targets individuals on probation and parole.

Description

The MCCJTP now operates in 18 of Maryland's 24 local jurisdictions. The program is overseen by local advisory boards comprised of state and local leaders and provides a wide range of services, including case management, screening, counseling, discharge planning, and community follow-up. The program also provides training for criminal justice and treatment professionals, both within Maryland and from outside the state. Researchers identified four of the key components of the program:

- strong collaboration between state and local providers;
- transitional case management services;
- long-term housing support; and
- a focus on co-occurring disorders.

Program participants are identified through a classification process at the local detention center, or through parole/probation. They are then referred to the local program director for assessment and eligibility and assigned to a case manager. A psychiatrist sees the patient to determine his or her mental illness or dual diagnosis needs, and to determine treatment possibilities. The case manager considers the client's needs and develops a service plan approved by the client, and then contacts relevant agencies, courts, families, etc. The plan is then presented to the court, and upon approval, the client is released and followed by the case manager into the community.

It is the job of the case manager to assure coordination with necessary providers. Case management services include crisis intervention, screening, counseling, discharge planning, and community follow-up. The program also provides routine training for criminal justice and treatment professionals. The MCCJTP is especially attentive to the housing needs of its clients; case man-

Mental Hygiene Administration, Division of Special Populations
continued

agers help clients become eligible for the U.S. Department of Housing and Urban Development Shelter Care Plus funds, which are supplemented by local matching funds. Case managers work with clients to find permanent housing options and to integrate supportive services into the housing arrangement.

From October 1, 1994, to September 30, 1995, the program served a total of 503 clients in eight jurisdictions. Of this number, 5 percent returned to state psychiatric hospitals, 20 percent returned to detention centers, and 5 percent returned to homelessness. Data from the first quarter of 1996 reflect a significant reduction in recidivism: the program served 241 clients, of which 1 percent returned to psychiatric hospitals, 7.4 percent returned to detention centers, and 2.4 percent returned to homelessness. The MCCJTP is discussed in-depth in a National Institute of Justice "Program Focus" piece entitled *Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program*.

Contact Information

Division of Specific Populations
Mental Hygiene Administration
201 West Preston Street
Baltimore, MD 21201
Phone: (410) 767-6603
Fax: (410) 333-5402

STATE: **Maryland**

AGENCY/ORGANIZATION:

**Maryland Mental Hygiene Administration
Division of Special Populations; Calvert,
Dorchester, and Frederick Counties.**

PROGRAM TITLE:

The TAMAR Project

POLICY STATEMENT(S):

**Development of Treatment Plans, Assignment
to Programs, and Classification/Housing
Decisions**

YEAR ESTABLISHED: **1998**

Overview

The TAMAR (Trauma, Addiction, Mental Health, and Recovery) project provides integrated, trauma-oriented services for women with mental illness and co-occurring substance abuse disorders in the correctional system.

Description

The TAMAR Project's goal is to provide integrated services for women held in local jails who have interrelated trauma, victimization, substance abuse, and mental illness issues. Meeting in groups, the women are encouraged to share their stories with one another and to engage in therapeutic activities such as art therapy and journal writing. Upon release, women in TAMAR are able to meet in continuing support groups.

A specialized Clinical Trauma Specialist works within the county detention centers and the community to develop an integrated network of childhood trauma-informed mental health and substance abuse treatment and social support services for program participants. In addition to establishing a new psycho-educational group intervention for women in the detention centers, the Clinical Trauma Specialists and project staff on the assessment and management of childhood violent victimization and to develop a 'one-stop-shop' model of service delivery for these women when they are released into the community

The TAMAR project was developed with a grant from the Substance Abuse Mental Health Services Administration (SAMHSA). The program development phase of the project began in October 1998. The TAMAR Project is part of a broader study being coordinated by the Center for Mental Health Services and the Center for Substance Abuse Prevention, both divisions of SAMHSA.

Contact Information

Division of Specific Populations
Mental Hygiene Administration
201 West Preston Street
Baltimore, MD 21201
Phone: (410) 767-6603
Fax: (410) 333-5402

STATE: **Massachusetts**

AGENCY/ORGANIZATION:

**Committee for Public Counsel Services, Mental
Health Litigation Unit (MHLU)**

PROGRAM TITLE:

Certification Training Program

POLICY STATEMENT(S):

Training for Court Personnel

YEAR ESTABLISHED: **1991**

Overview

The Mental Health Litigation Unit provides training for defense attorneys in Massachusetts who wish to be certified to accept assignments in mental health proceedings (e.g., civil commitment, outpatient commitment, and "extraordinary treatment" cases). The MHLU also provides training concerning the representation of defendants with mental illness in criminal cases.

Description

The primary mandate of the Mental Health Litigation Unit (MHLU) of the Committee for Public Counsel Services is to "provide trial and appellate representation to indigent persons against whom are filed petitions seeking (a) commitment to public or private psychiatric facilities (b) judicial authorization to administer or terminate certain types of treatment (e.g., antipsychotic medication, aversive behavior modification, life-support mechanisms) or (c) day-to-life commitment as a "sexually dangerous person." Typically, representation is provided by private attorneys certified by the MHLU to accept such assignments."

Attorneys who wish to be certified to accept assignments in mental health proceedings must apply for the program and, if accepted, complete a two-part training. The training covers both aspects of mental health law and diagnoses and treatment of mental illnesses. Attorneys who are certified must attend at least eight hours each fiscal year of approved continuing legal education programs to maintain their certification.

The base text for MHLU training on mental health proceedings is *Mental Health Proceedings in Massachusetts: A Manual for Defense Counsel*, by Stan Goldman, director of the MHLU. The text covers in-depth various aspects of mental health law including voluntary admission, involuntary admission, the commitment process, competency determination, and other topics. The focus of this portion of the training is on litigation strategy and technique. In addition, attorneys who wish to represent defendants in mental health proceedings must attend trainings on clinical aspects of mental illness and treatment. This training is provided by psychiatric professionals in conjunction with legal professionals.

**Committee for Public Counsel Services, Mental Health
Litigation Unit (MHLU)**
continued

There are currently approximately 650 private attorneys in Massachusetts certified to accept assignments in cases involving mental health issues.

Challenges/Areas for Improvement

Due to budgetary constraints, the MHLU has had difficulty monitoring attorney compliance with MHLU performance standards (available at: www.state.ma.us/cpcs/mhp/MHPSTDS.htm#performance%20stds). At times, the MHLU has been able to use student/interns to provide such monitoring, after extensive training.

Contact Information

Committee for Public Counsel Services
Mental Health Litigation Unit
44 Bromfield Street, Boston, MA 02108
Phone: (617) 482-6212
Fax: (617) 988-8489
Web site: www.state.ma.us/cpcs/mhp/index.htm

STATE: **Massachusetts**

AGENCY/ORGANIZATION:

**Department of Mental Health, Forensic
Division**

PROGRAM TITLE:

Forensic Transition Team (FTT) Program

POLICY STATEMENT(S):

**Release Decision, Maintaining Contact between
Individual and Mental Health System**

YEAR ESTABLISHED: **1998**

Overview

The Forensic Transition Team program provides comprehensive transition planning services to juvenile and adult offenders with mental illness incarcerated in state correctional institutions and county facilities that are eligible for parole. The FTT also works with individuals in the pretrial stage, those who have completed their sentence, and those who are released under public safety supervision. An inmate's diagnosis or criminal history will not disqualify him or her from participating in the program.

Description

The Forensic Transition Teams (FTT) are the primary mechanism through which the Department of Mental Health, Department of Corrections, Department of Youth Services, and parole and probation agencies seek to implement the goals established in a 1998 Memorandum of Understanding (MOU). Signed in 1998, the MOU established a collaborative effort to improve services to offenders with severe mental illness. As part of the MOU,

The parole board agreed to:

- Identify and refer inmates with mental illness who have upcoming parole hearings and collaborate with DOC and DMH in developing a discharge plan for the inmates.

DOC agreed to

- Identify and refer inmates who are potentially eligible for continuing care services, obtain releases allowing for specified information to be shared between the clinician, the Parole Board and the DMH.
- Work with the DMH Forensic Transition Team (FTT) Coordinator and/ or DMH case manager at the inmate's institution, and collaborate on development of a service plan for potential parolees, especially by facilitating the entry of the FTT Coordinator or DMH Case Manager into an inmate's facility.

And the DMH agreed to:

- Assess individuals for potential continuing care eligibility who are referred by DOC clinical staff or DOC

- mental health service provider, arrange for the provision of community mental health services, including case management services, and, with the client's signed consent, communicate with assigned parole officers on information regarding attendance and progress in treatment.
- Provide mental health evaluations and consultation regarding potential continuing care parolees upon referral by the Parole Board and to provide technical support to clinical staff employed through the contract between DOC and their health service provider, who are filing applications for continuing care and facilitate communication between DMH/ vended staff and DOC/ vended staff.
 - Maintain a database on the target population and provide consistent feedback on effectiveness of release planning efforts for this population.

To be eligible for work with an FTT, inmates must fit certain clinical criteria (e.g., diagnosis, functional impairment, and duration of illness), need DMH services, and be without other means to access those services.

FTT staff meet with eligible inmates to determine the offender's needs upon release and the potential risks to public safety. The FTT works with criminal justice officials as well as local mental health and other service providers to determine what services will be offered. After release, the FTT monitors the client's adjustment during a three-month transition period. FTT supports client reentry by helping them maintain contact with service providers and adhering to the conditions of their release. Within three months of the offender's release FTT staff transition out of the case.

The Department of Mental Health has developed a database on offenders with mental illness to track the success of the initiative. From April 1998 to September 2001, 63 percent of releasees had remained engaged in mental health services at the end of the three-month transition period. Only 4 percent had been reincarcerated and the same percentage had required acute hospitalization.

Contact Information

Massachusetts Department of Mental Health
Forensic Division
Central Office
25 Stanford Street
Boston, MA 02114
Phone: (617) 626-8000
Web site: www.state.ma.us/dmh

STATE: **Massachusetts**

AGENCY/ORGANIZATION:

Department of Mental Health, Department of Corrections, and the Massachusetts Parole Board

PROGRAM TITLE:

Cross Training

POLICY STATEMENT(S):

Training for Corrections Personnel

YEAR ESTABLISHED: **1998**

Overview

As part of a Memorandum of Understanding signed in 1998 (see previous example), the Department of Mental Health (DMH) has organized cross-trainings for parole board members and senior parole officers and administrators. The DMH trains the members of the parole board on basic mental health issues. A separate training for parole administrators focuses on improved release planning for parolees with mental illness.

Description

The 1998 Memorandum of Understanding identified education and training as crucial to realizing the goal of improved services to incarcerated individuals with mental illness. The cross-training both covers basic mental health issues and helps staff from all agencies to understand the new policies and procedures developed as part of the broad agreement. Specifically, the Department of Mental Health educates the parole board and parole administrators about the Forensic Transition Teams—a collaborative program to identify inmates with severe and persistent mental illness, improve discharge planning, and ensure continuity of care for parolees.

Challenges/Areas for Improvement

The DMH hopes to extend its cross-training efforts to the various regional parole offices. These trainings would bring representatives together from hospitals, community mental health providers, and parole offices. The goal would be to improve the cross-system knowledge among these groups and ultimately to facilitate collaboration between the different agencies at the regional level.

Contact Information

Massachusetts Department of Mental Health
Forensic Division
Central Office
25 Staniford Street
Boston, MA 02114
Phone: (617) 626-8000
Web site: www.state.ma.us/dmh

STATE: **Massachusetts**

AGENCY/ORGANIZATION:

Harbor Inn Residential Facility (Boston)

PROGRAM TITLE:

Peer education

POLICY STATEMENT(S):

Consumer and Family Member Involvement

YEAR ESTABLISHED: **N/A**

Overview

In Boston, peer educators visit Harbor Inn weekly, a residential facility on Long Island in Boston Harbor. The peer educators meet with residents who are in transition from hospitals to community settings.

Description

Many residents of the Harbor Inn facility have histories of involvement with the criminal justice system. Educators, who themselves are in treatment for mental illness, show videotapes or share written materials that promote group discussion of issues such as housing, basic living skills, and tobacco use that are relevant to the lives of those in the residence.

Challenges/Areas for Improvement

Many of the residents have difficulty finding training or services in their own communities and remain at Harbor Inn for a longer term than was originally intended.

Contact Information

Harbor Inn Residential Facility
P.O. Box 690527
Quincy, MA 02269
Phone: (617) 472-7367

STATE: **Massachusetts**

AGENCY/ORGANIZATION:

Hampshire County Jail and House of Correction

PROGRAM TITLE:

Case Management

POLICY STATEMENT(S):

Intake at County/Municipal Detention Facility

YEAR ESTABLISHED: **Mid 1970s**

Overview

The Hampshire County Jail goes to unusual lengths to connect inmates released from the jail (including those with mental illness) to community-based services.

Description

Case managers, who typically carry a caseload of 30 inmates, meet with inmates within the first 72 hours following their intake. If initial screenings uncover a history of mental health problems or suicide, the inmate is referred immediately for a more in-depth assessment. Case management proceeds throughout an inmate's incarceration; case managers are responsible for making appropriate referrals for treatment and for discharge planning.

Staff identify inmates who have received mental health services in the community from a provider contracting with the state Department of Mental Health. In these cases, they assign a post-release mental health case manager to the inmate before he or she is released. This improves the likelihood that the inmate will be connected immediately to case management services upon his or her return to the community.

Contact Information

Hampshire County Jail and House of Correction
P.O. Box 7000
Northampton, MA 01061-7000
Phone: (413) 584-5911
Fax: (413) 584-2695

STATE: **Missouri**

AGENCY/ORGANIZATION:

Lee's Summit Police Department

PROGRAM TITLE:

Crisis Intervention Team (CIT)

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene Response

YEAR ESTABLISHED: **2000**

Lee's Summit Police Department
continued

Contact Information

Lee's Summit Police Department

10 NE Tudor Rd.

Lee's Summit, MO 64086

Phone: (816) 969-7388

Fax: (816) 969-7746

Overview

Lee's Summit Police Department has established a Crisis Intervention Team (CIT) to improve police officers' response to people with mental illness. The Police Department also has promoted collaboration among various leaders in the community and the mental health system.

Description

The Lee's Summit Police Department serves a community of 70,000 people with approximately 104 sworn officers. The Crisis Intervention Team that the department has developed is similar to other CIT programs. It differs from other CIT programs, however, in that staff who receive CIT training and serve on the team include a broad range of personnel who interact with people with mental illness: school resource officers; traffic officers; detention officers; and DARE officers.

The Lee's Summit Police Department has implemented a 40-hour training curriculum and trained 22 officers to date. They also provide two eight-hour training courses: 1) introductory training for recruits; and 2) in-service training for patrol officers.

The Lee's Summit Police Department also coordinates with the local mobile crisis team, which CIT officers can contact for on-scene assistance.

The Lee's Summit Police Department actively campaigned to have the Crisis Intervention Team program implemented in the community, and have seized many opportunities to discuss the program with community organizations, the media, and the general public. The department also offers citizen ride-alongs to facilitate understanding between officers and citizens. As a result of these actions, many family members of people with mental illness report that their level of trust in the police department has increased.

The department also founded a coordinating council, which includes mental health care providers, consumers and other representatives from NAMI, local law enforcement, the Missouri Department of Mental Health, Western Missouri Mental Health staff, Truman Medical Center, Metro-area private mental health service providers, Jackson County Sheriff's Office, and Kansas City Police Department. The council meets monthly, provides guidance on training, and identifies people to write training curricula and teach courses.

STATE: **Nebraska**AGENCY/ORGANIZATION:
Lincoln Police DepartmentPROGRAM TITLE:
Emergency Protective Custody PolicyPOLICY STATEMENT(S):
On-Scene Assessment and On-Scene ResponseYEAR ESTABLISHED: **2000****Overview**

The Lincoln Police Department provides all patrol officers with mandatory recruit and in-service training regarding response to people with mental illness who appear dangerous to themselves or to others.

Description

There are approximately 200 patrol officers in the Lincoln Police Department. All of them receive mandatory recruit and in-service training concerning calls that involve the possibility of placing a person in emergency protective custody (EPC). In Nebraska, only peace officers (e.g., sheriffs, police, jailers) are allowed to place an individual in EPC. As a result, the police are notified when a service provider or family member feels a person with a mental illness is a danger to him or herself or others. If the officer suspects that the individual is dangerous, he or she will notify the Lancaster Mental Health center for an evaluation of the individual. The department has developed a partnership with the center for provision of these services.

The Lancaster Mental Health Center provides screening services 24 hours a day, 7 days a week for people referred by police officers. On-call staff may perform consumer assessment at the scene of the incident, the police station, or the center. After evaluation, if a person is determined to be potentially dangerous, he/she is taken to the County Crisis Center or Lincoln General Hospital. These services are entirely county-funded. The most likely outcome is that the person will be ordered to follow outpatient commitment.

The police department also participates in two interagency task forces: one involving adults with mental illness, and one that focuses on children/juveniles. During regular task force meetings, agency participants discuss specific cases and, if necessary, may share confidential information relevant to solving ongoing problems. These multi-agency meetings provide all involved parties with opportunities to share invaluable information and establish trust.

The Lancaster Mental Health Center is popular with officers from the Lincoln Police Department because of its effectiveness in engaging people with mental illness and in limiting their subsequent involvement with law enforcement

Lincoln Police Department
continued**Challenges/Areas for Improvement**

The police department would like to establish a liaison within the department to develop further relations between law enforcement and mental health service providers. This liaison would be on call 24 hours a day, 7 days a week.

Additionally, the task force is attempting to identify resources for a juvenile assessment center, because limited placements exist for juveniles who require mental health evaluations. The task force is also working with the local courts to clarify information-sharing boundaries and to prevent confidentiality violations.

Contact Information

Lincoln Police Department
575 South Tenth Street
Lincoln, NE 68508
Phone: (402) 441-7754

STATE: **Nevada**

AGENCY/ORGANIZATION:
The National Judicial College

PROGRAM TITLE:
Courses on Co-Occurring Disorders

POLICY STATEMENT(S):
Training for Court Personnel

YEAR ESTABLISHED: **N/A**

Overview

The National Judicial College provides a training course for judges regarding co-occurring mental health and substance abuse disorders.

Description

Founded in 1964, the National Judicial College has provided educational opportunities for 58,000 judges worldwide. Based on the premise that the public benefits from an informed judiciary, the college offers continuing education for judges in a range of topics. Affiliated with the University of Nevada, Reno, the National Judicial College offers a master's and Ph.D. program in judicial studies. Academic programs also include two-day to three-week residential sessions offered throughout the year as well as national conferences focused on contemporary issues such as prison overcrowding and the role of media in the courts.

The College recently began offering a course regarding co-occurring disorders, which educates judges who handle criminal cases involving defendants with mental illness who also have alcohol and drug addictions. Judges improve their ability to determine which approaches to treatment are likely to be effective given the defendant's situation, and they improve their understanding of how to monitor individuals with mental illness and history of drug abuse and their compliance with conditions of release. Methods used in the teaching include presentations, panels, videotape exercises, role play in the National Judicial College courtroom, and visits to 12-step meetings.

The College believes that the course will make the treatment options themselves more effective because judges will have a better idea of which option is right for each offender. The course focuses on showing judges how to evaluate the extent of an offender's substance abuse and mental health problem, as well as how to recognize the physiological and pharmacological aspects of substance abuse. The course also covers the correlation between addiction and mental illness.

Contact Information

The National Judicial College
Judicial College Building/358
University of Nevada, Reno
Reno, NV 89557
Phone: 800-JUDGE (800-255-8343) or (775) 784-6747
Fax: (775) 784-4234
Web site: www.judges.org

STATE: **New Jersey**

AGENCY/ORGANIZATION:
Division of Mental Health Services

PROGRAM TITLE:
Peer-counseling

POLICY STATEMENT(S):
Consumer and Family Member Involvement

YEAR ESTABLISHED: **2002**

Overview

The New Jersey Division of Mental Health Services, Department of Human Services, is seeking to facilitate employment of consumers as peer counselors in Assertive Community Treatment programs operated in many counties in the state.

Description

The division of mental health services is currently considering the adoption of a rule that includes specific provisions for peer counselors in Programs of Assertive Community Treatment (PACT). The proposed regulations will provide objective standards for the operation of PACT teams statewide as well as for the employment of peer specialists. At least one of the mental health specialists shall be a primary consumer. These specialists shall meet, at a minimum, one of the following requirements:

- Hold a bachelor's degree in a behavioral health science from an accredited institution and have two years, post bachelor's experience in the provision of mental health services; or
- A primary consumer who does not possess a bachelor's degree as required in this section for the mental health specialist position shall be regarded as a full, professional member of the clinical team, function under the same job description as other mental health specialists, and receive salary parity. The primary consumer may substitute demonstrated volunteer or paid experience working with individuals with serious and persistent mental illness in lieu of a bachelor's degree.

Decisions regarding disclosure to consumer recipients of PACT services, their families, and significant others that a staff person is himself/herself a consumer shall respect the individual preference of that staff person, be clinically driven, and be made in consultation with the PACT director/coach and the PACT team. Two or more individuals may share the mental health specialist position, in which, as defined in this section, a consumer is employed.

Division of Mental Health Services
continued

Challenges/Areas for Improvement

Medicaid reimbursement regulations are a barrier to the employment of peer counselors. The state Medicaid agency's willingness to defer to state mental health agency guidelines will make it possible for this plan to move forward.

Contact Information

New Jersey Division of Mental Health Services
50 East State Street
P.O. Box 727
Trenton, NJ 08625-0727
Phone: (800) 382-6717
Web site: www.state.nj.us/humanservices/dmhs/

STATE: **New Mexico**

AGENCY/ORGANIZATION:

Albuquerque Police Department

PROGRAM TITLE:

Crisis Intervention Team (CIT)

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene Response

YEAR ESTABLISHED: **1997**

Overview

The Albuquerque Police Department established a Crisis Intervention Team (CIT), which expands upon the model that the Memphis Police Department developed.

Description

After a consortium of mental health providers communicated the need for the Police Department to improve its response to people with mental illness, the Department established a CIT team. To participate in the program, all CIT officers are required to complete a 40-hour certification course, which is similar to the course that the Memphis Police Department developed. The training includes courses on officer safety, legal issues, psychopharmacology, and also includes role-play activities. The training discusses alternatives to the use of force and minimizing injuries to officers and citizens.

Officers are carefully selected through a screening process and are given incentive pay for their CIT participation. When calls involving people with mental illness come into dispatch, they are directed to CIT officers for response. As of 2001, of 425 patrol officers, 250 have been trained and 108 were active team members.

Albuquerque has expanded upon the basic Memphis CIT model by adding a detectives' bureau housed within the Special Investigations division. This bureau is assigned to follow up with CIT cases with a focus on prevention. There are four full-time detectives supervised by a sergeant to review CIT reports and identify people at high risk for contact with law enforcement and conduct follow-up. An example of a high-risk case would be a person who has repeated contacts with the police and has not received additional services. These detectives interact regularly with the mental health community to keep high-risk individuals from falling through the cracks. The goal is to reduce their contacts with police by connecting them with the appropriate services.

The mental health providers continue to interact with the assigned detectives to conduct follow-up with people determined to be at-risk. Outreach and education has also been conducted with mental health groups such as NAMI. Education has been provided so that family members are aware of the program and can ask for a CIT officer as needed.

Albuquerque Police Department
continued

Challenges/Areas for Improvement

In the future, the Albuquerque Police Department intends to provide crisis intervention training to its school resource officers (so that they may respond adequately to teens with mental illness), and also to improve data collection for program evaluation and development. In addition, the CIT plans to develop and implement an early warning system to provide preventive services to high-risk or potentially dangerous individuals.

Contact Information

Crisis Intervention Team Coordinator
Albuquerque Police Department
400 Roma NW
Albuquerque, NM 87102
Phone: (505) 875-3500

STATE: **New Mexico**

AGENCY/ORGANIZATION:

Bernalillo County Pretrial Services

PROGRAM TITLE:

Jail Diversion through Pretrial Services

POLICY STATEMENT(S):

Pretrial Release/Detention Hearing

YEAR ESTABLISHED: **1994**

Overview

The Pretrial Services Division works as part of a team with law enforcement, judges and mental health professionals to identify people with mental illness and/or developmental disabilities who may qualify for pretrial release.

Description

A small (three-person) pretrial services team ensures that all individuals with mental illness formally charged in Albuquerque are screened for conditional release. The team monitors the defendant's compliance with the conditions of release.

The program began in 1994, when the New Mexico Alliance for the Mentally Ill, in response to a court order and lawsuit, convened community groups to open channels of communication between criminal justice and mental health providers. A jail diversion project emerged, consisting of both prebooking (CIT-Memphis model) and post-booking (the Pretrial Services Division) diversion efforts.

Judges, attorneys, jail staff, mental health providers, family members, and police refer cases to the Pretrial Services Division. Pretrial Services Specialists provide a highly structured and concentrated form of supervision with stringent reporting requirements, taking into consideration the defendant's mental illness. Specialists regularly visit the defendant in the community and maintain contact with family members, case managers, and service providers.

Pretrial Service Specialists work closely with the local mental health center, where a Forensic Case Manager facilitates client treatment and acts as a liaison between treatment services and the criminal justice system. In addition, to facilitate and support the diversion effort, the adult probation department in Albuquerque has assigned two agents assigned to work specifically with persons with mental illness.

From September 1999 to September 2000, the number of clients served through the Pretrial Services Jail Diversion program totaled 110 persons, at least 61 percent of whom had been charged with misdemeanors. At least 68 percent of those who received community-based services had a dual diagnosis of mental illness and substance abuse.

Bernalillo County Pretrial Services

continued

According to an article that appeared in the *Albuquerque Journal* in 1999, in the first one and a half years of the Pretrial Services Jail Diversion program, about 40 cases a year were diverted. Of these, six have been rearrested for failing to meet their terms of release and none have been rearrested for a violent felony.

Challenges/Areas for Improvements Identified

The community is currently in the process of establishing a Mental Health Court (based on the Broward County model) and potentially starting a Homeless Court as well (based on the Homeless Court in San Diego). These efforts are intended to strengthen the continuum of care for people with mental health problems who are involved with or at risk of involvement with the criminal justice system.

Contact Information

Pretrial Services
Bernalillo County Metropolitan Court
401 Roma Avenue, NW
Albuquerque, NM 87102
Phone: (505) 841-8235

STATE: **New Mexico**

AGENCY/ORGANIZATION:

Forensic Intervention Consortium (Bernalillo County)

PROGRAM TITLE:

Forensic Intervention Consortium (FIC)

POLICY STATEMENT(S):

Determining Training Goals and ObjectivesYEAR ESTABLISHED: **1994****Overview**

Founded in 1994 with help from the National Alliance for the Mentally Ill, the Forensic Intervention Consortium focuses on establishing jail diversion programs that will work to identify persons with mental illness who are involved with or at risk of becoming involved with the criminal justice system. FIC works with both jails and the police to provide education on how to best manage offenders with mental illness.

Description

Since its inception, FIC has trained 120 officers of the Albuquerque Police Department, receiving support from the chief of police there. Training sessions are closed to the public and take place over a few days. Classes are kept small, with usually no more than 20 officers in attendance, and officers receive follow-up training. The cornerstone of FIC's project is the jail diversion program. Its most recent project is the development of mental health services within the New Bernalillo County Jail so that individuals with mental illness can immediately be screened and treated on site. In addition, FIC keeps a Forensic Pretrial Specialist at metro court to assist offenders with mental illness. The program receives funding from the New Mexico Department of Health and is supported by the University of New Mexico Mental Health Center.

Contact Information

Forensic Intervention Consortium
P.O. Box 143
Sandia Park, NM 87047
(505) 281-0911

STATE: **New York**

AGENCY/ORGANIZATION:

Center for Alternative Sentencing and Employment (CASES) (New York City)

PROGRAM TITLE:

The Nathaniel Project

POLICY STATEMENT(S):

Adjudication

YEAR ESTABLISHED: **1999**

Overview

The Nathaniel Project is a two-year alternative-to-incarceration program in New York City that includes intensive supervision and case management for felony offenders with serious mental illness.

Description

The Center for Alternative Sentencing and Employment Services is an independent nonprofit corporation in New York City, which provides services and supervision for almost 4,500 offenders a year. The Nathaniel Project offers comprehensive community-based case management services and intensive supervision and support. Staff assist participants in obtaining and engaging in treatment, supportive housing, and benefits—all crucial elements in establishing stability and avoiding criminal involvement. The project monitors participant progress and offers guidance and supportive counseling for a two-year period.

Referrals can be made by anyone, but typically come through court personnel. Candidates undergo a multi-step screening and risk-assessment process to assess their current situation, psychiatric and criminal history, and potential for success in the program. The Nathaniel Project will consider any prison-bound defendant who has been indicted on a felony charge, has a serious mental illness, and requires on-going psychiatric treatment and supportive services to function in the community.

Upon referral, Nathaniel staff conduct a psycho-social assessment of the individual as well as an evaluation of the circumstances in the pending criminal case. This allows staff to determine whether he or she meets the program's basic criteria: that he or she has a serious and persistent mental illness (including Mentally Ill Chemically Addicted) and is jail or prison-bound. The screening also determines whether the individual is stable enough to make use of program services and whether staff can develop a reasonable, individualized plan for consideration by the court and the District Attorney's Office.

When the judge approves the offender's participation in the program, project staff make arrangements for temporary or transitional housing prior to the inmate's release from custody; staff then meet with each client at the time of their release and escort them to their housing provider. During the first year of the pro-

Center for Alternative Sentencing and Employment (CASES) (New York City)

continued

gram participants receive intensive case management and supervision services.

During the first year, the case management focus is to help clients apply for and receive Medicaid and other public benefits, obtain stable housing or enter a residential treatment program, become engaged in community-based psychiatric treatment, and develop other community-based links that will help them achieve stability. In the first 90 days, when the risk of relapse is greatest, project staff directly administer treatment so that there is continuity during the transition to new housing and treatment providers. The project budget also includes a "subsistence" allowance for medication and basic needs such as food, clothing, and temporary housing, and for any gap in benefits.

Project staff meet regularly with the participant and various service providers to monitor progress, collect information for the court, intervene as an advocate for the participant with providers, assist providers in treatment planning and working with the participant. Above all, staff foster a close relationship with the participant to reinforce treatment compliance. This relationship is the critical element to compliance and helps participants achieve the goals and objectives outlined in their service plan contract. If the participant does not fulfill his or her program obligations, project staff will inform the court and/or probation promptly. Staff also escort clients to all court dates and present progress reports to the court as requested.

During the second year, case management shifts to a monthly monitoring and supervision model. Participants are expected to have a stable living situation, to be engaged in treatment, and to have developed a community-based support network. Frequency of contact is determined in coordination with other mental health treatment providers and by court requests for continued progress reports.

Contact Information

Center for Alternative Sentencing and Employment

The Nathaniel Project

346 Broadway

New York, NY 10013

Phone: (212) 732-0076

Fax: (212) 571-0292

Web site: www.cases.org

STATE: **New York**

AGENCY/ORGANIZATION:

Center for Alternative Sentencing and Employment Services (CASES) (New York City)

PROGRAM TITLE:

Parole Restoration Project (PRP)

POLICY STATEMENT(S):

Modification of Conditions of ParoleYEAR ESTABLISHED: **2001****Overview**

The Parole Restoration Project serves detained technical parole violators with special needs, including individuals with mental illness, substance abuse problems, women with dependent children, and young people (under 22 years old).

Description

The Parole Restoration Project was developed with funding from the New York State Department of Criminal Justice Services and the New York City Department of Corrections. Project staff identify parole violators with mental illness who are willing to volunteer in the program.

After identifying eligible violators, project staff assess their treatment needs, links them with community-based service providers, advocate for support of the treatment plan from parole field staff, and, when appropriate, recommend the restitution of parole.

When project staff are successful in securing a restitution of parole to the offender (in lieu of incarceration), the staff facilitate contact with providers and escort the offender to services. The project capitalizes on relationships with the Osborne Association/El Rio (outpatient drug treatment); the Women's Prison Association (residential and community supervision, family preservation); Friends of the Island Academy (crisis intervention and education); and the CASES Nathaniel Project to connect the parolee to services. PRP staff also monitor participant compliance through ongoing contact with community-based service providers, provides monthly reports to the Division of Criminal Justice Services, the Department of Correction and Division of Parole on participant progress, and notifies appropriate authorities in instances of noncompliance.

Contact Information

Center for Alternative Sentencing and Employment Services
The Parole Restoration Project
346 Broadway, Third Floor
New York, NY 10013
Phone: (212) 732-0076
Fax: (212) 571-0292
Web site: www.cases.org

STATE: **New York**

AGENCY/ORGANIZATION:

Commission of Correction and Office of Mental Health

PROGRAM TITLE:

Suicide Prevention Screening Guidelines Tool (SPSG)

POLICY STATEMENT(S):

Intake at County / Municipal Detention FacilityYEAR ESTABLISHED: **1984****Overview**

New York State has developed a Suicide Prevention Screening Guidelines Tool (SPSG) that is used in all local lockups, county jails, and state prisons throughout the state.

Description

The New York Commission of Correction and the Office of Mental Health developed SPSG, which has been validated through numerous research projects. The guidelines consist of a structured interview conducted during the booking process by booking officers and examines risk factors from past behavior, the inmate's current situation, and mental status. If there are indications that the inmate may be suicidal, the booking officer contacts the shift commander for immediate intervention, who arranges for increased supervision of the individual.

The New York State Local Correctional Suicide Prevention Crisis Service Program is a multifaceted program designed to facilitate the identification and treatment of prisoners who are suicidal and/or seriously mentally ill. This program has been specifically structured to establish administrative and direct service linkages among county jails, police lockups, and local mental health programs. It clearly defines the roles and responsibilities of mental health and local correction agencies in the identification and management of high-risk prisoners. The model also provides materials for training both officers and mental health service personnel.

The Crisis Service Program was designed in 1984 by the NYS Office of Mental Health, the NYS Commission of Correction, Ulster County Department of Mental Health, and a statewide task force. The task force included representatives from the following agencies: NYS Association of Chiefs of Police; NYS Sheriffs' Association; NYS Division of Criminal Justice Services; NYS Division of Alcoholism and Alcohol Abuse; NYS Office of Mental Retardation and Developmental Disabilities; NYS Division of Substance Abuse Services; and the Governor's Task Force on Alcoholism and Criminal Justice.

The Local Correctional Suicide Prevention Crisis Service Program contains the following six major components (descriptions of the components relate to the current curriculum and materials):

1. An **Eight-Hour Training Program** for jail and lockup officers in Suicide and Suicide Prevention is a training program provided prior to the implementation of the procedures. The key elements of this program are: a) trainer's manual, b) 50-minute video, and c) officer handbook.
2. A **Mental Health Resource Manual** can be used to familiarize local mental health personnel with mental health and operational issues relevant to police lockups and county jails. The major components of the manual are: a) an overview of the criminal justice system; b) suggestions regarding the best ways of providing mental health services with local correctional facilities; and c) a detailed explanation of New York State laws relative to the delivery of mental health services to jail and lockup inmates.
3. **Policy and Procedural Guidelines** for county jail, police lockup, and mental health agency personnel. The policies and procedures outline administrative and direct service actions that will enable staff to identify, manage, and serve inmates who have mental illness or are at a high risk for suicide.
4. **Suicide Prevention Intake Screening Guidelines** that can be administered during the intake process to facilitate identification of high-risk inmates. The guidelines are administered by jail and lockup officers prior to cell assignment. Administration time is approximately five minutes.
5. A **Four-Hour Refresher Training Program** for Jails and Lockup Officers training is designed as an in-service refresher course focusing on the essential aspects of identifying and managing suicide risk in jails and lockups as well as responding to the impact of a facility suicide on jail/lockup staff. It is based upon the basic eight-hour program and includes: 1) trainer's manual and 2) set of six videotapes.
6. **Criminal Justice System Training for Mental Health Services Providers** is a 14-hour training program designed to provide mental health staff and other service providers with basic knowledge of the criminal justice system, suicide prevention, New York State Mental Hygiene Law, and alternatives to incarceration. The training addresses many of the same

areas presented in the suicide prevention training for corrections and police officers and contains considerable New York State-specific information. The Manual of Criminal Justice Interventions for Mental Health Providers focuses on alternatives to incarceration for persons with mental illness and is a supplement to the 14-hour training program.

This program was designed for implementation based on adoption of all six interrelated program components. No individual component is intended to be freestanding.

Following the demonstration and refinement of the program, a statewide initiative was implemented to provide all New York State counties with training and technical assistance in implementing the program. This initiative was administered by the NYS Office of Mental Health, Bureau of Forensic Services, and the NYS Commission of Correction, Medical Review Bureau, in cooperation with the NYS Division of Criminal Justice Services, Office of Public Safety. All of the counties in New York State implemented the program.

Contact Information

NYS OMH Bureau of Forensic Services
Ulster County Department of Mental Health
239 Golden Hill Lane
Kingston, NY 12401
Phone: (845) 340-4168
Web site: www.omh.state.ny.us/omhweb/Suicide/suicide.htm

STATE: **New York**

AGENCY/ORGANIZATION:

Common Ground (New York City)

PROGRAM TITLE:

Common Ground

POLICY STATEMENT(S):

HousingYEAR ESTABLISHED: **1991****Overview**

Common Ground provides permanent housing for formerly homeless individuals. The program relies on a network of partners including the Center for Urban Community Services (CUCS) whose staff provides in house support services for the formerly homeless who live in Common Ground housing.

Description

Based upon a holistic model as a response to homelessness, Common Ground goes beyond just shelter for the homeless, providing a supportive and community setting within one of the buildings it owns. In order to create a sense of belonging, Common Ground offers facilities such as clinics, libraries, mental health services, computer centers, and art studios within each building where members of the program can become part of a community. The comprehensive support system helps homeless people regain a sense of stability and independence.

Funding for the program comes from a range of sources, including government and private grants, as well as rents and fees from property management.

Rent at the buildings is set at 30 percent of a tenant's salary. Supportive housing generally costs between \$10,000 and \$18,000 per year per tenant compared to \$25,000 for homeless shelters and \$160,000 for a psychiatric hospital. Common Ground maintains three buildings in Manhattan. Since 1991, 1,850 tenants have been housed.

Challenges/Areas for Improvement

Common Ground is currently looking for additional sites to provide supportive housing. The program is also trying to extend the number and involvement of corporate sponsors.

Contact Information

Common Ground Community
14 East 28th Street
New York, NY 10016
Phone: 212-471-0859
Fax: 212-471-0825
E-mail: info@commonground.org

STATE: **New York**

AGENCY/ORGANIZATION:

Division of Parole (Buffalo, New York City)

PROGRAM TITLE:

Dedicated Mental Health Caseloads

POLICY STATEMENT(S):

Modifications of Conditions of Supervised ReleaseYEAR ESTABLISHED: **1994****Overview**

The New York State Division of Parole has established dedicated mental health caseloads for parolees in the New York City region and the Buffalo region.

Description

In 1994, as part of a Memorandum of Understanding between the New York State Office of Mental Health (OMH) and the New York State Division of Parole (DOP), the DOP established dedicated mental health caseloads for parolees in the New York City region. Since then, dedicated mental health caseloads have been added in the Buffalo region. Parole officers in this program carry a reduced caseload of approximately 25 cases and work closely with community mental health agencies to help parolees engage in treatment.

The DOP worked with its regional directors to establish this program without any specialized funding. The program recognizes that it often takes increased time and interagency coordination to serve parolees with mental illness. Accordingly, the program involves specialized training for the parole officers, reduced caseloads, and agreements between the DOP and the OMH.

Challenges/Areas for Improvement

Only individuals with serious and persistent mental illness, as defined by the OMH, are currently eligible for the Dedicated Mental Health Caseloads. The DOP would like to expand the program to serve parolees who have mental health problems that do not fit the OMH standard of serious and persistent. There is, however, currently a waiting list for the program. In addition, the DOP is actively considering the creation of two related programs: the Parole Support and Treatment Program and the establishment of a transitional housing unit in the Sing-Sing State Prison that will help inmates with mental illness prepare for their transition into the community. (See the entry later in this appendix for more on the Parole Support and Treatment Program.)

Contact Information

New York Division of Parole
97 Central Avenue
Albany, NY 12206
Web site: parole.state.ny.us/index.html

STATE: **New York**

AGENCY/ORGANIZATION:

Division of Parole, Office of Mental Health

PROGRAM TITLE:

Memorandum of Understanding (MOU) between New York State Office of Mental Health and New York State Division of Parole

POLICY STATEMENT(S):

Release Decision

YEAR ESTABLISHED: **1994 (an earlier MOU between the two agencies was signed in 1985)**

Overview

The Memorandum of Understanding between the New York State Office of Mental Health (OMH) and New York State Division of Parole (DOP) describes a variety of areas for interagency collaboration for inmates with mental illness who are applying for parole.

Description

This MOU was prepared to enhance the opportunities for parolees with severe and persistent mental illness to adapt to living in their communities and to reduce the potential for recidivism. The MOU addresses discharge planning, entitlement applications, post-release aftercare, cross-training, and resolutions of disputes arising between the two agencies.

Through the MOU, the DOP and OMH agree to engage in collaborative prerelease planning, including early identification of inmates with severe and persistent mental illness and developing linkages to community-based mental health programs. The MOU also established a new intensive case management program for parolees with mental illness.

In the MOU, the parties also agreed on the importance of helping inmates complete applications for various social services (public assistance, Medicaid, food stamps) prior to release. In addition, there are provisions covering joint-training for OMH and DOP personnel. This training is, in part, intended to help parole staff gain access to mental health services for parolees.

Contact Information

New York State Division of Parole
97 Central Avenue
Albany, NY 12206
Phone: (518) 473-5572
Fax: (518) 473-5573

STATE: **New York**

AGENCY/ORGANIZATION:

Division of Parole, Office of Mental Health

PROGRAM TITLE:

Project Renewal, Parole Support and Treatment Program (PSTP)

POLICY STATEMENT(S):

Development of Transition Plan

YEAR ESTABLISHED: **2002**

Overview

The PSTP works with parolees to develop a long-term plan for their transition back into the community and provides transitional housing until long-term housing can be located.

Description

PSTP is a program for which parolees with chronic mental illness and co-occurring substance abuse disorders with a minimum parole term of six months may volunteer.

The PSTP is a collaborative effort between the New York Office of Mental Health (OMH), the New York Division of Parole (DOP) and Project Renewal, a New York City-based nonprofit that provides a variety of housing and support services for individuals with mental illness and/or substance abuse. Project Renewal will provide the supported transitional housing and case management for the PSTP, which will include 50 residential beds scattered among several locations. Project Renewal hopes to maintain groups of units to provide an element of peer support for program participants.

Program participants will be identified by the prerelease coordinators in conjunction with the OMH Central New York Psychiatric Center Satellite/Mental Health Units. Once involved in the program, a team of community-based mental health workers will work with a parole officer with a dedicated mental health caseload to ensure that necessary services, including basic life needs, mental health and substance abuse treatment, and housing, are supplied to the participant. Some program participants may require some period of transition before entering PSTP housing. Once the parolee is placed in PSTP housing, Project Renewal staff will provide supportive services at the housing site, as opposed to requiring the participant to access services from providers outside of the housing location. While involved in the program, the support team and the parole officer will work with the parolee to establish a long-term housing and services plan. Long-term housing options will vary for different parolees; some may be transitioned to congregate living facilities with in-house, 24-hour support, and some may be moved to less intensively supported housing.

Division of Parole, Office of Mental Health
continued

In addition to its work with PTSP, Project Renewal administers a range of rehabilitation programs intended for homeless individuals in New York City. Starting with mobile medical and psychiatric outreach teams, Project Renewal workers reach out to homeless in the streets, shelters, and transit terminals. Once the homeless person is willing to accept help, the program provides services such as short-term and permanent housing, psychiatric and medical support, substance abuse treatment, and employment training/job placement. Completely renovated by 1995, Holland House in midtown Manhattan has become one of the nation's only large scale permanent housing centers serving the homeless and the homeless with disabilities, including mental illness and HIV/AIDS. Approximately 35 percent of the 450 member staff of Project Renewal are formerly homeless clients, who help reach over 20,000 homeless and formerly homeless people each year.

Contact Information

Project Renewal
Project Renewal, Inc.
200 Varick Street
New York, NY 10014
Phone: (212) 620-0340
Fax: (212) 243-4868

STATE: **New York**

AGENCY/ORGANIZATION:

Fountain House (New York City)

PROGRAM TITLE:

Fountain House

POLICY STATEMENT(S):

Integration of Services

YEAR ESTABLISHED: **Mid-1940s**

Overview

Fountain House is the founding site and leading example of the Clubhouse model of rehabilitation. It provides education, housing, employment programs, and social opportunities for its members and helps them to access clinical treatment.

Description

Fountain House is operated by its members in partnership with professional staff. It provides community-based programming including opportunities for joining in the running of the Clubhouse, working at participating businesses throughout New York City, and taking advantage of Fountain House's housing, education, advocacy, and social and recreation activities.

The program's roots date back to the mid-1940s, when ten patients in a state mental hospital formed a self-help group. When they were released, they continued to meet in nearby New York City, calling their group "We Are Not Alone," or "WANA." Their goal, based on the concept of self-help through mutual help, was to assist one and other and ex-patients like themselves find jobs, places to live, and friendship—paths back to independence and productivity. In 1948, they established their first clubhouse, which was the genesis of Fountain House, the first program of its kind in the field of community support and psychiatric rehabilitation.

While clubhouses such as Fountain House do not directly provide clinical treatment services, they generally have strong links with appropriate agencies to ensure that members who need treatment are able to receive it.

Fountain House is able to meet the needs of members who are elderly or disabled by illness or disability. Ten percent of its members, for instance, are deaf or hearing-impaired. Approximately half of its members have histories of substance or alcohol abuse. And one in five are elderly. Fountain House meets the needs of its clients by accepting them as they present themselves and working with them from that point forward.

According to a document developed jointly by Fountain House members and staff, "the Fountain House vision is that people with mental illness everywhere achieve their potential and are respected as co-workers, neighbors and friends." Fountain House today serves 1,300 active members annually. Since its founding in 1948, it has helped more than 16,000 men and women to

Fountain House (New York City)
continued

achieve more independent, more productive, and more rewarding lives.

Fountain House is also nationally recognized center for research into the rehabilitation of individuals with mental illness. It is a key training base for the worldwide replication of Fountain House's pioneering Clubhouse model. In 1995, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the Fountain House Research Unit a five-year \$2.5 million grant to conduct a long-term experimental evaluation of a typical certified Clubhouse in Massachusetts. For its work on the project, the Research Unit was honored with the Massachusetts Commissioner of Mental Health's Award for Excellence in Research. The first published article from the project points out the advantages of programs, like Clubhouses, that blend employment services with other types of practical support.

Contact Information

Fountain House
425 West 47th Street
New York, NY 10036
Phone: (212) 582-0340
Fax: (212) 265-5482
Email: fhinfo@fountainhouse.org
Web site: www.fountainhouse.org

STATE: **New York**

AGENCY/ORGANIZATION:
Horizon Health Services (Erie County)

PROGRAM TITLE:
Alternatives to Incarceration (AIC)

POLICY STATEMENT(S):
Pretrial Release/Detention Hearing

Overview

The Alternatives to Incarceration program screens and assesses individuals at the Buffalo City Lock-Up or Erie County Holding Center, makes recommendations to the court at arraignment, provides case management services upon release, and links individuals with community service providers.

Description

The AIC program operates through Horizon Health Services, a private nonprofit behavioral health agency offering a range of mental health and substance abuse treatment services. The small AIC team, consisting of a court liaison, one case manager, and their supervisor, provides advocacy, case management, and mental health and addiction treatment services for individuals who have a history of nonviolent criminal behavior.

Each morning, the AIC court liaison arrives at the lockup to identify inmates who may be in need of mental health treatment. The court liaison speaks with lockup personnel, reviews new inmate arrival information, and walks through the lockup in search of individual behavior that may indicate serious mental health problems. Upon identification, the court liaison attempts to engage the individual and conduct a brief screening. The court liaison then returns to the AIC office to prepare for the individual's arraignment, usually a few hours later that day. Once an individual has been admitted to the program at arraignment, the AIC case manager is responsible for linking the individual to community treatment and following up with the client and the court regarding the progress for 90 days. All individuals are assessed for co-occurring disorders and provided a treatment group and other dual diagnosis treatment depending upon individual needs. Participants in the program also are assessed and treated for medical problems and provided medical care upon entry to the program.

Contact Information

Horizon Health Services
Transitions Counseling Center
3297 Bailey Avenue
Buffalo, NY 14215
Phone: (716) 833-3622

STATE: **New York**AGENCY/ORGANIZATION:
Office of Mental HealthPROGRAM TITLE:
Conference on Evidence-based PracticesPOLICY STATEMENT(S):
Evidence-Based PracticesYEAR ESTABLISHED: **2001**

Overview

The Office of Mental Health convened a statewide conference to acquaint county-level policymakers and local service providers with national best-practice trends.

Description

The New York State Office of Mental Health (OMH) held a Best Practices Conference in 2001 to advance the agency's efforts to bring best practices to the forefront of the mental health community. Conference sessions included the following:

- Evidence-based Practices: Challenges and Opportunities, Integrated Treatment for Schizophrenia: What does our research show?
- Promoting Medication Adherence: Overview and Discussion on Effective Treatment Strategies
- Best Practices for Effective Service for Children and Adolescents
- Theory and Practice: Assertive Community Treatment
- The Merging of Perspectives on Effective Use of Medications
- Practice Guidelines Development and Dissemination: Methods, Issues and Results, Updates from the Texas Medication Algorithm Project
- Self-Management Approaches: Promising Studies of an Emerging Best Practice,
- Framing the Significance of Evidence-based Practice for the Daily Lives of New York Families
- Understanding Best Practice in the Field of Supported Housing
- Supported Employment: Best Practices and Innovations
- The Implementation Challenge to State Mental Health Authorities

The New York conference was the first step in a projected series of initiatives designed to make adherence to best practices a top priority in the New York public mental health system. The OMH has developed its strategic statement around goals including striving to incorporate best practices into its priorities, which will shape these efforts to improve the effectiveness of the

Office of Mental Health
continued

adult and children's mental health system. Best practices should be incorporated whereby service design and delivery are based on the best research and evidence available, and best-practice guidelines are incorporated into treatment practices. Adherence to these guidelines is measured as part of the accountability process. This vision is part of the state's "ABCs of Mental health Care."

Contact Information

New York State Office of Mental Health
44 Holland Avenue
Albany, NY 12229
Phone: (518) 474-4403
Fax: (518) 474-2149
Webs site: www.omh.state.ny.us/

STATE: **New York**

AGENCY/ORGANIZATION:
Office of Mental Health

PROGRAM TITLE:
Pathways to Housing (New York City and Westchester County)

POLICY STATEMENT(S):
Housing

YEAR ESTABLISHED: **1992**

Overview

Pathways to Housing provides housing to individual who are homeless and have psychiatric disabilities and/or substance abuse problems. Unlike most programs that provide housing for this population, participation in Pathways housing is not contingent on the receipt of treatment. Instead, Pathways offers housing first, and then provides links to other clinical and support services.

Description

Pathways to Housing believes that housing is the key element in helping people with mental illness and substance abuse disorders to stabilize their lives and begin the process of recovery. Accordingly, Pathways focuses on clients who have been turned away from other programs because they refuse to participate in treatment, have histories of violence and incarceration, or have personality or behavioral problems.

Program participants are required to sign a standard lease agreement and must agree to two inspections a month, for up to six months. In addition they have access to support services through an Assertive Community Treatment (ACT) team. The service coordinator and tenant develop an individualized plan, based on the wishes of the tenant, which extends beyond housing to include education, vocation, mental health, physical health, alcoholism and substance abuse treatment, finances, self-care, and social and family network/support. About half of the program's staff are in recovery from substance abuse or a psychiatric disability, and oftentimes, were themselves once homeless.

Pathways was founded in 1992 by the Office of Mental Health. The program currently serves 300 individuals in scattered site locations throughout Manhattan, Queens, Brooklyn, the Bronx, and in Westchester County. Funding for the program comes from Section 8 vouchers, the HUD Shelter Plus Care Program, and the Office of Mental Health.

In a recent study, 225 homeless people with psychiatric disabilities were randomly assigned either to the Pathways program or to traditional New York City services. After one year, the self-reported quality of life improved at comparable rates and there were no differences in the levels of substance abuse be-

Office of Mental Health
continued

tween the two samples. The one significant difference that Pathways points to is that there was an 80 percent reduction in the amount of time spent homeless for the group assigned to Pathways versus a 23 percent reduction in time spent homeless among those assigned to traditional services. Additional data from 2000 indicates that 88 percent of the program's members remained housed after five years.

Contact Information

Pathways to Housing, Inc.
155 West 23rd Street
12th Floor
New York, NY 10011
(212) 289-0000

STATE: **New York**AGENCY/ORGANIZATION:
Office of Mental HealthPROGRAM TITLE:
Transitions TrainingPOLICY STATEMENT(S):
Training for Mental Health ProfessionalsYEAR ESTABLISHED: **2002****Overview**

The Office of Mental Health (OMH) sponsors the Transitions Training program to provide information to mental health and human services agencies regarding the difficulties faced by those people with mental illness who leave prison and must adjust to living in their community.

Description

The training program is designed for administrators and supervisors of mental health agencies that currently serve or intend to serve persons with mental illness who have been incarcerated. The goals of the training are to improve provider receptivity toward serving this population, increase the coordination between mental health providers and parole staff, and reduce the stigma surrounding involvement with the criminal justice system. The training is coordinated by the Howie T. Harp Advocacy Center.

The Transitions Training program employs forensic consumer co-trainers that have all experienced incarceration in state prison firsthand, and have struggled with recovery once released into the community. These consumers are especially effective trainers because they can assess how effective agency providers who attend the sessions have been in the past in helping this population in a positive and therapeutic manner. The training sessions cover topics such as the New York State criminal justice system, mental health services in prisons, and the experiences of incarceration, release, and reintegration.

Ten free sessions of training are offered to mental health provider agencies. Additional training sessions are available for a fee. The training manual itself also provides a wealth of contact information for agency providers looking for specific organizations that provide assistance to released inmates, ranging from ways to get involved in community service to programs for formerly incarcerated mothers.

Contact Information

NYS Office of Mental Health
Community Care System Management
Bureau of Adult Services Unit
44 Holland Avenue
Albany, NY 12229
Phone: (518) 402-6376
Fax: (518) 473-0066

STATE: **New York**AGENCY/ORGANIZATION:
University of Rochester, Department of PsychiatryPROGRAM TITLE:
Project LinkPOLICY STATEMENT(S):
SentencingYEAR ESTABLISHED: **1995****Overview**

Project Link is a collaborative effort among five community-service agencies. The project provides coordinated services to individuals with mental illness involved with, or at risk of involvement with, the criminal justice system.

Description

The Department of Psychiatry at the University of Rochester founded Project Link and continues to oversee the project. Project Link was developed in response to a 1993 study conducted by the Monroe County Office of Mental Health that identified a group of individuals with mental illness who had experienced repeated stays in the local jail and inpatient hospital over a period of three years. The project employs bachelor's-level "case advocates," who carry caseloads of 20 consumers and are supervised by a master's-level case coordinator. Consumers can be referred through a variety of avenues, including from the state correctional facilities, local jails, police, public defender's office, hospitals, and emergency rooms.

Project Link has a special focus on engaging consumers who are members of minority populations and, to this end, employs a diverse and well-trained staff.

Components of the project include a mobile treatment team that delivers services to 40 of the 100 project enrollees who are in the greatest need of assistance. The mobile treatment team includes a part-time forensic psychiatrist and a full-time psychiatric nurse practitioner. The project also operates a treatment residence for clients with chemical dependence, which is staffed around the clock.

Project Link staff work with consumers while they are still involved in the criminal justice system (e.g., in the courtroom, in the jail), working to have consumers placed in Project Link as an alternative to incarceration and a condition of release. Project Link staff also work with community corrections officials in using the leverage of sanctions to improve compliance.

Project Link staff conduct extensive training and cross-training efforts; they have presented seminars to representatives of the local parole, police force, bar association, and other criminal justice personnel.

Project Link has collected data concerning the effectiveness of the treatment program. The experiences of 46 individuals admitted to the mobile treatment team were examined between October 1, 1997 and December 1, 1998. The data for the period while involved with Project Link were then compared to data from the year prior to their involvement. Individuals involved in the project experienced a significant drop in mean number of days spent in jail per month (9.1 to 2.1) and mean number of hospital days (8.3 to 3). Using per diem rates, this translates to a reduction of \$30,908 to \$7,235 for total jail costs and from \$197,899 to \$42,247 in reduced hospital costs. In addition, consumer satisfaction ratings for the program were a mean of 4.6 out of 5 (5 being the highest level of satisfaction) and 35 of the 46 consumers reported that Project Link helped them cut down on their substance abuse.

Project Link received the American Psychiatric Association Gold Achievement Award in 1999 for its success in meeting the clinical, social, and residential needs of this difficult-to-serve population.

Challenges/Areas for Improvement

Maintaining ongoing funding support is the biggest obstacle to sustaining the program. To date, the principal source of funding for the project has been time-limited grants.

Contact Information

Project Link
Strong Ties Community Support Program
1650 Elmwood Avenue
Rochester, NY 14620
Phone: (716) 275-0300
Fax: (716) 461-9304

STATE: **New York**

AGENCY/ORGANIZATION:
Urban Justice Center

PROGRAM TITLE:

When a person with mental illness is arrested—How To Help: A New York City handbook for family, friends, peer advocates, and community mental health workers

POLICY STATEMENT(S):

Appointment of Counsel, Educating the Community and Building Community Awareness

YEAR ESTABLISHED: **2001**

Overview

Heather Barr, a staff attorney at the Urban Justice Center's Mental Health Project, prepared the handbook as a tool for people concerned about someone with a mental illness who is involved with New York City's Criminal Justice System.

Description

The handbook addresses questions ranging from how to track down someone who has been arrested to how to best work with a defense attorney to how to best advocate for a defendant during sentencing. In addition, it lists phone numbers and web sites that help the reader to access adequate legal services, psychological counseling, and information on how to handle a family member with mental illness. Included is a glossary of terms that someone new to the criminal justice system could find confusing.

Private foundations covered many of the costs that the Mental Health Project of the Urban Justice Center incurred to prepare the handbook.

Contact Information

Urban Justice Center Mental Health Project
666 Broadway, Tenth Floor
New York, NY 10012

STATE: **North Carolina**

AGENCY/ORGANIZATION:

Chapel Hill Police Department

PROGRAM TITLE:

Mobile Crisis Unit

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene ResponseYEAR ESTABLISHED: **1974****Overview**

The Chapel Hill Police Department formed a locally funded Mobile Crisis Unit to respond to vulnerable populations in the community, including people with mental illness or developmental disabilities and victims of domestic violence or sexual assault.

Description

As of 2001, four full-time crisis intervention advocates and a contract staff of six part-time advocates operate the Mobile Crisis Unit. The unit is on call 24 hours a day, 7 days a week to assist police officers who respond to people in crisis.

In addition to contracting intervention assistance from advocates, the Chapel Hill Police Department also trains all officers to appropriately respond to people with mental illness. Academy training is state-mandated but the department provides supplemental training as well. As part of the training, people with mental illness visit the classroom to speak to officers and interact informally with them. These consumers share their personal experiences with police encounters.

The departmental response protocol states that when an officer responds on-scene to a call, he or she will try to defuse the problem immediately, but may also contact the Mobile Crisis Unit for assistance. If necessary, the officer transports the person in crisis to North Carolina Memorial Hospital for emergency evaluation and/or commitment. The police department has a memorandum of understanding with North Carolina Memorial Hospital, which provides that individuals picked up by the police may be brought to the hospital and will be seen within a specified period of time.

The Mobile Crisis Unit also coordinates informal case conferences with the police department. Some individuals with mental illness frequently come into contact with officers. The unit can offer suggestions for officers on their interactions with those individuals whom they know well. The crisis unit can provide resources and measures to protect both the officer's and the individual's safety.

The Mobile Crisis Unit understands that providing an effective response to police situations involving people with mental illness depends on a community partnership among law enforcement, mental health care providers, crisis intervention advocates,

Chapel Hill Police Department

continued

and citizens. Relationships with a local community clubhouse and NAMI provide unit staff with the opportunity to interact with family members of people with mental illness and become actively involved in community education. Additionally, the crisis unit is hosting a support group for children of parents with mental illness.

Challenges/Areas for Improvement

Turnover among employees working in the local mental health center is high. As a result, the crisis unit regularly must form new relationships with staff at the mental health center. In addition, the Chapel Hill Police Department, with additional resources, would like to develop and implement a system for providing additional follow up and intervention to people who frequently come in contact with the police.

Contact Information

Director of Crisis and Human Services

Chapel Hill Police Department

828 Airport Road

Chapel Hill, NC 27514

Phone: (919) 968-2806

STATE: **North Carolina**

AGENCY/ORGANIZATION:
Department of Correction

PROGRAM TITLE:
**Sexual Offender Accountability and
Responsibility (SOAR) Program**

POLICY STATEMENT(S):
**Development of Treatment Plans, Assignment
to Programs, and Classification/Housing
Decisions**

YEAR ESTABLISHED: **1991**

Overview

SOAR is a voluntary day-treatment program for sex offenders. Correctional psychologists from state prisons across North Carolina refer candidates for the program.

Description

The SOAR program was established at Harnett correctional institution in North Carolina and is administered in two wings of one of the dormitories. Sexual offenders who admit their guilt and volunteer to enter the SOAR program are referred from prison units across the state. SOAR is based on the premise that 1) deviant sexual behavior is learned; 2) the treatment of sexual offenders involves learning appropriate and responsible social and sexual behavior to substitute for the negative behaviors that led to the commission of the offense.

SOAR is an intensive residential therapeutic community. Participants are in treatment six hours per day, five days per week for twenty weeks (approximately 600 hours of treatment). Approximately 40 participants are selected for each of two treatment cycles, with about 72 inmates completing SOAR each year. The program is staffed by psychologists with experience in working with sexual offenders as well as inmate peer counselors—inmates who have completed the SOAR program and who, as peer counselors, provide support services to staff and participants.

The SOAR program has an approximate annualized operating cost of \$183,000 per year, a cost of \$7.16 per inmate (which does not include the cost of incarceration). The primary criteria used for evaluating the program's success are periodic analyses of recidivism statistics. As of April 2000, 302 SOAR participants had been released into the community and lived in the community for an average of three years. Of these, 25 participants (8.3 percent) were readmitted to the North Carolina Department of Prisons (for any reason, including parole violations). Eleven participants (3.5 percent) returned to the department of prisons for either a conviction on a new sexual offense or a charge that may have been sexually motivated. SOAR staff is in the process

Department of Correction
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of collecting data regarding non-SOAR sex offenders released from custody for comparison purposes.

Challenges/Areas for Improvement

Treatment of sex offenders faces a number of challenges. Despite research to the contrary, the stigma that sex offenders cannot be treated persists. In addition, the lack of trained and experience staff to work with this population presents ongoing difficulties. Also, sex offenders who are identified as such by the prison population will often be reluctant to be housed in the general population for fear of harassment or violence by the other inmates.

Contact Information

Psychological Services Coordinator
SOAR Program
Harnett Correctional Institution. #3805
P.O. Box 1569
Lillington, NC 27546
Phone: (910) 893-2751
Web site: www.doc.state.nc.us/dop/health/mhs/special/soardesc3.htm

STATE: **Ohio**

AGENCY/ORGANIZATION:

Department of Mental Health

PROGRAM TITLE:

Coordinating Centers of Excellence

POLICY STATEMENT(S):

Evidence-Based PracticesYEAR ESTABLISHED: **2002****Overview**

The Ohio Department of Mental Health is in the process of establishing Coordinating Centers of Excellence (CCOE) responsible for disseminating evidence-based or promising practices across the state.

Description

The eight centers of excellence are planned with the hope that they can promote local initiative and raise statewide quality measures. Each center is “hosted” within an existing entity, such as a university or county mental health boards and agencies. At the time of this writing, there are four centers for excellence in place and four in the developmental stages. The centers work closely with the department of mental health to focus their efforts on particular interventions, treatments, and populations. The four extant centers of excellence are discussed below:

- *Learning Excellence* is a program for children and adolescents run by Ohio State University that assists “alternative schools” in addressing the educational, social, emotional, and behavioral needs of those involved in the program.
- The *Ohio Medication Algorithm Project (OMAP)* is a program run by the University of Cincinnati and Butler County CMH for adults, adolescents, and children that promotes utilization of medication algorithms to guide psychiatric medication decisions.
- *Substance Abuse/Mental Illness (SAMI)* is a program operated by Case Western Reserve University for adults with co-occurring substance abuse and mental illness that promotes utilization of the integrated treatment model for SAMI services.
- The *Use of Advance Directives* is a program setup by the Washington County ADAMHS Board to encourage the use of psychiatric advance directives among mental health consumers and clinicians in the state.

The four centers in the developmental stages are:

- Multi-Systemic Therapy (MST) is a program being coordinated by the Stark County CMH Board for children and adolescents that hopes to increase statewide use of MST.

Department of Mental Health

continued

- The Medical College of Ohio is setting up a program for people living with mental illness and their families in which evidence-based psychosocial rehabilitation practices to strengthen family involvement will be encouraged.
- The Ohio Council of Behavioral Health care Organizations is planning a program for adults living with mental illness to improve service quality by promoting client servicing “clustering” to organize services.
- A program for adults with mental illness involved with the criminal justice system is being organized to promote diversion programs using the GAINS Center model by Summit ADAMHS and NEOUCOM.

Calendar year 2001 marked the ending of the long-standing Longitudinal Study of Mental Health Services and Consumer Outcomes in a Changing System (LCO) and the beginning of a new study, the Innovation Diffusion and Adoption Research Project (IDARP). The fifth and final wave of data collection of the LCO study was completed in 1998. During the past two years LCO results were disseminated to a wide range of constituent groups (consumers, family members, agencies, boards, state and national leaders). In addition, efforts were made to evaluate the effectiveness of various dissemination methods and formats.

The IDARP project goes several steps further in the study of dissemination by seeking to identify factors and processes associated with the successful adoption and assimilation of innovative evidence-based practices by behavioral health organizations across Ohio. The study focuses on evidence-based practices that are being put forth by the Coordinating Centers of Excellence. Key informants (agency directors, clinical staff, CCOE leads) will provide information to better understand the processes by which evidence-based practices are adopted and what factors lead to their long-term success. This research is expected to provide valuable information to the centers of excellence and to pave the way for organizations wishing to adopt these practices in the future. The research will also reduce the likelihood that organizations will misattribute their successes or failures to factors that are irrelevant to the adoption of innovative practices.

Contact Information

Ohio Department of Mental Health
30 E. Broad Street, Eighth Floor
Columbus, OH 43266-0414
Phone: (614) 466-2596
Web site: www.mh.state.oh.us/

STATE: **Ohio**

AGENCY/ORGANIZATION:

Hamilton County Department of Pretrial Services

PROGRAM TITLE:

Hamilton County Early Intervention Services

POLICY STATEMENT(S):

**Appointment of Counsel; Pretrial Release/
Detention Hearing**

Overview

The Hamilton County Pretrial Services Department interviews arrestees, identifies defendants who may have a mental illness, and presents the court with various options for their adjudication.

Description

When pretrial services staff identify a defendant as possibly having a mental illness, the initial court appearance is postponed from the morning calendar to the afternoon. The defendant consults with an attorney, and a mental health clinician conducts an assessment. Options are then presented to the court at the afternoon hearing.

Pretrial services interviewers ask a series of questions developed by the Court Psychiatric Clinic to be used as a screening tool to identify individuals who may have a mental illness or developmental disability. These questions include:

1. Have you ever been in special education classes?
2. Have you ever been in a psychiatric/mental hospital?
3. Have you ever seen a psychiatrist, psychologist, or case manager?
4. Have you ever taken medications for psychiatric reasons for your nerves?
5. Have you ever been in psychiatric outpatient treatment?
6. Have you ever heard voices?
7. Have you ever thought about or attempted suicide?

A positive response to any of these questions triggers an additional inquiry by mental health staff. The mental health staff use BASIS-32, a standardized, self-report problem behavior and symptom identification tool, for this assessment. The tool yields an overall impairment score that results from scores of five specific domains: mental health functioning including relationships, depression, and anxiety; daily living skills; impulsivity; addictive behavior; and psychosis. Early identification with swift intervention to treatment services for arrestees who may have mental health problems is the primary objective of the project, which seeks to enhance the ability to quickly determine eligibility for pretrial diversion, pretrial release, and intermediate sanctions.

Hamilton County Department of Pretrial Services
continued

The county is conducting pilot studies involving persons entering the criminal justice system. The studies will collect information about rates of psychiatric and substance abuse disorders, extent of traumatic life events, and overall cognitive functioning. Such data will facilitate a more effective treatment strategy in the development of appropriate alternatives to incarceration.

Contact Information

Hamilton County Department of Pretrial Services
1000 Sycamore, Room 111
Cincinnati, OH 45202
Phone: (513) 946-6165

STATE: **Ohio**

AGENCY/ORGANIZATION:

Summit County Jail

PROGRAM TITLE:

Screening Procedure; Alcohol, Drug Abuse and Psychotherapy Team (ADAPT)

POLICY STATEMENT(S):

Intake at County / Municipal Detention Facility

YEAR ESTABLISHED: **1992**

Overview

The Summit County Jail uses a three-tiered approach to screen inmates for mental illness upon their admission to the facility. The Alcohol, Drug Abuse and Psychotherapy Team (ADAPT) serves inmates with mental health concerns incarcerated in the jail.

Description

Inmates admitted to the facility receive an initial screening from the booking officer. Next, a mental health worker performs a cognitive function examination, which is followed by an evaluation by a clinical psychologist. The county also employs a crisis intervention specialist who is a member of the jail's staff. The crisis intervention specialist receives 40 hours of training per year from the facility's mental health coordinator.

Inmates who are at high risk may be housed in the mental health housing units where they are more closely observed and monitored by ADAPT staff and deputies. These inmates may include those who are actively psychotic, suicidal, or in withdrawal.

The primary responsibilities of ADAPT staff include:

- psychosocial assessments
- crisis intervention
- management of acute psychotic episodes
- monitoring of detoxification
- suicide prevention
- prevention of psychological deterioration during incarceration
- chemical dependency treatment
- education focused on individual needs
- elective therapy services.

These services are available at no cost to all inmates of the jail and referrals are made to community agencies for follow-up services.

Corrections staff for the mental health unit are selected jointly by the ADAPT director and correction security supervisors. These deputies work only on the mental health unit. Jail mental health services are enhanced by the use of a computer-

Summit County Jail

continued

ized information tracking system. This system is used to track all inmates who have received a mental health evaluation. The information contained in the system includes demographics, diagnosis, staff time, and the number of inmates using each type of service.

Contact Information

Summit County Jail
205 E. Crosier Street.
Akron, OH 44311

Phone: (330) 643-2171

Fax: (330) 643-4138

Web site: www.co.summit.oh.us/sheriff/corrections.htm

STATE: **Oklahoma**

AGENCY/ORGANIZATION:

Broken Arrow Police Department

PROGRAM TITLE:

Mobile Outreach Crisis Intervention Services

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene Response

YEAR ESTABLISHED: **2001**

Overview

The Broken Arrow Police Department established a partnership with the Mobile Outreach Crisis Intervention Services (MOCS), a community-based mental health organization, to assist the police as second responders to crisis calls involving people with mental illness.

Description

The Broken Arrow Chief of Police is a member of the MOCS advisory board, along with representatives from NAMI, Parkside Hospital (a local mental health facility), and the Tulsa Police Department. In this role, the chief became acquainted with the MOCS services and their benefit to the police and their clients. As a result, the police department and MOCS jointly developed the following response protocols.

After an officer responds on-scene and encounters a person who may have a mental illness that appears to be a factor in the incident, the officer can call MOCS immediately for an evaluation. It is estimated that responding officers call MOCS about three times weekly for assistance. Once MOCS arrives on-scene, they can assess the mental health needs of the individual. If the individual is in need of services but is not violent, MOCS can take the person to a mental health facility without police escort. This saves time for the police and expedites services to the client. Also, in facilitating patient commitment, MOCS has more flexibility than the police—police can only detain and transport to the nearest mental health facility individuals who are a danger to themselves or others.

When not responding to these types of calls, MOCS also provides preventive and follow-up services to clients released from mental health facilities after commitment. The team is able to meet with family members and to coordinate services. MOCS is also available to the police to assist with SWAT team incidents. MOCS provides guidance and support in barricade situations in which the person may have a mental illness.

The State of Oklahoma mandates two hours of annual police in-service training on mental illness. Broken Arrow Police Departments requires four hours of training and provides the opportunity for an additional eight hours of in-service training on mental illness. Additionally, two hours of mandatory training for new recruits are provided in the academy.

Broken Arrow Police Department

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This service is funded through a grant from the Oklahoma State Department of Mental Health. A state law was passed to provide funds for a state-certified training program modeled after the Memphis Crisis Intervention Team. At the time of this writing, the training program was in the process of being made available to all Oklahoma law enforcement agencies.

Contact Information

Headquarters Division Commander
Broken Arrow Police Department
2302 S 1st Place
Broken Arrow, OK
Phone: (918) 259-8499
Fax: (918) 451-8242

STATE: **Oklahoma**

AGENCY/ORGANIZATION:

Tulsa County Division of Court Services

PROGRAM TITLE:

Jail Diversion of Mentally Ill

POLICY STATEMENT(S):

Pretrial Release/Detention HearingYEAR ESTABLISHED: **1999**

Overview

Tulsa Pretrial Services, in conjunction with a local hospital for people with mental illness, administers a jail diversion program for nonviolent defendants with mental illness.

Description

The jail diversion program targets defendants at five different points in the criminal justice system:

1. the initial contact made by law enforcement
2. screening and evaluation upon jail booking to assure continuity of treatment while in custody
3. screening for pretrial release
4. ongoing bail review process for those detained as situations change (i.e., amendment of charges by the district attorney)
5. assessment for the presentence investigation report.

In their annual report for the year 2000, pretrial services reported that one in four program participants with serious mental illness were reincarcerated within eight months, and 39 percent of those rearrested were booked on charges of drugs or an alcohol related offense.

Contact Information

Tulsa County Division of Court Services

Tulsa County Courthouse

500 S. Denver Room B-3

Tulsa, OK 74103

Phone: (918) 596-5795

STATE: **Oregon**

AGENCY/ORGANIZATION:

Lane County Public Safety Coordinating Council

PROGRAM TITLE:

Lane County Diversion Program

POLICY STATEMENT(S):

Prosecutorial Review of Charges and AdjudicationYEAR ESTABLISHED: **1997**

Overview

With the approval of the prosecutor, some defendants with co-occurring mental health and substance abuse disorders are referred to the drug court program and offered the possibility of community-based treatment in lieu of incarceration.

Description

Defendants identified as having co-occurring mental health and substance abuse disorders are referred to the same drug court program as defendants who have substance abuse problems only. Shared elements of the program include: a single judge; voluntary participation; the use of graduated sanctions; program progress monitored by the court, with appearances at least once a month; and dismissal of charges upon successful completion.

There are some important variations in the program for defendants with a co-occurring mental illness and a substance abuse problem. Eligibility for defendants with co-occurring disorders is determined by the jail mental health staff and negotiated with the district attorney and public defender. These individuals receive collaborative mental health and substance abuse treatment and the range of sanctions is sensitive to the mental health problems of this population. In addition, there is a mental health specialist/court liaison who serves the dual role of case manager and liaison to the judge.

Contact Information

Lane County Public Safety Coordinating Council

125 E. Eighth Avenue

Eugene, OR 97401

Phone: (561) 682-2121

STATE: **Oregon**

AGENCY/ORGANIZATION:

Lane County Sheriff's Office

PROGRAM TITLE:

Interim Incarceration Disenrollment Policy

POLICY STATEMENT(S):

Intake at County / Municipal Detention Facility

YEAR ESTABLISHED: **2001**

Overview

The Interim Incarceration Disenrollment Policy in Lane County helps detainees and inmates retain their benefits when incarcerated for short periods of time. For those individuals who are not receiving benefits when they arrive at the jail, or whose benefits are suspended while incarcerated, the program helps to expedite their enrollment in appropriate benefit programs upon their release.

Description

At the behest of officials in Lane County, Oregon has adopted the Interim Incarceration Disenrollment Policy, which specifies that individuals cannot be disenrolled from their health plan during their first 14 days of incarceration, during which the state makes the Medicaid payments. In addition, Lane County officials have developed a relationship with the local application-processing agency for Medicaid and Social Security Insurance. Now, the application process for those individuals who did not have benefits prior to incarceration or whose incarceration period lasts longer than 14 days can begin while the detainee is still in custody.

The jail has also started an initiative to ensure that inmates in their jail diversion program—all of whom are diagnosed with severe and persistent mental illness—can access their state health plan benefits upon their release. First, the inmates receive help from jail employees in filling out the plan application. Then staff members fax each application to the Senior and Disabled Services (SDS) office a day or two before the inmate's release. The applications are processed rapidly. Finally, the SDS office faxes to the jail the inmate's temporary cards, which can be used immediately to access all health plan benefits. A permanent care provider is sent after the inmate has a managed care organization. In case there are problems or inmates need help with other issues, the jail staff stays in regular contact with former inmates.

Prior to developing this initiative, inmates had to wait several weeks for their applications to be processed, during which time they were without health care coverage.

Contact Information

Lane County Sheriff's Office

125 East Eighth Avenue

Eugene, OR 97401

Phone: (541) 682-4150

Web site: www.lanesheriff.org

STATE: **Pennsylvania**

AGENCY/ORGANIZATION:

**Consumer Satisfaction Team, Inc.
(Philadelphia)**

PROGRAM TITLE:

Consumer Satisfaction Team (CST)

POLICY STATEMENT(S):

Accountability

YEAR ESTABLISHED: **1990**

Overview

The Consumer Satisfaction Team, Inc. (CST) was developed in Philadelphia in response to the closure of a state hospital. The CST visits various locations where mental health services are offered or where consumers are located and conducts informal interviews with consumers to determine their level of satisfaction with the services.

Description

In 1990, when the State of Pennsylvania closed the Philadelphia State Hospital, consumers, family members, and advocates in the city wanted to ensure that the needs and preferences of the people discharged from the hospital were incorporated into the design of community-based mental health services. A group of these individuals formed CST, Inc.

CST staff make unannounced visits to mental health and substance abuse treatment sites. They also visit consumers in their places of residence, in clubhouses, and in drop-in centers. In 1999 CST teams in Philadelphia and Delaware County made approximately 1,000 site visits and interviewed approximately 7,500 consumers. CST prefers informal interviews over surveys.

Through persistent advocacy CST has won support of local authorities for incorporation of CST's findings in the overall evaluation of the system's ability to provide services in the community. The Philadelphia Office of Mental Health funds CST, Inc.

The Philadelphia CST has served as a model for a number of state and local systems wishing to formalize methods for obtaining consumer feedback. The CST has provided training to a wide variety of audiences, including other CST teams, advocacy organizations, behavioral health professionals, state mental health officials, and many others.

Contact Information

Consumer Satisfaction Team, Inc.

520 N. Delaware Avenue, Seventh Floor

Philadelphia, PA 19123

Phone: (215) 413-3100

Web site: www.thecst.com

STATE: **Pennsylvania**

AGENCY/ORGANIZATION:

Department of Corrections

PROGRAM TITLE:

Forensic Community Re-Entry and Rehabilitation for Female Prison Inmates with Mental Illness, Mental Retardation, and Co-occurring Disorders

POLICY STATEMENT(S):

Release DecisionYEAR ESTABLISHED: **2002****Overview**

The program provides comprehensive transition planning for female inmates who have a mental illness.

Description

The forensic community re-entry and rehabilitation program was developed in response to the higher percentage of inmates with mental illness who serve their maximum sentences as compared to inmates without mental illness. The lack of sufficient community-based resources makes it difficult for the parole board to approve a parole plan, which leads to inmates with mental illness being denied parole at rates significantly higher than other inmates. In 2000, 16 percent of inmates served their maximum sentence, compared with 27 percent of inmates who have a mental illness. Of those inmates who were classified as having a serious mental illness, 50 percent served their maximum sentence. Once inmates with mental illness are released, they return home to neighborhoods where they are frequently unwelcome and where the lack of community services makes their successful reintegration very difficult.

The Pennsylvania Department of Correction (DOC), in conjunction of the Pennsylvania Board of Probation and Parole and the Pennsylvania Community Providers Association, collaborated to apply for funding for this program from the U.S. Department of Justice, Bureau of Justice Assistance. The funding was received in 2001 and the program will begin in May 2002. The program will employ Community Placement Specialists (CPSs) who will oversee the transition of the program participants from the prison to the community. The program will also provide transitional housing for a limited time (30 to 60 days) for those participants who do not have adequate community housing accommodations.

DOC mental health staff will refer inmates with mental illness, mental retardation, or substance abuse problems to the program approximately 12 months prior to their release. Mental health staff will then interview the inmates and develop an assessment of their needs and strengths and forward this information to the community placement specialist. The CPS will locate

Department of Corrections

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community-based treatment and support services (housing, mental health, substance abuse, childcare, employment training) in the inmate's home jurisdiction. The CPS will also ensure that the inmate is enrolled in any relevant pre-parole or reentry classes or services and will oversee the development of a transition plan that is acceptable to all of the relevant parties (providers, parole board, housing services, etc.) Once offenders are paroled, parole agents will supervise their treatment and supervision and the CPS will conduct follow-up with service providers to monitor the participant's progress.

The pilot program will be located at the State Correctional Institution at Muncy, a close security female institution that houses the inmates with the most serious mental illnesses. The DOC estimates serving 20-40 participants in the first program year.

Contact Information

Chief Psychologist
 Pennsylvania Department of Corrections
 2520 Lisburn Road
 P.O. Box 598
 Camp Hill, PA 17001-0598
 (717) 731-7797
 Web site: www.cor.state.pa.us

SCI Muncy
 P.O. Box 180
 Muncy, PA 17756
 (570) 546-3171

STATE: **Rhode Island**

AGENCY/ORGANIZATION:
Department of Corrections

PROGRAM TITLE:
**Women's Discovery Program and
Safe Release Program**

POLICY STATEMENT(S):
Development of Transition Plan

YEAR ESTABLISHED: **1999**

Overview

The Department of Corrections (DOC) provides mental health treatment services and specialized discharge planning for female inmates with mental illness and co-occurring substance abuse disorders.

Description

Since 1993, the Women's Discovery Program has provided substance abuse treatment for female inmates in Rhode Island state prisons. Beginning in 1999, with the support of a grant from SAMHSA, the DOC added the Safe Release Program, which targets female inmates with mental illness or co-occurring substance abuse disorders.

Women who volunteer for the Discovery Program and remain active participants for 30 days become eligible for the Safe Release Program. The Safe Release Program is overseen by the Providence Center, a local community-based mental health provider. Eligible inmates receive mental health treatment and specialized case management services. (The Safe Release Program is not the only mechanism for inmates to receive psychiatric services; the Department of Corrections provides mental health services to eligible inmates even if they do not enter the Discovery Program.)

The case managers who oversee the discharge planning for inmates with mental illness are employed by the Providence Center, and they continue to provide case management services for up to one year after the inmate is released. This includes helping inmates locate community-based substance abuse and mental health services, housing, employment, and other services. When appropriate, Providence Center case managers will even provide transportation for the inmate from the prison to a mental health facility upon release. The use of community-based mental health providers as discharge planners ensures continuity of care after the inmate is released.

Challenges/Areas for Improvement

The Safe Release Program is funded by a grant from SAMHSA, which will ultimately expire. Continued funding of the program is not assured.

Department of Corrections
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Another challenge reported by program administrators is that individuals with co-occurring mental health and substance abuse problems remain extremely difficult to serve, both while incarcerated and once they are released. The lack of affordable housing, the small number of appropriate treatment programs, and the dearth of employment opportunities are all enormous obstacles to overcome.

Contact Information

Rhode Island Department of Corrections
John O. Pastore Government Center
40 Howard Avenue
Cranston, RI 02920
Phone: (401) 462-2611
Web site: www.doc.state.ri.us/

STATE: **Rhode Island**

AGENCY/ORGANIZATION:

Fellowship Health Resources

PROGRAM TITLE:

Fellowship Community Reintegration Services

POLICY STATEMENT(S):

Modification of Conditions of Supervised ReleaseYEAR ESTABLISHED: **2002****Overview**

The Fellowship Community Reintegration Services (CRS) provides discharge planning and advocacy for released offenders to help them receive appropriate community placements and services, as well as assistance with applications for entitlements and any necessary education or employment referrals.

Description

The Rhode Island Department of Mental Health, Retardation, and Hospitals contracted with the Fellowship Health Resources, a nonprofit agency, to administer Fellowship CRS. Clients may be placed in any of a variety of community agencies, including residential substance abuse treatment facilities or may be placed on home confinement with provisions made for service delivery. Fellowship CRS tracks its clients for one year post-release to gather outcome data and determine the appropriateness of available placements.

Contact Information

Fellowship Health Resources, Inc.
25 Blackstone Valley Place, Suite 300
Lincoln, RI 02865-1163
Phone: (401) 333-3980
Fax: (401) 333-3984
Web site: www.fellowshipr.org

STATE: **Tennessee**

AGENCY/ORGANIZATION:

Memphis Police Department

PROGRAM TITLE:

Crisis Intervention Team

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene ResponseYEAR ESTABLISHED: **1987****Overview**

The Crisis Intervention Team (CIT) is made up of specially-trained officers who provide immediate response to and management of calls for service involving people with mental illness who are in crisis.

Description

The Memphis Police Department's CIT program began when the mayor established a task force consisting of representatives from law enforcement, NAMI, mental health facilities in Memphis, local citizens, the University of Memphis, and the psychology department and medical center at the University of Tennessee. From this collaboration, a close partnership was initiated between the Memphis Police Department and the University of Tennessee Medical Center Psychiatric Unit (also called "The Med.") The CIT officers' goals are to de-escalate or to eliminate encounters that may be potentially injurious to consumers, police officers, or citizens.

The CIT consists of 213 patrol officers (approximately a quarter of the department's uniform officers) who receive extensive training in responding to people with mental illness. Officers in the department volunteer to become members of the CIT, and are compensated through income increases, written commendations, and annual awards ceremonies.

CIT officers complete a 40-hour training program, receive a week of annual in-service training (attended by all uniform officers), and then receive an additional eight hours of specialized training. Staff at the Med provide most of the officer training, and family members of consumers also contribute to the training curricula. Training topics include recognizing mental illness and medications, crisis de-escalation techniques, defense weapons training, and role-playing sessions. The CIT officers also visit patients' homes, the Veterans Administration hospital, and NAMI-facilitated state mental hospitals.

Each of Memphis's seven precincts employs CIT officers who are familiar with each area. When responding to a call for service involving a person with a possible mental illness, a CIT officer is guided by state statute and training guidelines to assess whether the subject should be transported to the Med for further assessment and provision of services and support. The Med has an open-door policy and will provide assessments 24

Memphis Police Department
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hours a day, 7 days a week, and is prepared to admit any person within 15 minutes of arrival. This ensures that officers are immediately available to return to patrol duties.

Once admitted to the Med, unit staff assess the need to transfer the consumer to the state hospital or provide referrals to community mental health programs and other resources.

The Memphis CIT has served as a model of an advanced, proactive response to mental illness in the community, and has been duplicated in numerous police departments nationwide.

As a result of the CIT officers transporting consumers in crisis to the Med, this mental health facility has experienced a 40 percent to 50 percent increase in the amount of new patients admitted. Before the CIT program, officers who made arrests would take the subject directly to jail. However, the jail is not fully equipped to diagnose and provide management of mental illness and substance abuse disorders.

Challenges/Areas for Improvement

The department is developing and identifying resources to create a detoxification unit at the Med. Officers responding to calls for service in which the subject appears to be intoxicated would transport the person to the Med instead of the city jail. As a result of this program, citizens with possible substance abuse disorders or co-occurring mental illness would be diverted from the jail to a medical facility that will focus on providing immediate and long-term care rather than incarceration.

Contact Information

Coordinator
Crisis Intervention Team
Memphis Police Department
201 Poplar Ave.
Memphis, TN 38103
Phone: (901) 576-5735

STATE: **Texas**

AGENCY/ORGANIZATION:
Department of Criminal Justice

PROGRAM TITLE:
Mentally Retarded Offender Program

POLICY STATEMENT(S):
Development of Treatment Plans, Assignment to Programs, and Classification / Housing Decisions

YEARS ESTABLISHED: **1984; expanded in 1995**

Overview

The Mentally Retarded Offender Program (MROP) was established to mitigate the negative effects of incarceration and to promote successful reintegration into the community for inmates with mental retardation.

Description

Programming is in place to provide habilitative, social support, continuity of care, and security services to offenders identified as mentally retarded or intellectually impaired. Interdisciplinary teams, including a physician or registered nurse, psychologist, social caseworker, vocational supervisor, social work supervisor, and rehabilitation aid, perform needs assessments to determine services. Services for the identified population remain in place through transitional/discharge planning.

MROP is operated within two specialized housing units: 731 beds for male intellectually impaired offenders at one location and an additional 106 beds at another location for female inmates. MROP is intended to ensure that mentally retarded offenders are provided sheltered housing and work conditions, fair discipline, and protection from other prisoners.

Offenders participate in a group intelligence test when they are processed into TDCJ-ID Diagnostic Unit. If an offender scores below 70, he or she is then administered the Culture Fair test. If the offender scores below 70, the offender is then sent to a diagnostic facility where the Wechsler test is individually administered. Those scoring below 74 on the full-scale IQ are transferred to the MROP for comprehensive evaluation.

The Interdisciplinary Team (IDT) will complete a comprehensive evaluation to determine the presence or scope of mental retardation within 30 days of arrival to the MRO facility. As a result of the evaluation/needs assessment, the team will develop an Individualized Habilitation Plan (IHP). Evaluations by the various disciplines of the team are conducted to assess, diagnose, and identify treatment requirements of individuals who are dually diagnosed (substance abuse and/or mental illness).

Department of Criminal Justice
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Offenders with mental retardation are housed in the least restrictive environment appropriate to their habilitation, treatment, safety, and security needs. MROP housing assignment and cell assignment status are initially determined on the day the client arrives at the sheltered facility.

MROP services include medical care; psychiatric services (for offenders who exhibit signs and symptoms of mental illness); education (academic, special education, prerelease and vocational classes), occupational therapy; substance abuse treatment; ongoing treatment planning and monitoring (to measure client progress and suitability of services); and continuity of care (transitional/discharge planning).

Contact Information

Texas Department of Criminal Justice
P.O. Box 13084
Austin, Texas 78711-3401
Phone: (512) 463-9988
Web site: www.tdcj.state.tx.us/

STATE: **Texas**

AGENCY/ORGANIZATION:

Department of Criminal Justice, Texas Tech University Health Sciences Center for Telemedicine

PROGRAM TITLE:

Telepsychiatry

POLICY STATEMENT(S):

Development of Treatment Plans, Assignment to Programs, and Classification/Housing Decisions

YEAR ESTABLISHED: **1994**

Overview

The Texas Technical University Health Sciences Center (TTUHSC) provides medical care in the western portion of Texas to inmates under the supervision of the Texas Department of Criminal Justice. In 1994, TTUHSC began using telemedicine to deliver health services, including mental health services, to adult inmates and juveniles in several facilities.

Description

TDCJ has contracted with TTUHSC to provide health services to 26 adult institutions, where approximately 33,000 inmates are incarcerated. TTUHSC conducts approximately 2,000 telemedicine consultations per year for inmates, via closed circuit, interactive video technology. Researchers there are currently developing a newer computer-based desktop system.

Prior to the implementation of telemedicine, most inmates needing specialized medical care were transported from the prison to a specialist, hospital, or other facility. Each trip cost between \$200 and \$1,000. The use of telemedicine in appropriate circumstances has helped to save significant transportation expenses.

Previously, the TTUHSC had provided telepsychiatry and telepsychology to inmates on a limited basis. A recent telepsychiatry initiative, however, has more than doubled the number of telepsychiatry consultations that TTUHSC conducts. Approximately one-third of all telemedicine consultations are in telepsychiatry and telepsychology. The TTUHSC telemedicine program has been recognized nationally as a leader in the field.

Contact Information

TTUHSC Center for Telemedicine
4BC416
3601 4th Street
Lubbock, TX 79430
Phone: (806) 743-4440
Fax: (806) 743-4010
Web site: www.ttuhs.edu/telemedicine/

STATE: **Texas**

AGENCY/ORGANIZATION:

**Department of Criminal Justice,
University of Texas Medical Branch**

PROGRAM TITLE:

Non-formulary Drugs

POLICY STATEMENT(S):

Development of Treatment Plans, Assignment to Programs, and Classification/Housing Decisions

YEAR ESTABLISHED: **1995**

Overview

The Texas Department of Criminal Justice (TDCJ) has developed policy and guidelines for facility-level providers to obtain non-formulary drugs for offenders in the custody of the Texas Department of Correction.

Description

TDCJ has spelled out the procedure for obtaining non-formulary drugs for offenders in custody as part of the Pharmacy Policy and Procedure Manual. The prescribing physician must provide documentation in the offender's health record about what role the desired drug will have in the offender's treatment plan (e.g., diagnosis, special considerations) and also provide documentation about the unavailability of an acceptable substitute in the formulary.

Procedures and a flow diagram have been developed to show the protocols for what happens when such a request is made. Requests for non-formulary medication are made to the clinical pharmacist assigned who, in turn, evaluates the request by a review of information provided by the prescribing physician/psychiatrist and/or a review of other relevant information including the target disease, previous medications used for the indication, dosages, compliance allergies, diagnostic procedure, TDCJ Disease Management guidelines, national standards and guidelines, and applicable scientific literature.

Contact Information

The University of Texas Medical Branch at Galveston
Texas Department of Criminal Justice Hospital
301 University Boulevard
Galveston, Texas 77555
Phone: (409) 772-3547
Fax: (409) 772-7623
Web site: www2.utmb.edu/tdcj/

STATE: **Texas**

AGENCY/ORGANIZATION:

Department of Mental Health and Mental Retardation

PROGRAM TITLE:

The Texas Medication Algorithm Project (TMAP)

POLICY STATEMENT(S):

Development of Treatment Plans, Assignment to Programs, and Classification/Housing Decisions

YEAR ESTABLISHED: **1996**

Overview

TMAP is a collaborative effort designed to improve the quality of care and achieve the best possible patient outcome by establishing a treatment philosophy for medication management. TMAP developed and instituted a set of algorithms to illustrate the order and method in which to use various psychotropic medications.

Description

The underlying principle of TMAP is that optimizing patient outcomes translates into the most efficient use of resources. TMAP is intended to develop and update continuously treatment algorithms and to train systems to utilize these methods to minimize emotional, physical, and financial burdens of mental disorders for clients, families, and health care systems.

TMAP was developed over four phases.

- **Phase 1:** Through the use of scientific evidence and the development of consensus among experts, TMAP developed guidelines, resulting in the development of algorithms for the use of various psychotropic medications for three major psychiatric disorders: schizophrenia, major depressive disorder, and bipolar disorder.
- **Phase 2:** During phase 2 a feasibility trial of the project was conducted and the suitability, applicability, and costs of the algorithms, were evaluated.
- **Phase 3:** The third phase was a comparison of the clinical outcomes and economic costs of using these medication guidelines versus traditional treatment/medication methods.
- **Phase 4:** The fourth phase is the implementation of TMAP throughout clinics and hospitals of the Texas Department of Mental Health and Mental Retardation and is known as TIMA, the Texas Implementation of Medication Algorithms. Collaboration for this project includes public sector and academic partners, parent

Department of Mental Health and Mental Retardation
continued

and family representatives, and mental health advocacy groups. Graphic presentations of algorithms and explanatory physicians' manuals are available on the TMAP Web site.

Contact Information

Texas Department of Mental Health and Mental Retardation
909 West 45th Street
P.O. Box 12668
Austin, TX 78711-2668
(512) 454-3761
Web site: www.mhmr.state.tx.us/centraloffice/medicaldirector/TMAPtoc.html

STATE: **Texas**

AGENCY/ORGANIZATION:
Houston Police Department

PROGRAM TITLE:
Crisis Intervention Team

POLICY STATEMENT(S):
On-Scene Assessment and On-Scene Response

YEAR ESTABLISHED: **1997**

Overview

The Houston Police Department established a Crisis Intervention Team to improve the response to people with mental illness who come in contact with law enforcement and who are considered potentially dangerous to themselves or to others.

Description

Representatives of the mental health community began working with the Houston Police Department in 1991 by participating in problem-solving discussions. In 1997, a committee consisting of the Houston Police Department, probation services, the sheriff's office, mental health professionals, and other agencies developed the Crisis Intervention Team (CIT). The team is modeled after the Albuquerque, New Mexico, program.

When a call for service involving a person with a mental illness is answered, the call-taker notes that it should be routed to a CIT officer. Dispatch will call a CIT officer to respond. On-scene, the CIT officer will first try to de-escalate the situation. The goal is to protect the officer, the individual who is the subject of the call, and all others. In the majority of cases, the person is brought to a mental health facility.

The Houston Police Department holds a 40-hour training course for officers who volunteer to become members of the Crisis Intervention Team. Crisis intervention, communication, officer safety, psychopharmacology, psychosis, and mental retardation are among the topics included in the curriculum. The Houston Police Department staff psychologist and another member of the department's psychological services division lead the course. An officer teaches one section of the course and a consumer (a former attorney who had numerous encounters with HPD) discusses the mental health code. Two psychiatrists (one from each of the major hospitals utilized by officers) speak with the class. The course also includes two afternoons of role-play activities.

Call-takers and dispatchers also receive training to learn what questions should be asked to determine if the call involves a person with a mental illness. This training is designed to educate the non-sworn personnel of the department how to provide a timely and appropriate response to people in the community who have a mental illnesses.

Houston Police Department
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Additionally, in 2002 all 5,500 officers were required to take an eight-hour basic training course on communication skills and de-escalation techniques appropriate for responding to people with mental illness.

As a result of the Houston CIT program, estimated time for obtaining a mental health warrant dropped from three to four hours to 15 minutes. This reduces the amount of time that a person with mental illness remains in police custody and it expedites treatment.

Challenges/Areas for Improvement

The Houston Police department's aim is to have 25 percent of patrol officers trained in the more extensive, 40-hour Crisis Intervention Unit training. As of 2001, 577 (10 percent) officers had received this training. Those officers will have the opportunity to use and maintain their CIT skills and become acquainted with the mental health providers, hospital staff, and the citizens with mental illness who have repeated contacts with the police.

There are only five categories of calls that are currently tracked by Houston Police Department's CIT. The unit is in the process of expanding their tracking system to include demographic information, alcohol or substance abuse usage, weapons involved, and other categories.

Contact Information

Houston Police Department
Training Division
17000 Aldine Westfield
Houston, TX 77073
Phone: (281) 230-2300
Fax: (281) 230-2314

STATE: **Texas**

AGENCY/ORGANIZATION:

Parole Board, Texas Council on Offenders with Mental Impairments

PROGRAM TITLE:

Medically Recommended Intensive Supervision Program (MRIS)

POLICY STATEMENT(S):

Release Decision

YEAR ESTABLISHED: **1989**

Overview

The Medically Recommended Intensive Supervision (MRIS) Program addresses inmates with mental illness applying for parole. It is a collaborative effort among the Texas Board of Pardons and Parole; the Texas Council on Offenders with Mental Impairments (TCOMI); Correctional Managed Health Care providers; and the Texas Department of Criminal Justice Parole Division.

Description

The Medically Recommended Intensive Supervision Program was formerly known as the Special Needs Program and was renamed in November 2001. TCOMI staff, in conjunction with Correctional Managed Health Care, identifies inmates who may be eligible for this program. Potentially eligible inmates go before a three-member MRIS Parole Board panel, which determines whether the inmates should be considered for MRIS and, if so, what the conditions of release will be. TCOMI provides background information for this hearing, including the offender's treatment history while incarcerated. Panel decisions are made by majority vote. TCOMI reports back to the parole board at least once a quarter on the status of the releasee's progress. On the basis of these reports the MRIS panel can modify the conditions of release.

Contact Information

Texas Board of Pardons and Paroles
Phone: (512) 406-5458
Fax: (512) 496-5483
Web site: www.tdcj.state.tx.us/bpp/index.html

STATE: **Texas**

AGENCY/ORGANIZATION:

Texas Council on Offenders with Mental Impairments

PROGRAM TITLE:

Post-release aftercare system

POLICY STATEMENT(S):

Release Decision; Development of Transition Plan; Modification of Conditions of Supervised ReleaseYEAR ESTABLISHED: **1987; redirected to focus on offenders with mental illness in 1989****Overview**

The Texas Council on Offenders with Mental Impairments was established to provide a formal structure for criminal justice, health and human services, and other affected organizations to communicate and coordinate on policy, legislative, and programmatic issues affecting offenders with special needs. Special needs offenders include those with serious mental illness, mental retardation, terminal or serious medical conditions, physical disabilities, and those who are elderly.

Description

The council is made up of nine appointed members with experience in managing special needs offenders, plus representatives from various state agencies that focus on issues such as alcohol and drug abuse and mental health matters, as well as mental health advocates. The council's responsibility is to identify mentally impaired offenders as well as the services that are needed by this special population. The council funds community-based alternatives to incarceration in order to deliver these needed services. It also works to develop a statewide plan for meeting the needs of offenders with mental health disabilities and to provide a continuum of care throughout the criminal justice system experience. To further this goal TCOMI oversees a wide variety of programs, including:

- Intensive Case Management (1 to 25 Ratio)
- Specialized Community Supervision / Parole Officers
- Joint Treatment Planning
- Pre-release Screening, Referral and Placement Services
- Vocational Rehabilitation
- Rehabilitative / Psychological Services
- Crisis Stabilization Services
- Local Advisory Committee

In order to assess the effectiveness of the community-based programs, the Legislative Budget Board (LBB) established an outcome measure of reduction in arrests as one indicator of

Texas Council on Offenders with Mental Impairments
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performance. Based upon the analysis of arrest rates for FY '99, the reduction in arrests was 34 percent. In addition to measuring arrest data, TCOMI also compiles data on the number of offenders with special needs sentenced or returned to prison during the fiscal year. Of the 1,882 offenders served by TCOMI programs 37, or 2 percent were admitted or returned to prison during FY '00.

Contact Information

Texas Council on Offenders with Mental Impairments
8610 Shoal Creek Road
Austin, TX 48757
Phone: (512) 406-5406
Fax: (512) 406-5416
Web site: www.tdcj.state.tx.us/tcomi/

STATE: **Utah**

AGENCY/ORGANIZATION:

Department of Corrections

PROGRAM TITLE:

The Adaptive Services for Environmental Needs Development (ASEND) Program

POLICY STATEMENT(S):

Development of Treatment Plans, Assignment of Programs, and Classification/ Housing Decisions

YEAR ESTABLISHED: **1997**

Overview

The Adaptive Services for Environmental Needs Development program designates space at the Utah State Prison to provide programming for those inmates who are mentally impaired or retarded. ASEND programming is designed to assist the inmate to live successfully in the population and to prepare for release to the community.

Description

Since 1986, the Utah Department of Corrections has been operating the Advantage Program at the Utah State Prison to address the needs of offenders with an IQ below 70. In 1999, space was designated at the prison and new policies, procedures and programmatic approaches were implemented under the name ASEND. ASEND operates in a segregated living unit within the Utah State Prison and falls under the Division of Institutional Operations (DIO).

ASEND's objective is to assist individuals in acquiring and maintaining skills that enable them to cope more effectively with the demands of their lives and to raise their levels of physical, mental, and social functioning. ASEND is also intended to increase offender safety.

The Division of Institutional Operations has an existing screening and referral process, which can provide referrals to ASEND. Referrals may also come from DIO psychologists, social service workers, correctional habilitative specialists, housing unit administrative staff, school staff assigned to work at DIO, and inmates themselves. In order to qualify for ASEND, offenders need to meet one of three primary criteria and three of a set of secondary criteria. Primary criteria include a) an IQ of 80 or below; b) cognitive or intellectual deficits as documented by testing instruments; c) documented history of being victimized by other offenders while living inside a correctional facility and which occurred in part as a result of the intellectual, cognitive, and social deficits. Secondary criteria include such issues as prior history of services for people with disabilities, poor personal hygiene, inappropriate behavior, difficulty completing tasks that

Department of Corrections

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are routinely completed by other offenders, poor work record (within the institution), low literacy level.

The program is comprised of the following components: 1) written individual habilitative plan; 2) education program component; 3) cognitive programming component; 4) employment job readiness component; 5) modified behavior privilege matrix; 6) additional services coordination for inmates who are mentally ill or have history of sexual abuse and/or substance abuse.

The project has and continues to develop in collaboration with advocates, volunteers, and leaders in the community. The relationships that have evolved around ASEND are cited as one of the key factors that enhance the work of the program.

Contact Information

Utah Department of Corrections

14717 S Minuteman Dr

Draper, UT 84020

Phone: (801) 545-5500

Web site: corrections.utah.gov

STATE: **Utah**

AGENCY/ORGANIZATION:

Multiple criminal justice and mental health partners

PROGRAM TITLE:

Forensic Mental Health Coordinating Council

POLICY STATEMENT(S):

Release DecisionYEAR ESTABLISHED: **2002**

Overview

The Forensic Mental Health Coordinating Council is a joint effort between a wide array of criminal justice and mental health partners in Utah. The participating organizations include: the Division of Mental Health; the State Hospital; the Department of Corrections; the Board of Pardons and Parole; the Attorney General's Office; the Division of Services for People with Disabilities; the Division of Youth Corrections; the Commission on Criminal and Juvenile Justice; the state court administrator; local mental health authority; and the Governor's Council for People with Disabilities.

Description

In 2002, the Utah State Legislature expanded the membership and responsibilities of the Mental Health and Corrections Advisory Coordinating Council and renamed it the Forensic Mental Health Coordinating Council. The council will develop policies for coordination between the Division of Mental Health and the Department of Corrections (DOC), advise the DOC on care issues for inmates with mental illness, promote communication between the various agencies, and generally serve as a central advisory body for the various agencies and issues at the intersection of corrections and mental health.

The Mental Health Advisory Council focused primarily on issues of care within the correction's system, especially the transfer of inmates between prison and the state hospital. In 2001, the council had begun to look at more systemic issues and eventually this shift in focus resulted in new legislation renaming the council and authorizing a broader scope and membership for its activities.

Contact Information

Utah Division of Mental Health
120 North 200 West #415
Salt Lake City, UT
Phone: (801) 538-4270
Fax (801) 538-9892

STATE: **Virginia**

AGENCY/ORGANIZATION:

Department of Corrections (Brunswick Correctional Center)

PROGRAM TITLE:

Sex Offender Residential Treatment Program (SORT)

POLICY STATEMENT(S):

Development of Treatment Plans, Assignment to Programs, and Classification/Housing DecisionsYEAR ESTABLISHED: **2001**

Overview

The SORT Program provides comprehensive assessment and treatment services for inmates who have been identified as being at a risk for committing a sex offense upon their release.

Contact Information

SORT Program Director
Virginia Department of Corrections
Office of Health Services
6900 Atmore Drive
Richmond, Virginia 23225

STATE: **Virginia**

AGENCY/ORGANIZATION:

Department of Corrections

PROGRAM TITLE:

Mental Health Services Training Program

POLICY STATEMENT(S):

Training for Corrections Personnel

YEAR ESTABLISHED: **1997**

Overview

The Virginia Department of Corrections (DOC) has developed a comprehensive mental health training program for security and other non-treatment staff.

Description

In 1997 the DOC established a full-time Mental Health Training Coordinator position at the Academy for Staff Development. The training coordinator oversees training for security and other non-treatment staff and training for clinical staff. The training program relies on a group of 50 adjunct trainers, all of whom are qualified mental health professionals who have completed a training class for trainers prior to offering classes on an institutional, regional, or statewide basis.

The training for security and non-treatment staff includes the following courses:

- Basic skills for correctional officers – includes six hours on mental health issues
- Basic skills in mental health issues – a three day class for security staff who work in special housing units
- Basic skills for counselors – a one day class on mental health issues
- Basic skills for probation and parole officers – includes four hours on mental health issues
- Basic skills for qualified mental health professionals – a three day class to be offered for the first time in September 2001

Training for treatment staff covers a range of topics including the MMPI-II; the PAI; psychotropic medications; criminal thinking and psychopathy; grief issues; risk assessment; and other topics.

Each class is evaluated by the participant and instructors and the feedback is provided to the mental health training coordinator and the director of the academy. The coordinator sits in on classes when feedback indicates areas for improvement and the coordinator has discretion on how revisions should be made. All classes are reviewed and revised, as necessary, on an annual basis. Focus groups are used to develop new training classes.

Department of Corrections

continued

Support from the academy and central office for the full-time position of mental health training coordinator was crucial for implementing this program. This position is funded through the departmental budget. The training coordinator and mental health program director maintain a strong collaborative relationship.

Contact Information

Virginia Department of Corrections
6900 Atmore Drive
Richmond, VA 23225
Phone: (804) 674-3299
Academy for Staff Development
Mental Health Training Coordinator
River Road West
Crozier, Virginia 23039
Phone: (804) 784-6869

STATE: **Virginia**

AGENCY/ORGANIZATION:

Fairfax County Sheriff's Office

PROGRAM TITLE:

Offender Aid and Restoration

POLICY STATEMENT(S):

Intake at County / Municipal Detention FacilityYEAR ESTABLISHED: **1981****Overview**

Discharge planning the Fairfax County Jail is conducted by Offender Aid and Restoration (OAR), a nonprofit organization.

Description

Discharge planning at the Fairfax County Jail links detainees with mental illness who are on release with mental health and related services and also helps to maintain the inmate's family ties during incarceration—providing the inmate with an additional support system. OAR is 90 percent funded by the county and consists of eight professional staff members, all of whom have at least a bachelor's degree in criminal justice, psychology, or sociology. Detainees deal with the same professional staff person from intake through discharge.

The program collaborates closely with criminal justice partners and offers a comprehensive array of services. OAR works closely with the county jail's mental health unit and holds weekly meetings with the jail's psychiatrist. OAR also communicates with the judge, the booking staff, and the jail's forensic unit. OAR provides the following services:

- transportation and housing assistance to individuals with mental illness on release;
- emergency services for those without plans at release;
- volunteers trained to teach, mentor, and tutor educational classes in the facilities and serve as post-release guides;
- teachers to instruct in life skills, such as parenting and preparation for release
- group therapy for inmates and their families;
- support groups for families and close friends of inmates; and
- emergency funds for family food, clothing, and other necessities during the former provider's jail stay.

Contact Information

Fairfax County Sheriff's Office

Correctional Services Division

10520 Judicial Drive

Fairfax, VA 22030

Phone: (703) 246-2100

Fax: (703) 273-2464

Web site: www.co.fairfax.va.us/ps/sheriff/csd/csd.htmSTATE: **Virginia**

AGENCY/ORGANIZATION:

Roanoke County Police Department

PROGRAM TITLE:

Crisis Intervention Team

POLICY STATEMENT(S):

On-Scene Assessment and On-Scene ResponseYEAR ESTABLISHED: **2000****Overview**

The Roanoke County Police Department Crisis Intervention Team (CIT) is modeled after the Albuquerque, New Mexico, Crisis Intervention Program and was initiated through a group discussion between Roanoke County Police Department, local mental health care providers, and the media.

Description

The 911 Call Center tries to flag any calls that involve people with mental illness. Dispatch makes an effort to assign these calls to CIT-trained officers. As of 2001, there were eight CIT-trained officers with at least one CIT officer on duty for each shift at the department. However, limited staffing makes it impossible to ensure that a CIT officer handles every call involving a person with a mental illness. In response to the lack of available resources, officers must fill out a special form for every call in which it is suspected that a person may have a mental illness that is a factor in the incident. This form includes all pertinent questions to help officers without CIT training to ask the appropriate questions. These forms are later reviewed by the sergeant to determine whether the officer reacted appropriately and to flag whether the person is acting in a way consistent with mental illness and is receiving necessary services.

Once an officer has determined that a person has a mental illness and may be a danger to him- or herself, or others, the officer must fill out paperwork for an emergency custody order (ECO). When the ECO is granted, the officer brings the individual to a designated facility for evaluation. Roanoke's designated facility is Blue Ridge Behavioral Healthcare. If, upon assessment, the facility agrees that the person is in imminent danger, they must go to the magistrate and get a temporary detaining order to have the person hospitalized for 72 hours. The department has an excellent relationship with Blue Ridge Healthcare (the designated facility) and the Louis Gale Clinic. The clinic has donated staff time to help develop the training and provide instruction for the CIT program.

At the time of this writing, the Virginia Department of Criminal Justice Services is reviewing this training for possible use as statewide in-service training. Additionally, the department will be working toward statewide adoption of their training.

Roanoke County Police Department
continued

Contact Information

Roanoke County Police Department
3568 Peters Creek Road
Roanoke, VA 24019
Phone: (540) 561-8067
Fax: (540) 561-8114

STATE: **Virginia**

AGENCY/ORGANIZATION:
University of Virginia

PROGRAM TITLE:
Institute of Law, Psychiatry, and Public Policy

POLICY STATEMENT(S):
Training for Court Personnel

YEAR ESTABLISHED: **1980**

Overview

The Institute of Law, Psychiatry, and Public Policy provides an interdisciplinary educational program made up of mental health law, forensic psychiatry, and forensic psychology. The institute also conducts research and provides support for attorneys and policymakers in this field.

Description

The mission of the institute is to better understand and manage violence in society, especially among individuals with mental disorders; to strengthen the rights of individuals with mental illness, improve law and policy in areas such as civil commitment, competence, and substance abuse; and improve the capacity of mental health professionals to provide information to the courts.

A major goal of the institute is the education and training of University of Virginia students who wish to enter the fields of law and psychiatry. The institute uses an interdisciplinary approach to further this goal. Students study with a faculty of attorneys, psychiatrists, psychologists, and social workers in order to synthesize the different facets of mental health law.

Staff members of the institute also offer an array of services, including consultation on capital cases involving mental illness, forensic evaluations, and a directory that helps courts to locate mental health professionals with forensic training. The institute also provides a number of training opportunities for lawyers and mental health professionals on various issues in mental health law.

Contact Information

University of Virginia
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Charlottesville, VA 22908-0660
Tel: (434) 924-5435
Fax: (434) 924-5788
Office: 1107 West Main St.
Web site: www.ilppp.virginia.edu/index.html

STATE: **Washington**

AGENCY/ORGANIZATION:

Department of Corrections

PROGRAM TITLE:

Dangerous Mentally Ill Offender (DMIO) Program

POLICY STATEMENT(S):

Development of Transition Plan and Modification of Conditions of Supervised ReleaseYEAR ESTABLISHED: **2000****Overview**

The DMIO program was created by legislation passed by the Washington State Legislature. The relevant statute requires identification of eligible offenders, provision for financial and medical eligibility determination for eligible offenders, collaborative prerelease planning, and a study of the impact of the law. The statute also appropriates \$10,000 per person annually for up to five years to provide additional services to the offenders.

Description

The DMIO program requires substantial collaboration from the various criminal justice and mental health partners. The DMIO Implementation Council includes representatives from the Department of Social and Health Services (DSHS), Department of Corrections (DOC), Regional Support Networks (RSNs), WA Community Mental Health Council, National Alliance for the Mentally Ill—WA, Washington Advocates for the Mentally Ill, Washington Association of County Designated Mental Health Professionals, and mental health consumers.

After selection for the voluntary program, offenders meet multiple times with a transition planning team that includes representatives from mental health and substance abuse services, community corrections, the offender's family, DOC risk management specialists, family members, and developmental disability services (when appropriate). The planning team considers a wide range of issues including notification of victims and community, housing and mental health/substance abuse service needs, eligibility for benefits, crisis plans, daily life and recreation issues, and others. The planning teams are expected to follow the program participant for at least thirty days after his or her release after which the Regional Support Networks (components of the Washington State mental health system) and community corrections officers maintain oversight of the individual.

The DMIO legislation also requires an outcome study of the effects of the legislation to be conducted by the Washington State Institute for Public Policy and the Washington Instituted for Mental Illness research and Training.

Department of Corrections

continued

Preliminary findings concerning the implementation of the DMIO legislation were released in March 2002. This report detailed several challenges that the implementation of the legislation is facing; these challenges are discussed below. Obstacles to implementation notwithstanding, the program has achieved significant early success in providing treatment for participants. The implementation analysis uses data from a previous study that tracked the transition of offenders with mental illness prior to the DMIO legislation (Community Transition Study—CTS). Eighty-three percent of DMIO participants have received prerelease mental health services from community providers compared with 10 percent of CTS offenders. Similarly, 94 percent of DMIO program participants received community mental health services in the three months post-release compared with 29 percent of CTS offenders. Recidivism rates over the long term are not yet available.

Challenges/Areas for Improvement

The DMIO implementation process has encountered significant obstacles. First, the preliminary study suggests that the process for identifying eligible participants needs to be evaluated and standardized; there is currently insufficient consensus on what constitutes a “mental disorder” and “dangerousness.” Second, insurance providers have placed the program in jeopardy by refusing to provide insurance to RSNs who accept DMIO participants. At the time of this writing this situation had caused eight of fourteen RSNs to withdraw or not sign contracts of participation in the program.

Contact Information

DMIO Program Manager
Community Protection Unit
Washington State Department of Corrections
Office of the Secretary
P.O. Box 41127, MS 41127
Olympia, WA 98504-1127
Phone: (360) 586-4371
Fax: (360) 586-9055

Mental Health Program Administrator
Mental Health Division
Washington State Department of Social and Health Services
Phone: (360) 902-0867

STATE: **Washington**

AGENCY/ORGANIZATION:

Dependency Health Services and Central Washington Comprehensive Mental Health

PROGRAM TITLE:

Integrated Mental Health Crisis and Detoxification Programs

POLICY STATEMENT(S):

Co-Occurring Disorders

YEAR ESTABLISHED: **1990s**

Overview

Dependency Health Services and Central Washington Comprehensive Mental Health collaborate to serve clients who have co-occurring substance abuse and mental health disorders.

Description

Dependency Health Services, also known as Yakima Human Services, provides a variety of substance abuse treatment services in Yakima County. One of the programs that Dependency Health Services runs is a detoxification center, which serves individuals in crisis situations involving drugs and alcohol. Clients can be referred by the court, hospitals, friends and family, the police, or others.

Central Washington Comprehensive Mental Health (CWCMMH) is a non-profit organization, which provides a full range mental health services, rehabilitation and support services, as well as community education to individuals, families and organizations in multiple counties in Washington. At their Yakima center, CWCMMH provides crisis services 24 hours a day, seven days a week. Mental health professionals assess and stabilize individuals in crisis by providing immediate intervention and by facilitating further treatment as needed.

The CWCMMH mental health crisis services and the Dependency Health Services detoxification center are located in the same building. These programs have collaborated for a number of years to provide integrated services to individuals with co-occurring disorders. Individuals admitted to the mental health crisis center who display signs of substance abuse can be immediately referred to treatment professionals from Dependency Health Services. The reverse is also true for individuals admitted to the detoxification center who display signs of mental illness. This collaboration allows for comprehensive treatment to be offered to individuals regardless of the agency to which they are originally referred. Integrated treatment has helped better prepare people for reentry into the community and thus cut down on subsequent hospitalizations, crisis situations, and involvement with the criminal justice system.

Dependency Health Services recently merged with CWCMMH.

Dependency Health Services and Central Washington Comprehensive Mental Health

continued

Contact Information

Detox Center Director
Dependency Health Services
401 South Fifth Avenue
Yakima, WA 98902
Phone: (509) 453-29000

Central Washington Comprehensive Mental Health
Yakima Center
402 South 4th Avenue
Yakima, WA 98902
Phone: (509) 575-4084
Web site: www.cwcmh.org

STATE: **Washington**

AGENCY/ORGANIZATION:

King County District Court

PROGRAM TITLE:

Mental Health Court

POLICY STATEMENT(S):

**Appointment of Counsel; Adjudication;
Institutionalizing the Partnership**YEAR ESTABLISHED: **1999****King County District Court**

continued

Contact Information

King County Mental Health Court

W-1034 King County Courthouse

Seattle, WA 98104

Phone: (206) 296-3502

Web site: www.metrokc.gov/kcdc/mhhome.htm**Overview**

The King County Mental Health Court seeks to increase the efficiency of case processing, improve access to public mental health treatment services, improve the well-being and reduce recidivism for misdemeanants with mental illness, as well as increase public safety.

Description

King County's Mental Health Court offers misdemeanor defendants with mental illness a single point of contact with the court system. The court is staffed by a judge, prosecutor, defender, treatment court liaison, and probation officers. Defendants may be referred to the mental health court by jail psychiatric staff, police, attorneys, family members, or probation officers. A defendant may also be referred by another district court at any point during regular legal proceedings if the judge feels the defendant could be better served by the mental health court. The court reserves the right not to accept cases into its jurisdiction.

Participation in the program is usually voluntary, as defendants are asked to waive their rights to a trial on the merits of the case and enter into a diversion or plea agreement with an emphasis on community-based treatment. The exception is that cases in which competency issues have been raised are always eligible for transfer to the mental health court. A court liaison to the treatment community is present at all hearings and is responsible for developing an initial treatment plan and linking the defendant up with appropriate services. Defendants receive court-ordered treatment; successful participation in the treatment plan may result in dismissed charges or reduced sentencing. If the defendant is placed on probation, the case will be assigned to a mental health specialist probation officer. The mental health specialist probation officers carry substantially reduced caseloads in order to provide a more intensive level of supervision to this traditionally high-needs population.

A one-year follow-up study of the court showed that those individuals who chose to participate in the program received an increased amount of treatment services and experienced less future problems within the criminal justice system, i.e., lower rates of new bookings.

STATE: **Washington**

AGENCY/ORGANIZATION:
Seattle Police Department

PROGRAM TITLE:
Crisis Intervention Team

POLICY STATEMENT(S):
On-Scene Assessment and On-Scene Response

YEAR ESTABLISHED: **2001**

Overview

The Seattle CIT program represents a collaboration between Seattle law enforcement and mental health and medical professionals. A committee of mental health practitioners, the police, and interested community members oversaw the creation of the program after reviewing and visiting relevant programs and responses used in other cities.

Description

The Seattle CIT program is based on the Memphis model and is very similar in most respects. Unlike Memphis, however, Seattle does not provide specialty pay for CIT officers, and the selection of personnel and job assignment procedures are different. CIT officers are in every patrol unit. Patrol officers responding to a call that involves a person with a mental illness will call in a CIT officer as necessary. CIT officers must undergo a 40-hour training course, which is conducted by local mental health professionals. As of 2001, Seattle had 203 CIT-trained officers and 160 actively working in patrol. In addition, Seattle CIT staff work closely with the Seattle Mental Health Court.

To complement the CIT program, King County health care providers have developed a Crisis Triage Unit Center for people in crisis. The unit is open 24 hours a day, seven days a week and is available for officers to bring individuals who appear to have a serious mental illness. Officers are not asked to diagnose individuals in crisis. As a result, many of the people brought into the triage unit may be abusing drugs or may have other conditions that can mimic the symptoms of mental illness. The crisis triage unit has agreed to accept individuals in crisis regardless of their diagnosis.

Seattle is currently attempting to replicate a program that Albuquerque has developed called "team within a team." In this program, a detective is assigned to the Crisis Intervention Team and serves as a liaison with the Mental Health Court, mental health practitioners, and the community. The detective can provide follow-up, be on call for the court, and go out on appointments with mental health providers as needed. This officer is also responsible for following up on cases that would normally fall through the cracks when an incident is largely the result of untreated mental illness and is basically noncriminal (e.g., a dispute between neighbors). Albuquerque has four detectives assigned to these tasks.

Seattle Police Department
continued

Challenges/Areas for Improvement

Though the Seattle Police Department CIT maintains its own database containing the number of people with mental illness involved in police calls for service, this information includes only cases that are coded and closed as mental illness calls. This does not include cases prioritized by the police department as robbery or assaults, but which also may involve suspects with mental illness. Because of this tagging system, the CIT's internal statistics may not accurately reflect the number of offenders with mental illness in the community.

Contact Information

Crisis Intervention Unit
Seattle Police Department
610 Third Avenue, Unit 400
Seattle, WA 98104
Phone: (206) 684-8183
Fax: (206) 233-3988

STATE: **Wisconsin**

AGENCY/ORGANIZATION:

**National Alliance for the Mentally Ill (NAMI)
Wisconsin**

PROGRAM TITLE:

***Mental Health Services for Mentally Ill Persons
in Jail: A Manual for Families and
Professionals Including Jail Diversion
Strategies***

POLICY STATEMENT(S):

**Educating the Community and Building
Community Awareness**YEAR ESTABLISHED: **1998**

Overview

The manual provides information on what happens when a person with mental illness becomes involved with the criminal justice system.

Description

NAMI Wisconsin has 34 affiliates serving 40 counties throughout the state, with a membership of nearly 5,000 people. NAMI Wisconsin published the *Manual for Families and Professionals Including Jail Diversion Strategies* in 1998 and distributed it to sheriffs, jail administrators, human services administrators, and legal professionals. A collaborative effort with 16 different contributors from various fields, the handbook's goal is for persons with mental illness to receive better services and appropriate jail diversion.

The manual focuses on the possible path of someone with mental illness in the criminal justice system. The manual begins by introducing and describing the major mental illnesses and proceeds to describe the mental health system, explains the workings of the criminal justice system and commitment procedures, shows the option of jail diversion programs, details mental health services for persons who are incarcerated, and defines statutes and terms used in the Wisconsin Mental Health System. NAMI Wisconsin distributed the manual to all of its affiliates.

Contact Information

NAMI Wisconsin
4233 West Beltline Highway
Madison, WI 53711
Phone: (608) 268-6000
Fax: (800) 236-2988

STATE: **Wisconsin**

AGENCY/ORGANIZATION:

Wisconsin Correctional Service

PROGRAM TITLE:

Community Support Program (Milwaukee)

POLICY STATEMENT(S):

Pretrial Release/Detention HearingYEAR ESTABLISHED: **1978**

Overview

Participation in the community-based program is offered as an alternative to incarceration for offenders with mental illness, or as a preventive measure for individuals with mental illness in the community who are at high risk for incarceration.

Description

Developed more than 20 years ago in response to overcrowded jails, a lawsuit, and a burgeoning number of persons with mental illness entering the criminal justice system, the Community Support Program (CSP) is designed to help offenders with mental illness live successfully in the community. The CSP operates out of a small clinic staffed by nurses, case managers, and a psychiatrist. In addition to providing mental health treatment, the CSP helps clients obtain benefits and housing. Services provided are clustered into groups, and one or more staff members handle a "clustered" service. For example, a full-time financial services advocate manages clients' benefits claims, while another caseworker handles housing services. This allows staff to develop expertise in their individual area, aiding in negotiations with the community.

Referrals to the program commonly come from other programs that the Wisconsin Correctional Service operates for the state's courts, such as pretrial services. Other referral sources include probation and parole, private attorneys, and psychiatric hospitals. Core elements of the model include the following: medical and therapeutic services, money management, housing and other support services, day reporting and close monitoring, and participation backed by firm legal authority.

The Milwaukee CSP collects a variety of yearly program-level and client-level outcome data. Highlights of their 1999 Annual Evaluation Report include the following:

- 93 percent of CSP consumers maintained their independent living status;
- 87 percent of CSP consumers remained arrest free during this time period.

In addition, new data will be collected and measured by the program in 2001. New information will include responses to a consumer survey regarding consumers' feelings about program

Wisconsin Correctional Service
continued

services, data on consumers' employment status, psychiatric symptom management, and a measure of independent living.

Challenges/Areas for Improvement

In 1995, two components were added to the existing CSP model: an employment program and a 24 hour a day, 7 days a week Forensics CSP to provide outreach to clients who were unsuccessful in the site-based CSP or who need assistance in their home. A more recent need identified by the program is more hospital and crisis beds available in the community.

Contact Information

Community Support Program
Wisconsin Correctional Service
2023 W. Wisconsin Avenue
Milwaukee, WI 53233
Phone: (414) 344-6111
Web site: www.wiscs.org

STATE: **West Virginia**

AGENCY/ORGANIZATION:

Division of Corrections, Mt. Olive Correctional Complex

PROGRAM TITLE:

Behavior Modification Treatment Level System

POLICY STATEMENT(S):

Development of Treatment Plans, Assignment to Programs and Classification/Housing Decisions

YEAR ESTABLISHED: **N/A**

Overview

The WV Division of Corrections has implemented a Behavior Modification Treatment Level System at the Mt. Olive Correctional Complex. Mental health staff at the facility have established this system to facilitate effective inmate management and to provide an incentive for inmates placed in the Mental Health Unit (MHU) to achieve an appropriate functioning level.

Description

Prior to the implementation of the system on the Mental Health Unit, inmates housed in this area were locked down in their cells for twenty-three hours per day. Programming levels were not in place and the inmates were not receiving individualized mental health treatment. Prior to implementation, four-point restraint techniques occurred on a regular basis; since its implementation, these techniques have been used only in one incident. Additionally, inmates on the MHU used to be single-celled with limited inmate-to-inmate contact. Since the implementation of this system, the MHU inmate population has been sufficiently stabilized to allow for double bunking.

Challenges/Areas for Improvement

One of the fundamental challenges for effective implementation of this system has been in the selection of staff that are philosophically aligned with an rehabilitative model as opposed to a punitive model. An interview selection board was used to screen potential staff to work on the mental health unit: employees more geared toward working in a punitive environment are less receptive to support the treatment level systems. Additional challenges include the perceptions of facility staff regarding inmates assigned to the MHU. Through a combination of education and incremental steps, the facility has integrated the otherwise segregated mental health population into the general population. Using structured recreation time and softball games helped to alleviate anxieties among both staff and members of the inmate population (both general and MHU). Inmate compliance with psychotropic medication regimens recommended by the treating psychiatrists also presented a challenge, which has been mitigated by consistent treatment and the building of rapport between the treatment team and the inmates.

Division of Corrections, Mt. Olive Correctional Complex
continued

Contact Information

Mount Olive Correctional Complex
1 Mountainside Way
Mount Olive, WV 25185
Phone: (304) 442-7213 or (304) 537-1407
Fax: (304) 442-7225

STATE: **N/A**

AGENCY/ORGANIZATION:
Federal Bureau of Prisons

PROGRAM TITLE:
Pharmacy and Therapeutics Committee

POLICY STATEMENT(S):
Development of Treatment Plans, Assignment to Programs, and Classification/Housing Decisions

YEAR ESTABLISHED: **N/A**

Overview

In order to deliver consistent and cost-effective medical care, the Pharmacy and Therapeutics Committee of the Federal Bureau of Prisons (BOP) established the National Formulary for the Federal Bureau of Prisons. The Committee's objectives are to ensure that inmate medical care will be delivered consistently and cost-effectively as a result of the Formulary's implementation.

Description

Implementation of the formulary includes review of evidence-based scientific literature for both new and existing drugs and to determine their appropriate role in BOP's pharmacotherapeutic armamentarium. It is the committee role, through the National Formulary, to stay current with BOP Clinical Treatment Guidelines for medical and mental health conditions, as well as to reflect the generally accepted professional practices of the medical community at large.

The committee meets annually and is composed of pharmacists and clinicians from the bureau and other institutions and includes the chief physician and chief psychiatrist. It is chaired by the chief pharmacist. The committee reviews the formulary and updates it according to evidence-based medicine. New drugs are reviewed by conducting literature searches and cost/benefit analyses to determine whether the side effect of a given drug is worth the benefit of administering it.

The committee promotes the use of atypical drugs over typical drugs due largely to the side effects attributed to more traditional or typical medication. They encourage clinicians to contact them with information about the use of new drugs in order to have outcome information available at the annual meeting. If there is a request at the institution level for a drug that is not on the formulary, the committee checks the diagnosis to ensure an appropriate correlation for the condition, checks whether there is an existing medication in the formulary that they believe is as effective and, if so, will not approve the request. The only experimental drugs that are approved are those that have been approved by the Federal Drug Administration.

Contact Information

Health Programs Section
Federal Bureau of Prisons
320 First St., NW
Washington, DC 20534
Phone: (202) 307-2867, ext. 106.

STATE: **N/A**

AGENCY/ORGANIZATION:
Federal Judicial Center

PROGRAM TITLE:
Handbook for Working with Mentally Disordered Defendants and Offenders

POLICY STATEMENT(S):
Training for Courts Personnel

YEAR ESTABLISHED: **N/A**

Overview

The Handbook for Working with Mentally Disordered Defendants and Offenders is a reference guide for federal probation and pretrial services officers. It details mental health disorders and ways to identify and supervise defendants and offenders with mental illness.

Description

The handbook discusses symptoms for which federal parole officers should look that may suggest a mental illness. The manual utilizes the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* to outline the typical features of a prisoner with a given illness, such as schizophrenia or post-traumatic stress disorder. The manual also covers the supervision of individuals with co-occurring disorders. The final section analyzes the different classes of child molesters and pedophiles so that officers of the court may better identify them. There is also a glossary defining much of the terminology found in mental health cases.

Contact Information

Federal Judicial Center
Thurgood Marshall Federal Judiciary Building
One Columbus Circle NE
Washington DC 20002-8003
Phone: (202) 502-4000
Web site: www.fjc.gov

STATE: **N/A**

AGENCY/ORGANIZATION:
International Center for Clubhouse Development

PROGRAM TITLE:
Clubhouse Certification

POLICY STATEMENT(S):
Consumer and Family Member Involvement

YEAR ESTABLISHED: **2001**

Overview

The International Center for Clubhouse Development (ICCD) publishes standards for programs that receive its certification.

Description

Started at Fountain House in New York, clubhouses have become an integrated part of the mental health community in many areas. The International Center for Clubhouse Development (ICCD) publishes standards for programs that receive its certification. Among its most firmly held principles is the importance of employment in the recovery of clubhouse "members." Two of the ICCD standards are meant to encourage training and consistency in maintaining benefits of members who are working in transitional or more competitive employment. Clubhouses receiving ICCD certification are expected to provide sufficient training to ensure appropriate access to benefits by clubhouse members.

The International Standards for Clubhouse Programs, consensually agreed upon by the worldwide clubhouse community, define the Clubhouse Model of rehabilitation. The principles expressed in these standards are at the heart of the clubhouse community's success in helping people with mental illness to stay out of hospitals while achieving social, financial, and vocational goals. The standards also serve as a kind of "bill of rights" for members and a code of ethics for staff, board, and administrators. The standards insist that a clubhouse is a place that offers respect and opportunity to its members. The standards provide the basis for assessing clubhouse quality, through the International Center for Clubhouse Development (ICCD) certification process.

Every two years the worldwide clubhouse community reviews these standards, and amends them as necessary. The process is coordinated by the ICCD Standards Review Committee, made up of members and staff of ICCD-certified clubhouses from around the world.

Contact Information

International Center for Clubhouse Development
425 West 47th Street
New York, NY 10036
Phone: (212) 582-0343
Fax: (212) 397-1649
Email: iccdnyc@compuserve.com
Web site: www.iccd.org/

STATE: **N/A**

AGENCY/ORGANIZATION:

Mental Health Statistics Improvement Program

PROGRAM TITLE:

Consumer Surveys

POLICY STATEMENT(S):

AccountabilityYEAR ESTABLISHED: **1996****Overview**

Under the auspices of the Mental Health Statistics Improvement Program (MHSIP), consumers and professionals have worked together to develop consumer surveys that are now in use in a number of states. These surveys, which in some states have been translated into Spanish, Cambodian, traditional Chinese, Portuguese, Russian, and Vietnamese, among other languages, provide an opportunity for consumers to evaluate the services that they receive.

Description

The MHSIP, which is supported by the Center for Mental Health Services, seeks to provide objective, reliable and comparable information about mental health services to help mental health policymakers and providers improve those services. Originally organized in the 1970s, the MHSIP is guided by the MHSIP Ad Hoc Group, which is composed of representatives from local, state, and federal mental health agencies, recipients of mental health treatment, advocacy group representatives, and delegates from related social service providers.

The MHSIP Consumer Survey is a key component of the MHSIP Consumer Report Card, which is an effort to develop a tool to assess the quality and cost of mental health and substance abuse services. The Consumer Survey has been increasingly adopted by states and other entities for implementation since it became available in 1996.

The original version of the survey contained 40 questions, including questions about general satisfaction, access to services, appropriateness of treatment, and outcomes of care. A more recent version, developed in February 2000, has 28 questions. Since 1996, the survey has since been adapted and modified slightly by different states.

Contact Information

Mental Health Statistics Improvement Program

Phone: (405) 522-3824

Web site: www.mhsip.orgSTATE: **N/A**

AGENCY/ORGANIZATION:

NAMI (National Alliance for the Mentally Ill)

PROGRAM TITLE:

Training Courses

POLICY STATEMENT(S)/ISSUE:

WorkforceYEAR ESTABLISHED: **1990****Overview**

NAMI has developed a comprehensive course for mental health providers, which is taught by mixed teams of consumers and family members. NAMI has also developed training courses for consumers and families to help them better understand and manage their mental illness or support their family members who have mental illness.

Description

The NAMI Provider Education Program is designed to help mental health providers better understand the consumer experience of mental illness. The teaching team for the provider course consists of five people: two family members; two consumers; and a mental health professional who is also a family member or a consumer. All of the teaching team members are appropriately trained educators.

The provider course is currently being taught in 13 states: Connecticut, Indiana, Kentucky, Minnesota, Missouri, Montana, New Jersey, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont, Washington, Washington DC, and Wisconsin. Evaluations of early classes indicate that providers have changed clinical practice as a result of what they have learned in the course.

The NAMI Family-to-Family Education Program is a free 12-week course for family caregivers of individuals with severe brain disorders (mental illnesses). The course is taught by trained family members. All instruction and course materials are free for class participants. Developed by NAMI-Vermont in 1990, the course is now taught by more than 2,000 trained NAMI volunteers in 43 states, four large municipalities, and two provinces of Canada. To date, 50,000 family members have graduated, and the project continues to expand.

The Family-to-Family curriculum focuses on schizophrenia, bipolar disorder (manic depression), clinical depression, panic disorder, and obsessive-compulsive disorder (OCD). The course discusses the clinical treatment of these illnesses and teaches the knowledge and skills that family members need to cope more effectively.

NAMI (National Alliance for the Mentally Ill)
continued

NAMI also offers a course called “In Our Own Voices: Living with Mental Illness.” This course is an informational outreach program on recovery presented by trained consumers to other consumers, families, students, professionals, and all people wanting to learn about mental illness. The course is designed to help people better understand the process of coping with serious mental illnesses.

Contact Information

NAMI
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Web site: www.nami.org

STATE: **N/A**

AGENCY/ORGANIZATION:

National Association of State Mental Health Program Directors (NASMHPD) Research Institute

PROGRAM TITLE:

Center for Evidence Based Practices

POLICY STATEMENT(S)/ISSUE:

Evidence-Based Practices

YEAR ESTABLISHED: **2001**

Overview

The NASMHPD Research Institute is joining with the New Hampshire Dartmouth Psychiatric Research Center and the Medical University of South Carolina to develop methods for the dissemination of Evidence Based Practices.

Description

The Center for Evidence Based Practices, which is supported by various government and foundation sources, will provide hands-on assistance with replication of proven interventions. At the same time, the center will conduct research to determine those factors that improve acceptance and implementation of proven models.

The center’s mission is to help state mental health agencies (SMHA) develop and implement evidence based practices, performance measures, and quality improvement processes. To accomplish this mission the center will pursue three major activities. First, the center will identify, share and promote knowledge about evidence-based practices. This will involve serving as a repository of innovative programs and national trends, surveying states on key issues, hosting national and regional conferences, and maintaining a dedicated website. Second, the center will conduct research and develop knowledge about evidence-based practices, including studying emerging and promising practices to transform them to an evidence based foundation. Third, the center will provide technical assistance to individual states, including convening in-state focus groups, bringing in outside experts, and evaluating the design and implementation of state-based evidence based practice programs.

Challenges/Areas for Improvement

Over the last few years, states have implemented mental health performance measurement systems. As states move forward, they encounter issues related to standardization, implementation, benchmarks, and uses of the performance measures. Quality improvement initiatives to address these concerns are needed at the systemic level rather than at the programmatic or service levels. In addition, states need to better learn from ventures in different states.

National Association of State Mental Health Program Directors (NASMHPD) Research Institute
continued

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STATE: **N/A**

AGENCY/ORGANIZATION:
National Council for Community Behavioral Healthcare (NCCBH)

PROGRAM TITLE:
Governing Principles

POLICY STATEMENT(S)/ISSUE:
Consumer/Family Member Involvement

YEAR ESTABLISHED: **1970**

Overview

The National Council for Community Behavioral Healthcare (NCCBH) includes the following among the principles of governance it suggests to its members: "Governing boards should include members of or access to the views and input of individuals who are consumers and/or family members of consumers of the organization's services."

Description

NCCBH is a nonprofit trade association serving the education, advocacy, and networking needs of more than 800 community providers of mental health and addiction treatment services. Since 1970, the National Council has grown to become an important voice in the shaping of federal law, policy, and regulations that govern the behavioral health care world.

The goals of NCCBH are as follows:

- advocate for public policy that promotes their vision and secures adequate resources promote development of innovative, locally responsive services in nontraditional settings;
- promote development of fair exchange partnerships and alliances among and between consumers, public and private payers, providers and others; and
- provide business development and managerial training that empowers members to support their vision in a rapidly changing health care environment.

Contact Information

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Web site: www.nccbh.org

STATE: **N/A**

AGENCY/ORGANIZATION:

National Parole Board of Canada

PROGRAM TITLE:

**Risk Assessment for Pre-Release Decisions/
Post-Treatment Report**

POLICY STATEMENT(S):

Release Decision

YEAR ESTABLISHED: **1995**

Overview

The National Parole Board of Canada conducts psychological and psychiatric examinations as part of its risk assessment procedures for certain inmates.

Description

Psychological and psychiatric examinations are standard elements of the National Parole Board risk-assessment procedures; there are no separate risk-assessment procedures solely for offenders with mental illness. Prerelease psychological and psychiatric examinations are required for some inmates and can be requested when information concerning the mental status of the offenders is not otherwise sufficient.

The National Parole Board standards are based on the consideration of two elements: 1) Information about the offender's criminal history risk factors and assessment of identified areas at time of incarceration; and 2) Information about the behavior of the offender during incarceration or on conditional release in the community. Issues relevant to offenders with mental illness that are considered include the impact of treatment programs in which the offender has participated (the offender must have benefited from these programs), the effect of medication that the offender is prescribed, and the release plan that addresses the programming and other community-based interventions that will contribute to the inmate's success.

Contact Information

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410 Laurier Avenue West
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K1A 0R1
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Fax: (613) 995-4380
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STATE: **N/A**

AGENCY/ORGANIZATION:

National Parole Board of Canada

PROGRAM TITLE:

New Board Member Training

POLICY STATEMENT(S):

Training for Corrections Personnel

YEAR ESTABLISHED: **1994**

Overview

New board members of the National Parole Board of Canada receive extensive training on issues regarding offenders with mental illness. The parole board utilizes standard reference materials on mental illness and risk assessment as well as materials developed internally.

Description

New Parole Board Members are acquainted with the *Diagnostic Manual for Mental Disorders*, a standard reference tool about mental illness. The *Diagnostic Manual* contains information on symptomatology and treatment of a wide variety of mental illnesses. The training also covers the *Historical and Clinical Risk Guide for Violent Offenders with Mental Illness* (also known as HCR20), which is a standard publication used in criminal justice and noncriminal justice situations (e.g., hospital emergency wards). In addition, one of the chapters of the National Parole Board's internal risk-assessment manual is devoted to issues related to offenders with mental illness, and the board is in the process of developing an even more in-depth guide to this subject for parole board members. The board uses case studies as part of the training and contracts with experts in the field of mental health and criminal justice to help deliver the training.

Challenges/Areas for Improvement

One of the biggest challenges noted by the director of Board Member Training is the difficulty in overcoming the stigma surrounding mental illness as well as keeping training information current.

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STATE: **N/A**AGENCY/ORGANIZATION:
N/APROGRAM TITLE:
Assertive Community Treatment (ACT or PACT)POLICY STATEMENT(S):
Integration of ServicesYEAR ESTABLISHED: **1970s****Overview**

ACT programs provide comprehensive, locally based treatment to people with serious and persistent mental illness.

Description

The Program of Assertive Community Treatment model was developed in Madison, Wisconsin, in the 1970s. Six states (Delaware, Idaho, Michigan, Rhode Island, Texas, Wisconsin) currently have statewide ACT programs. Nineteen states have at least one or more ACT pilot programs in their state.

Unlike many other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, around-the-clock staffing of a psychiatric unit, but within their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. Recently, ACT teams have placed a greater emphasis on inclusion of consumers as treatment team members, either in the traditional professional positions or as peer counselors able to communicate more effectively with a team's clients.

ACT teams provide services 24 hours a day, seven days a week, 365 days a year. To make ACT programs more accessible, states have adopted funding strategies approved by Medicaid for this purpose. As part of their contracting process, states monitor ACT programs for compliance with certain agreed-upon practice standards.

ACT strives to lessen or eliminate the debilitating symptoms of mental illness each individual client experiences and to minimize or prevent recurrent acute episodes of the illness, to meet basic needs and enhance quality of life, to improve functioning in adult social and employment roles, to enhance an individual's ability to live independently in his or her own community, and to lessen the family's burden of providing care.

The ACT model is indicated for individuals in their late teens to their elderly years who have a severe and persistent mental illness causing symptoms and impairments that produce

Assertive Community Treatment (ACT or PACT)
continued

distress and major disability in adult functioning (e.g., employment, self-care, and social and interpersonal relationships). ACT participants usually are people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder (manic-depressive illness); those who experience significant disability from other mental illnesses and are not helped by traditional outpatient models; those who have difficulty getting to appointments on their own as in the traditional model of case management; those who have had bad experiences in the traditional system; or those who have limited understanding of their need for help.

Challenges/Areas for Improvement

Despite the documented treatment success of PACT, only a fraction of those with the greatest needs have access to this uniquely effective program. In the United States, adults with severe and persistent mental illnesses constitute one-half to one percent of the adult population. It is estimated that 20 percent to 40 percent of this group could be helped by the ACT model if it were available.

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An Explanation of Federal Medicaid and Disability Program Rules¹

INCOME-SUPPORT BENEFITS

People with disabilities, including those disabled by a severe mental illness, are entitled to monthly income-support payments through two different federal programs: SSI for those with low incomes and SSDI for people who have worked and paid Social Security taxes. Many people whose SSDI benefit is too low because they worked only a short time can qualify for both SSDI and SSI.²

These federal disability benefits are linked with health care coverage:

- In most states, SSI recipients automatically have Medicaid coverage. Where they do not, a separate application will enable most to secure Medicaid.³
- All SSDI recipients qualify for Medicare after a 24-month wait. People who have been getting SSI or SSDI payments when arrested cannot receive benefits while in jail. But whether and how they remain eligible when released varies.

When Inmates Lose SSI

Generally, the length of time a person is in jail determines whether, or when, federal SSI benefits will be affected. The monthly payments are nearly always interrupted while someone is in jail, but benefits are payable up until the time of incarceration and sometimes a little longer, and can resume shortly thereafter, as long as the person has been in jail less than a year (see below).

When incarceration is for less than 12 consecutive months, the federal Social Security Administration (SSA) considers this a “suspension” and payments should resume soon after the person leaves jail—as long as SSA is informed of the release and the person submits a simple form with evidence showing that he or she again meets the financial requirements.⁴ SSA presumes that these individuals remain disabled under federal rules.

To complete this reapplication process, the Social Security office must be able to verify that the person has been released. Families, community mental health workers or jail administrators can assist people in this situation by making sure SSA is alerted to the need to resume benefits and told where to send the checks.

1. The information in this appendix is reprinted with the permission of the Bazelon Center for Mental Health Law from their policy brief, *For people with serious mental illnesses: Finding the Key to successful transition from jail to community*, March 2001. *Finding the Key* is available online at: www.bazelon.org/findingthekey.html or can be ordered at: <http://store.bazelon.org>.

2. SSDI benefit amounts depend on wages and length of time employed. For more

information on the complex eligibility rules for SSI and SSDI, contact a local Social Security Office or call 1-800-772-1213.

3. The following states do not automatically grant Medicaid coverage to those on SSI: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia

4. 20 C.F.R. § 416.1321(b).

People who have been incarcerated for a year or more and have had their benefits suspended for at least 12 months must file a completely new application for SSI upon their release. They will have to show that they are still disabled under the eligibility standards (see below).

When Inmates Lose SSDI

People who qualify for SSDI remain eligible as long as they meet the federal definition of disability. SSDI benefits are suspended following a conviction and confinement in jail for 30 days or longer. But SSDI benefits are not terminated, no matter how long the term. However, Social Security must verify that the person is no longer in a correctional facility before payments can resume. Specifically:

- SSDI benefits are suspended if someone has been convicted and confined in jail longer than 30 days, whether or not it is a full calendar month.⁵
- SSDI benefits are suspended for any 30-day period during which an individual is confined in a jail or prison in connection with a verdict of not guilty by reason of insanity or guilty but insane, or a finding of incompetence to stand trial.⁶
- SSDI benefits that were already paid are recovered. For example, someone arrested on the fifth of the month who has already cashed that month's check will have future checks reduced until the benefits paid for that month are recovered.

Federal rules on payment of SSDI benefits to inmates were different for people incarcerated before April 1, 2000.⁷ The above description applies to everyone incarcerated since that date. A worker's dependents, such as a spouse or child, sometimes receive SSDI.

These payments are not suspended or terminated when the worker is in jail; they continue even when the worker loses benefits.⁸

How Time in Jail Affects Eligibility for SSI Benefits

In jail less than one calendar month: Inmate remains eligible for SSI and should receive the full cash benefit.

For example, someone who enters jail on February 10 and is released before midnight March 31 should lose no cash payments.

In jail throughout a calendar month: Inmate will have SSI payments suspended but not terminated.⁹ This means that an inmate who is in jail on the first of the month and stays the whole month is not eligible for a cash payment for that month.

For example, someone who enters jail on February 10 and is not released until April 1 will not lose February's payment (not being in jail for the whole month) but will lose the March payment.

In jail at least one month and then released after the first of another month: Inmate can receive an SSI cash payment for part of the month in which he or she is released.¹⁰

For example, someone who enters jail on February 10 and is released May 15 the same year will not lose the February payment, but will lose March and April benefits. In May, the person will be eligible for half of the monthly benefit. While this will be paid eventually, it could be delayed if the Social Security Administration (SSA) is not informed promptly that the individual has been released.

In jail for 12 consecutive calendar months: Inmate's eligibility is terminated.¹¹ Technically, termination occurs after 12 continuous months of suspension. Only full months count.

For example, someone who enters jail on February 1st of one year and is released on February 10th the following year will have SSI eligibility terminated because benefits were suspended for 12 continuous months. This person will have to file a new application and resubmit evidence of disability.

But someone who enters jail on February 10th of one year and is released on February 10 a year later has benefits suspended for March through January and prorated for February of the second year. This person's eligibility will not be terminated because benefits were not suspended for 12 continuous months.

Qualifying for SSI or SSDI on Release

Inmates not receiving benefits when sent to jail can apply for SSI or SSDI while incarcerated, in anticipation of their release. They usually need assistance, however, to obtain the appropriate forms and gather the necessary evidence.

5. 42 U.S.C. § 402(x)(1)(A)(i), as amended by Public Law 106-170.

6. 42 U.S.C. § 402(x)(1)(A)(ii) as amended by Public Law 106-170.

7. The old rules will continue to apply to individuals whose jail or prison confinement began before April 1, 2000. Although it is not described here, the Bazelon Center has a memorandum that lays out those rules. If you would like a copy, send a request with a stamped (\$.34) self-addressed envelope to: Bazelon Center Publica-

tions Desk, 1101 15th Street N.W., Suite 1212, Washington D.C. 20005

8. 20 C.F.R. § 404.468(a).

9. 20 C.F.R. § 416.211

10. 20 C.F.R. § 416.421

11. 20 C.F.R. § 416.1335

Normally, review of an application takes about three months, so an inmate should apply as long as possible before the release date.

SSA will assess eligibility based on the application. If it is approved before the inmate's release, payments will begin as of the first day of the calendar month following release.¹² If the application is approved after the inmate is released, benefits are payable at that time, and SSI (but not SSDI) benefits are backdated to the first day of the month following release.

An individual with a severe mental illness may also qualify for advance emergency payments. To be eligible, people must demonstrate:

- a financial emergency;
- that they are likely to qualify for assistance; and
- that they have not already received assistance for that benefit period.

Why Benefits Are Lost and What Can Be Done About It

Jails have an incentive to inform SSA that a person is confined; they receive federal payments when they supply information resulting in suspension or termination of SSI or SSDI benefits. But they have no such incentive to advise SSA when someone is released so that benefits can be restored.

Jails and prisons can enter into agreements with SSA to provide monthly reports of inmates' names, Social Security numbers, dates of birth, confinement dates and other information. The institution receives \$400 when this information is sent within 30 days of the inmate's arrival and \$200 if it is sent within 90 days.¹³ This information should-but does not always-include an estimated release date.

Jails, prisons and hospitals can also enter into pre-release agreements with the local Social Security office, which will help their staff learn the rules for pre-release processing of applications and reapplications for SSI.¹⁴ When such an agreement exists, SSA processes claims more quickly, inmates have assistance in gathering the information needed to support their application, and benefits are often payable immediately upon release or shortly thereafter.

Health Care Coverage

Medicare and Medicaid are two sources of health coverage. People eligible for SSDI (and those over age 65) are covered by Medicare, after a 24-month wait. Low-income individuals qualify for Medicaid in various ways; in most states anyone who qualifies for SSI is covered. Medicaid provides better mental health care coverage than Medicare.

Medicaid

Medicaid is a joint federal-state program. To qualify, a person must fall into one of several eligibility categories. Once eligible, the individual is covered by a package of services defined by the state under broad federal requirements. Federal law requires some services to be available, such as physician services and general hospital care. Others are offered at state option-among them, various community-based mental health clinic and rehabilitative services. As a result, Medicaid coverage varies from state to state. However, all states cover a significant array of mental health services for people with severe mental illnesses.

Most jail inmates with severe mental illnesses have incomes below the Medicaid limit and may therefore be eligible for coverage. Usually their eligibility for SSI is what qualifies them for Medicaid. In 32 states, SSI eligibility results in automatic Medicaid coverage. In seven other states, SSI recipients are automatically eligible for Medicaid but must submit a separate application for Medicaid. In the 11 states that use different rules,¹⁵ people who receive SSI nearly always qualify for Medicaid, although they must go through a separate application process.

Some low-income individuals do not receive SSI or SSDI disability benefits, either because their disability is not severe enough to meet strict federal standards or because they have not applied. But they may still be eligible for Medicaid.

Currently, 39 states cover people who become "medically needy" when their income is reduced by high health care expenses.¹⁶ States can extend Medicaid coverage to people in other categories, such as low-income families or individuals who, without access to community-based services, would be forced to live in a health care institution. Also, a number of states use waivers of federal rules to cover other groups of uninsured low-income people through Medicaid.

12. 20 C.F.R. § 416.211

13. 42 U.S.C. § 1382(e)(1)(I) as amended by Public Law 104-193, the Personal Responsibility & Work Opportunities Reconciliation Act of 1996 (SSI-incentive effective for reporting individuals whose confinement began after March 1, 1997); 42 U.S.C. § 402(x) as amended by Public Law 106-170, the Ticket to Work & Work Incentives Improvement Act of 1999 (SSDI-incentive effective for reporting individuals whose confinement began after April 1, 2000).

14. Pre-Release Procedure for the Institutionalized, authorized under Section

1631(m) of the Social Security Act, 42 U.S.C. § 1383(m). See POMS SI 00520.900-930 (Eligibility).

15. See note 2.

16. 42 C.F.R. § 435.300. States that do not cover the medically needy population under Medicaid are: Alabama, Arkansas, Arizona, Colorado, Delaware, Indiana, Mississippi, Missouri, Nevada, New Mexico, Ohio, South Carolina, South Dakota and Wyoming.

17. Social Security Act § 1905(a)(A) and 42 U.S.C. § 1396(d)(a)(27)(A).

Information about eligibility rules can be obtained from the state Medicaid agency.

Medicaid Rules on Jail Inmates

Under Medicaid law, states do not receive federal matching funds for services provided to individuals in jail.¹⁷ However, federal law does not require states to terminate inmates' eligibility, and inmates may remain on the Medicaid rolls even though services received while in jail are not covered.¹⁸ Accordingly, someone who had a Medicaid card when jailed may be able to use it again immediately after release to obtain needed services and medication.

However, the situation for inmates who qualify for Medicaid through their eligibility for SSI can be complicated. Everyone whose SSI eligibility is terminated will lose Medicaid. When SSI benefits are suspended due to incarceration, states have the option to—and generally do—terminate an inmate's Medicaid eligibility.

When an inmate's Medicaid eligibility is not tied to SSI, the state has the flexibility under federal law to suspend the eligibility status during incarceration. But the federal Medicaid rules establish only minimum requirements, while states are permitted to impose more restrictive policies.¹⁹ Unfortunately, most states have procedures that terminate Medicaid eligibility automatically any time someone is in jail.²⁰

Under federal rules, eligibility should be reinstated upon release unless the person is no longer eligible (see below). Before ending someone's Medicaid eligibility, states must make a redetermination of the person's potential for qualifying under all the state's eligibility categories.²¹ This redetermination need not be conducted until release is imminent, but if the released inmate still meets the state's eligibility standards for Medicaid, eligibility should not be ended. Regrettably, this redetermination often does not occur.

Even inmates who keep their Medicaid eligibility may lose Medicaid coverage unnecessarily because of procedures in correctional facilities. Something as simple as the loss of a Medicaid card following arrest can make it impossible to obtain mental health services from Medicaid providers upon release. This often happens because jails take possession of all personal property when booking a person. In many jurisdictions, this property is destroyed if it is not claimed within a certain time. Inmates cannot claim the property themselves

and if they have no one to do it for them, their Medicaid card is destroyed.

There is one exception to the rule that no Medicaid reimbursement is available for jail inmates. When someone is transferred from a jail to a hospital for acute health services (for example, an appendectomy), the hospital can claim federal Medicaid reimbursement for this service. Also, if a person is in an institution temporarily pending "other arrangements appropriate to his needs," services may remain Medicaid-reimbursable.²²

Generally, however, mental health services furnished to inmates must be funded by correctional systems or state or local mental health systems, not by Medicaid.

FEDERAL RULES ON MEDICAID REINSTATEMENT

- Jail inmates can have their Medicaid suspended.
- Upon release, federal policy requires that their benefits resume.
- Many individuals will be incarcerated for so long that their Medicaid benefits will have been suspended for longer than the state's customary period of time after which a redetermination of eligibility is conducted (time varies by state). The state will reassess whether these inmates remain eligible for Medicaid. However, this assessment should be conducted prior to release because, under federal policy, a state may not drop someone from Medicaid without determining whether or not the person can qualify under any of the state's eligibility categories.²³
- States are permitted to use simplified procedures for redetermining the eligibility of individuals who have been incarcerated, according to federal HCFA officials:²⁴ Regardless of the simplified procedures used, unless a state has determined that an individual is no longer eligible for Medicaid, States must ensure that incarcerated individuals are returned to the rolls immediately upon release. Thus, allowing individuals to go directly to a Medicaid provider and demonstrate his/her Medicaid eligibility.²⁵

18. Social Security Act § 1905(a)(A).

19. National Gains Center for People with Co-Occurring Disorders in the Justice System, *Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders* (1999); Tim Westmoreland, *Medicaid & HIV/AIDS Policy* 15-17 (1999).

20. *Ibid.*

21. 42 C.F.R. § 435.916.

22. 42 C.F.R. § 435.1009(b).

23. 42 C.F.R. § 435.916.

24. Letter from HHS Secretary Donna Shalala to Congressman Charles Rangel, April 6, 2000.

25. Letter from Sue Kelly, Associate Regional Administration, Division of Medicaid and State Operations, HCFA Region II, to New York Medicaid Director, September 14, 2000.

Coverage After Release

When Medicaid eligibility is linked to SSI, a person may have to jump through many administrative hoops before Medicaid benefits resume, depending on state policy and administrative procedures. For example, a former inmate may have to visit the local SSA and state Medicaid offices to confirm that he or she has been released and complete other administrative paperwork. As a result, people on SSI may have no health care coverage during the time between their release from jail and reinstatement of their SSI payments—normally at least one or two weeks.

One way services can be covered immediately after someone is released from jail is for the state to continue the person's Medicaid eligibility pending reinstatement on SSI, which will in turn restore federal Medicaid eligibility. Once the individual's SSI is reinstated, the federal government will provide retroactive reimbursement for Medicaid-covered services furnished for up to three months after the person left jail. This means that even though federal dollars may not be available immediately for services provided after release to former inmates whose Medicaid eligibility is tied to SSI, nearly all of these individuals will eventually be covered. Providers can be paid by the state and the state will eventually receive federal funds. The state will remain fully liable only for services to the very few individuals who are not found re-eligible for SSI and Medicaid.

Medicare

Medicare coverage is also suspended when someone is incarcerated. It will not resume until the person's SSDI payments resume. For more information on Medicare, call 1-800-MEDICARE (1-800-633-4227).

CONCLUSION

Federal rules on how and when inmates receive benefits are complex, but they do provide opportunities for inmates to obtain federal entitlements upon release. Instead of fostering recidivism, states and localities should support access to the benefits needed by people with severe mental illnesses who are released from jail.

Project History / Methodology

The *Criminal Justice / Mental Health Consensus Project Report* is the result of dozens of days of meetings among leading criminal justice and mental health policymakers and practitioners from across the country, surveys administered to state and local government officials in communities in 50 states, hundreds of hours of interviews with administrators of innovative programs, and thousands of hours reviewing materials describing research, promising programs, policies, and legislation. This appendix describes the history and the methodology of this project in greater detail.

PROJECT ORIGINS

The Council of State Governments (CSG) developed the Criminal Justice / Mental Health Consensus Project in response to requests from state government officials for recommendations to improve the criminal justice system's response to people with mental illness. State government officials identified this issue as particularly pressing for several reasons. Practitioners and advocates have approached lawmakers in capitols across the country explaining the urgency of the problem. Newspaper headlines describe tragedies involving people with mental illness that seemingly could have been prevented. And, the current approach to responding to people with mental illness has placed an enormous strain on criminal justice and state budget resources.

On October 28–29, 1999, CSG convened a small, national, bipartisan working group of leading criminal justice and mental health policymakers from across the country. At

that meeting, the policymakers identified key issues regarding people with mental illness involved with the criminal justice system. CSG staff developed a draft document, which, in many respects, served as minutes of that meeting. This draft document also incorporated suggestions that working group members submitted subsequent to the October meeting. The working group met again on January 19–20, 2000 to provide comments and suggestions regarding the draft document.

The two meetings made it clear that the issue was far too complex to explore comprehensively in just two short meetings. Furthermore, the interests represented needed to be expanded considerably to reflect the cross-section of perspectives and professionals who have a significant stake in the issue.

PROJECT ORGANIZATION

To accomplish these goals, CSG partnered with six organizations: the Police Executive Research Forum (PERF), the Pretrial Services Resource Center (PSRC), the Association of State Correctional Administrators (ASCA), the National Association of State Mental Health Program Directors (NASMHPD), the Bazelon Center for Mental Health Law, and the Center for Behavioral Health, Justice & Public Policy. Together, staff from these organizations formed the *Consensus Project* Steering Committee, which two legislators (Rep. Mike Lawlor of Connecticut and Sen. Robert Thompson of Pennsylvania) co-chaired. The Steering Committee designed an 18-month initiative to build on the ideas developed during the first two working group meetings, to broaden the support base for these

recommendations, and to identify efforts in jurisdictions across the country that could help inform the implementation of the recommendations.

The Steering Committee established four advisory boards: law enforcement, courts, corrections, and mental health. PERF, PSRC, ASCA, and NASMHPD, respectively, coordinated these advisory boards. The criminal justice advisory boards included policymakers and practitioners whose focus was either law enforcement, court, or corrections-related. Each of the criminal justice advisory boards also included a cross-section of representatives of the mental health system: a state mental health director, a clinician, a provider, a consumer, and an advocate. Of course, those five perspectives alone could not represent the diverse views of the mental health community. The mental health advisory board provided an opportunity for the mental health experts serving on each of the criminal justice advisory boards to share notes and develop recommendations that targeted the mental health system only.

In forming the advisory boards, each coordinator identified practitioners and policymakers widely respected by their counterparts across the country, ensuring an impressive level of expertise across the project. In addition, coordinators invited people to serve on the advisory board who were leaders in their respective membership associations, such as the National Sheriffs' Association, the National Correctional Health Commission, the American Probation and Parole Association, the National Association of County Officials, the National District Attorneys Association, the National Criminal Justice Association, the National Mental Health Association, the National Alliance for the Mentally Ill, the National Association of County Behavioral Health Directors, the National Center for State Courts, the International Association of Paroling Authorities, and other groups. This provided each advisory board with liaisons to many of the major associations whose members the policy statements would affect.

ROLE OF ADVISORY BOARDS

PERF and ASCA convened their advisory boards three times over the 18-month period. The advisory groups that

NASMHPD and PSRC coordinated met twice. They also established "peer groups." The positions represented on these peer groups were similar to those included on the advisory boards. The establishment of the peer group, however, enabled the coordinators to consult an additional 10-20 leading practitioners.

For each round of meetings, the advisory boards/peer groups adhered to a similar agenda, format, and set of goals. At the first round of meetings, each advisory board reviewed draft policy statements that the first two working group meetings generated, identified additional issues that needed to be considered, and agreed upon a methodology to identify programs, policies, and legislation that might inform further discussion of the policy statements. They also began planning the dissemination of the work product to affiliated professional organizations.

Between the first and second advisory board meetings, coordinators surveyed the field for promising programs and policies. PERF staff asked numerous departments whether they—or any other departments they knew of—were doing something innovative regarding people with mental illness. Using this snowball sample to identify a handful of departments, PERF subsequently interviewed in detail officials and staff at these agencies about their efforts.

Coordinators for the other advisory boards employed different approaches to obtain this information. NASMHPD staff administered an email list serve. ASCA staff distributed a lengthy questionnaire to every state corrections system and numerous jail and community corrections administrators. PSRC staff followed up on leads that advisory board members and the literature provided.

At the second round of meetings, advisory board (or peer group) members met to comment on the policy statements that the advisory board developed, explored the issues that the advisory group had determined needed further consideration, and discussed the programs and policies that the coordinators had identified.

For the third round of meetings, members of the four advisory boards met concurrently, in the same location. There, they reviewed and commented on the final draft of the *Consensus Project Report*. They also had an opportunity to exchange comments on the work of the other advisory boards.

Advisory Board	Coordinator	Meeting I	Meeting II	Meeting III
Law Enforcement	Police Executive Research Forum	October 23, 2000	May 31-June 1, 2001	
Courts	Pretrial Services Research Center	November 14-15, 2000	April 23-24, 2001	
Corrections	Association of State Correctional Administrators	November 30, 2000	May 17-18, 2001	January 10-11, 2002
Mental Health	National Association of State Mental Health Program Directors	January 8-9, 2001	April 17-18, 2001	

REPORT PREPARATION

PERF staff were the primary authors of Chapter II: Contact with Law Enforcement. PSRC staff and ASCA staff were the primary authors of Chapter III: Pretrial Issues, Adjudication, and Sentencing and Chapter IV: Incarceration and Reentry, respectively. NASMHPD staff authored Chapter I: Involvement with the Mental Health System, Chapter VII: Elements of an Effective Mental Health System, and Policy Statement 23: Maintaining Contact Between Individual and Mental Health System. Staff from the Bazelon Center and the Center for Behavioral Health, Justice & Public Policy contributed to the chapters that NASMHPD staff authored. They also provided extensive commentary on the chapters that focused on the various aspects of the criminal justice system.

CSG staff served as editors of the overall document. Although CSG staff were the lead writers of the sections and chapters not addressed above (i.e., Executive Summary, Introduction, Chapter V: Improving Collaboration, Chapter VI: Training Practitioners and Policymakers and Educating the Community, Chapter VIII: Measuring and Evaluating Outcomes, and the appendices), these sections of the report reflect an extensive, collaborative effort among the members of the Steering Committee and the members of the advisory boards.

The project partners developed and maintained a common vision for the report by communicating regularly—often speaking by telephone or emailing each other several times a day. In addition, over the two-year lifespan of the project, the Steering Committee had approximately 10 all-day meetings.

Steering Committee

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- Association of State Correctional Administrators (ASCA)
- Bazelon Center for Mental Health Law
- The Center for Behavioral Health, Justice, and Public Policy
- National Association of State Mental Health Program Directors (NASMHPD)
- Police Executive Research Forum (PERF)
- Pretrial Services Resource Center (PSRC)

PROJECT COORDINATOR

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The Council of State Governments (CSG) is a nonprofit, nonpartisan organization serving all elected and appointed state government officials. CSG's income is derived from five sources: annual dues paid by each state and member jurisdiction; donations from the private sector; federal grants; foundational grants; and secretariat group fees. Founded in 1933, CSG has a long history of providing state leaders with the resources to develop and implement effective public policy and programs. Owing to its regional structure and its constituency—which includes state legislators, judges, *and* executive branch officials—CSG is a unique organization. With its headquarters in Lexington, Kentucky, CSG has four regional offices, representing the West, Midwest, South, and East. The national Criminal Justice / Mental Health Consensus Project is coordinated by CSG's Eastern Regional Conference (CSG/ERC), which is the only CSG regional office with a criminal justice program.

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Association of State Correctional Administrators (ASCA)

ASCA is a membership organization comprised of the directors of state correctional agencies and the administrators of the largest jail systems in the United States. The association is dedicated to the improvement of correctional services and practices through promoting and facilitating the advancement of correctional techniques, research in correctional practices, and the development and application of correctional standards and accreditation. Formed in 1970, ASCA was formally incorporated as a New York State not-for-profit corporation in 1985.

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Bazelon Center for Mental Health Law

The Judge David Bazelon Center for Mental Health Law is a nonprofit legal advocacy organization based in Washington D.C. The Bazelon Center's advocacy is based on the principle that every individual is entitled to choice and dignity. The Center has fought successfully against institutional abuse and arbitrary confinement of individuals with mental illness, and for opening up public schools, workplaces, housing and other opportunities for community life.

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The Center for Behavioral Health, Justice, and Public Policy

The Center for Behavioral Health, Justice, and Public Policy promotes service integration for persons with mental illness and/or addictive disorders in the justice system. The center's initiatives focus on evidence-based practices and policies that divert individuals from criminal justice settings, improve their quality of care while under custody, and assure that upon discharge they have access to appropriate treatment and support services to ensure successful reentry to community settings.

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National Association of State Mental Health Program Directors (NASMHPD)

NASMHPD is an organization that advocates for the collective interests of state mental health authorities and their directors at the national level. NASMHPD analyzes trends in the delivery and financing of mental health services and identifies public mental health policy issues and best practices in the delivery of mental health services. The association apprises its members of research findings and best practices in the delivery of mental health services, fosters collaboration, provides consultation and technical assistance, and promotes effective management practices and financing mechanisms adequate to sustain the mission.

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Police Executive Research Forum (PERF)

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. Incorporated in 1977, PERF's primary sources of operating revenues are government grants and contracts and partnerships with private foundations and other organizations.

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Pretrial Services Resource Center (PSRC)

PSRC is an independent, nonprofit clearinghouse for information on pretrial issues and a technical assistance provider for pretrial practitioners, criminal justice officials, academicians, and community leaders nationwide. The center offers assistance regarding pretrial services programming and management and jail overcrowding. Since its inception in 1976, the Resource Center has helped criminal justice professionals achieve the often conflicting goals of supporting the rights of defendants, ensuring public safety, and maintaining the integrity of the criminal justice system by providing information, publications, training, and assistance on pretrial services at the federal, state, and local levels.

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Bibliography

- Alexander, M. J. *Validating the MINI Screen for Mental Health Problems in Chemical Dependency Treatment Settings*. Orangeburg, NY: The Nathan Kline Institute of the Center for the Study of Issues in Public Mental Health.
- _____. *Validating the DALI Screen for Substance Abuse in Mental Health Treatment Settings*. Orangeburg, NY: The Nathan Kline Institute of the Center for the Study of Issues in Public Mental Health.
- American Bar Association. *ABA Criminal Justice and Mental Health Standards*. Washington, DC: American Bar Association, 1989.
- _____. *ABA Standards for Criminal Justice: Pretrial Release*. Third edition. Washington, DC: American Bar Association, 1989.
- _____. *ABA Standards for Criminal Justice: Providing Defense Services*. Third edition. Washington, DC: American Bar Association, 1992.
- _____. *ABA Standards for Criminal Justice: Sentencing*. Third edition. Washington, DC: American Bar Association, 1994.
- American Correctional Association. *Standards for Small Jail Facilities*. Lanham, MD: American Correctional Association, 1989.
- _____. "Management of Mentally Ill Inmates." *Jail Managers Bulletin* III, no. 3 (1992).
- _____. "Working with Inmates with Mental Illness." *Jail Operations Bulletin* IV, no. 10 (1996).
- American Probation and Parole Association. *Probation and Pre-Sentence Investigation*. Position Statement. Available at: www.appa-net.org/about%20appa/probatio1.htm.
- American Psychiatric Association. *Jails and Prisons: Report of the Task Force on Psychiatric Services in Jails and Prisons*. Washington, DC: American Psychiatric Association, 1989.
- _____. *Diagnostic and Statistical Manual of Mental Disorders*. Fourth edition. Washington, DC: American Psychiatric Association, 1994.
- Appelbaum, Paul S. "Advance Directives for Psychiatric Treatment." *Hospital and Community Psychiatry* 42, no. 10 (October 1991).
- Applegate, Brandon, Holly Atkins, and Gillian F. Hobbs. "Mentally Ill and Substance Abusing Inmates: One Jail's Solution to Traditionally Fragmented Service Delivery." *American Jails* XII, no. 1 (March/April 1998): 69-72.
- Barr, Heather. *When a Person With Mental Illness Is Arrested: How to Help*. New York: Urban Justice Center, 2001.
- Barton, Richard. "Psychosocial Rehabilitation Services in Community Support Systems: A Review of Outcomes and Policy Recommendations." *Psychiatric Services* 50, no. 4 (April 1999).

- Bazon Center for Mental Health Law. *Finding the Key to Successful Transition from Jail to Community: An Explanation of Federal Medicaid and Disability Program Rules*. Washington, DC: Bazon Center for Mental Health Law, 2001.
- Bellasai, J. "Pretrial Diversion: The First Decade in Retrospect." *The Pretrial Services Annual Journal* 1 (1978).
- Beck, A.J. and L.M. Maruschak. *Mental Health Treatment in State Prisons, 2000: Bureau of Justice Statistics Special Report*. Washington DC: U. S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, June, 2001.
- Bixler, James B. and Brice D. Emery. *Successful Programs for Individuals with Co-Occurring Mental Health and Substance Abuse Disorders: Examples from Five States*. Alexandria, VA: National Association of State Mental Health Program Directors, National Association of State Alcohol and Drug Abuse Directors.
- Borum, R. *Misdemeanor Offenders with Mental Illness in Florida: Examining Police Response, Court Jurisdiction, and Jail Mental Health Services*. Tampa, Florida: University of South Florida, Department of Mental Health Law and Policy, Louis de la Parte Florida Mental Health Institute, 1999.
- Brown, Collie. "Jailing the Mentally III." *State Government News* (April 2001): 28.
- Burns, Robert J. *Strengthening the Mental Health Safety Net: Issues and Innovations*. Washington, DC: National Governors Association Center for Best Practices. Available at: www.nga.org/center.
- Butterfield, Fox. "Prisons Replace Hospitals for the Nation's Mentally III." *New York Times*, 5 March, 1998, Section A, p.1.
- California Board of Corrections. *Mentally III Offender Crime Reduction Grant Program: Annual Report June 2000*. Available at: www.bDCorr.ca.gov/cppd/miocrg/miocrg_publications/miocrg_publications.htm
- Clark, John and D. Alan Henry. "The Pretrial Release Decision." *Judicature* 81, no. 2 (1997).
- Cohen, Aaron, Kenneth Matyniak, and Janice Wilberg. "Milwaukee County Task Force on the Incarceration of Mentally III Persons." *American Jails* III, no. 2 (Summer 1989): 20-26.
- Cohen, Fred. *The Mentally Disordered Inmate and the Law*. Kingston, NJ: Civic Research Institute, 1998.
- Coleman, Ray. "How to Keep the Mentally III Out of Jail." *Corrections Managers' Report* IV, no. 3 (October/November 1998): 1-14.
- Conly, Catherine. *Coordinating Community Services for Mentally III Offenders: Maryland's Community Criminal Justice Treatment Program*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1999.
- Cox, Judith F. and Pamela C. Morschauser. "A Solution to the Problem of Jail Suicide." *Journal of Crisis Intervention and Suicide Prevention* 18, no. 4 (1997): 178-84.
- Cox, Judith F., Pamela C. Morschauser, Steven Banks, and James L. Stone. "A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems." *Journal of Behavioral Health Services and Research* 28, no. 2 (May 2001): 177-87.
- Cross, T., B. Bazron, K. Dennis, and M. Isaacs. *Towards a Culturally Competent System of Care: a Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, DC: Georgetown University Child Development Center, Child and Adolescent Service System Program Technical Assistance Center, 1989.
- Culhane, D. P., S. Metraux, and T. Hadley. "The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems." *Housing Policy Debate* 12, (2001).
- Denckla, Derek and Greg Berman. *Rethinking the Revolving Door: A Look at Mental Illness in the Courts*. New York: Center for Court Innovation. 2001.
- Ditton, Paula M. Bureau of Justice Statistics Special Report: *Mental Health and Treatment of Inmates and Probationers*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 1999.
- Dupont, Randolph. "How the Crisis Intervention Team Model Enhances Policing and Community Mental Health." *Community Mental Health Report* (November/December 2001).
- Drake, Robert. Presentation at National Corrections Conference. Boston: 18-20 July, 2001.
- Drake, Robert E., Susan M. Essock, Andrew Shaner, Kate B. Carey, Kenneth Minkoff, Lenore Kola, David Lynde, Fred C. Osher, Robin E. Clark, and Lawrence Rickards. "Implementing Dual Diagnosis Services for Clients With Severe Mental Illness." *Psychiatric Services* 52 (2001): 469-76.
- Drapkin, Martin. *Developing Policies and Procedures for Jails: A Step-by-Step Guide*. Lanham, MD: American Correctional Association, 1996.

- Druss, Benjamin. Robert M. Rohrbaugh, Carolyn M. Levinson, Robert A. Rosenheck. "Integrated Medical Care for Patients With Serious Psychiatric Illness: A Randomized Trial." *Archives of General Psychiatry* 58 (2001): 861-68
- Edens, J. F., R. H. Peters, and H. A. Hills. "Treating Prison Inmates with Co-occurring Disorders: An Integrative Review of Existing Programs." *Behavioral Sciences and the Law* 15, (1997): 439-57.
- Evans, Katie and J.M. Sullivan. *Dual Diagnosis: Counseling the Mentally Ill Substance Abuser*. New York: Guilford Press, 1990.
- Federal Task Force on Homelessness and Severe Mental Illness. *Outcasts on Main Street: A Report of the Federal Task Force on Homelessness and Severe Mental Illness*. Washington, DC: Government Printing Office, 1992.
- Felix, A., C. Barber, and M. Lesser. "Serving Homeless Paroled Offenders with Mental Illness." *Community Mental Health Report* (May/June 2001): 49-64.
- Giuliano, Joseph D. "A Peer Education Program to Promote the Use of Conflict Resolution Among At-Risk School Age Males." *Public Health Reports* 109, no. 2 (March-April 1994).
- Goldkamp, John. "Danger and Detention: A Second Generation of Bail Reform." *The Journal of Criminal Law and Criminology* 76, no.1 (1985).
- Goldkamp, John and Cheryl Irons-Guynn. *Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload: Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance, 2000.
- Gorman, Jack. *The Essential Guide to Psychiatric Drugs*. New York: St. Martin's Press, 1997.
- Griffin, P.A. "The Back Door of the Jail: Linking Mentally Ill Offenders To Community Mental Health Services." In *Jail Diversion for the Mentally Ill: Breaking Through the Barriers*. Colorado: U. S. Department of Justice, Federal Bureau of Prisons, National Institute of Corrections, 1990.
- Haddad, Jane. "Managing the Special Needs of Mentally Ill Inmates." *American Jails* VII, no. 1 (March/April): 62-65.
- Hare, Robert. "Psychopaths: New Trends in Research." *The Harvard Mental Health Letter*, (September 1995).
- Hartwell, S. W., D.H. Friedman, and K. Orr. "From Correctional Custody to Community: The Massachusetts Forensic Transition Program." *New England Journal of Public Policy* 16, no. 2 (Spring/Summer 2001): 73 - 81.
- Hatfield, Agnes. *Dual Diagnosis: Substance Abuse and Mental Illness*. Arlington, VA: National Alliance for the Mentally Ill, 1993.
- Haycock, Joel. "Listening to 'Attention Seekers': The Clinical Management of People Threatening Suicide." *Jail Suicide Update* 4, no. 4 (1992): 8-11.
- _____. "Manipulation and Suicide Attempts in Jails and Prisons." *Jail Suicide Update* 4, no. 4 (1992): 2-6.
- Hayes, Lindsay M and Joseph Rowan. *National Study of Jail Suicides: Seven Years Later*. Alexandria, VA: National Center on Institutions and Alternatives, 1988.
- _____. *Prison suicide: An Overview and Guide to Prevention*. Alexandria, VA: National Center on Institutions and Alternatives, 1995.
- The Health Foundation of Greater Cincinnati. *Mental Illness and Substance Abuse in the Criminal Justice System*. Cincinnati: The Health Foundation of Greater Cincinnati, 2000.
- Hiday, V. A., M. S. Swartz, J. W. Swanson, R. Borum, and H. R. Wagner. "Criminal Victimization of Persons with Severe Mental Illness." *Psychiatric Services* 50, no.1 (1999): 62-8.
- Janofsky, Jeffrey S., Mitchell H. Dunn, Erik J. Roskes, Jonathan K. Briskin, and Majstina Rudolph Lunstrum. "Insanity Defense Pleas in Baltimore City: An Analysis of Outcome." *American Journal of Psychiatry* 153, no.11 (November 1996): 1464-68.
- Keith, S., D. Regier, D. Rae, and S. Matthews. "The Prevalence of Schizophrenia: Analysis of Demographic Features, Symptom Patterns, and Course." *International Annals of Adolescent Psychiatry* 2 (1992).
- Kessler, R. C. et al. "A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness." In *Mental Health United States 1999*. Edited by R.W. Manderscheid and M. J. Henderson. Rockville, MD: Center for Mental Health Services, 1999.
- Koegel, Paul et al. "The Causes of Homelessness." In *Homelessness in America*. Oryx Press, 1996.

- Kupers, T. A. *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*. San Francisco: Jossey-Bass Publishers, 1999.
- Lamb, H. R., R. Shaner, D. M. Elliot, W. J. DeCuir, and J. T. Foltz. "Outcome for Psychiatric Emergency Patients Seen by an Outreach Police—Mental Health Team." *Psychiatric Services* 46, no. 12 (1995): 1267-71.
- Lamon, S. S., N. L. Cohen, and N. Broner. "New York City's System of Criminal Justice Mental Health Services." In *Serving Mentally Ill Offenders and Their Victims*. New York: Springer Publishing Company, 2001.
- Laudet, S., S. Magura, H. Vogel, and E. Knight. "Recovery Challenges Among Dually Diagnosed Individuals." *Journal of Substance Abuse Treatment* 18 (2000).
- Legal Action Center. *Getting to Work: How TANF Can Support Ex-Offender Parents in the Transition to Self-Sufficiency*. Washington, DC: Legal Action Center, April 2001.
- Lehman, A. F. and D. M. Steinwachs. "Translating Research into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations." *Schizophrenia Bulletin* 24 (1998): 1-10.
- Lev, Julian. "Jail as a Psychiatric Emergency Room." *American Jails* XII, no. 4 (September/October 1998): 72-74.
- Lezak, D. and E. Edgar. *Preventing Homelessness Among People with Severe Mental Illness: A Guide for States*. Delmar, NY: Policy Research Associates, National Resource Center on Homelessness. 1996.
- Lipton, Liz. "Suit Seeks Mandatory Discharge Planning for New York Jail Inmates." *Psychiatric News* (October 6, 2000).
- _____. "Jail Program Helps Inmates Avoid Health Care Gap." *Psychiatric News* 36, no. 16 (2001).
- Little Hoover Commission. *Being There: Making a Commitment to Mental Health*. Report #157. Sacramento, CA: Little Hoover Commission, November 2000.
- _____. *Young Hearts & Minds: Making a Commitment to Children's Mental Health*. Report #161. Sacramento, CA: Little Hoover Commission, October 2001.
- Logical Health Care Solutions. *Glossary of an Evolving Health Care Marketplace*. Sterling, VA: Logical Health Care Solutions, 1999.
- Lupton, Gary. "Identifying and Referring Inmates with Mental Disorders: A Guide for Correctional Staff." *American Jails* X, no 2 (May/June 1996): 49-52.
- Lurigio, A., and J. Swartz. "Changing the Contours of the Criminal Justice System to Meet the Needs of Persons With Serious Mental Illness." In *Criminal Justice 2000, Volume 3: Policies, Processes, and Decisions of the Criminal Justice System*, Edited by J. Horney. Washington, DC: U.S. Department of Justice, National Institute of Justice (2000): 45-108.
- MacArthur Research Network on Mental Health and the Law. *The MacArthur Community Violence Study*. Available at: www.macarthur.virginia.edu/violence.html.
- _____. *The MacArthur Violence Risk Assessment Study Report*. Available at: www.macarthur.virginia.edu/risk.html
- Marley, J. A. and S. Buila. "When Violence Happens to People With Mental Illness: Disclosing Victimization." *American Journal of Orthopsychiatry* 69, no. 3 (1999): 398-402.
- Mauer, Mark. *Intended and Unintended Consequences: State Disparities in Imprisonment*. Washington, DC: The Sentencing Project, 1997.
- McDonald, D., and M. Teitelbaum. *Managing Mentally Ill Offenders in the Community: Milwaukee's Community Support Program*. Washington, DC: U.S. Department of Justice, National Institute of Justice, 1994.
- Meehan, Bill. "Critical Incident Stress Debriefing Within the Jail Environment." *Jail Suicide/Mental Health Update* 7, no. 1 (1997): 1-5.
- Meuser, K. T. et al. "Trauma and Post-Traumatic Stress Disorder in Severe Mental Illness." *Journal of Consulting and Clinical Psychology* 66, no. 3 (1998): 493-99.
- Milazzo-Sayre, Laura J. et. al. "Chapter 15: Persons Treated in Specialty Mental Health Care Programs, United States, 1997." In *Mental Health, United States, 2000* edited by Ronald W. Manderscheid and Marilyn J. Henderson. Rockville, MD: U. S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services, 2000.
- Minkoff, Kenneth. "Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders Psychiatric Services." *Psychiatric Services* 52 (2001): 597-99.

- Monohan, J., H. J. Steadman, E. Silver, P. S. Appelbaum, P. C. Robbins, E. P. Mulvey, L. H. Roth, T. Grisso, and S. Banks. "The MacArthur Violence Risk Assessment Study." *Community Mental Health Report* (May/June 2001): 51-63.
- Morrisey, Erin, Louis Muzeraki and Allison Young. "Community Mental Health Centers and County Jails: Divergent Perspectives?" *American Jails* XI, no. 1 (1997): 50-52.
- NAMI. "Housing Position Paper." Available at: www.nami.org/update/unitedhousing.html.
- NASMHPD Research Institute. *FY 1998 SMHA Profiling System*. Alexandria, VA: NASMHPD 1998.
- _____. *Position Statement on Employment and Rehabilitation for Persons with Severe Psychiatric Disabilities*. Alexandria, VA: NASMHPD, December 10, 1996.
- _____. *Proposed New HCPCS Procedure Codes for Mental Health Services: Definitions*. Alexandria, VA: NASMHPD, December 21, 2001.
- National Association of Pretrial Services Agencies. *Performance Standards and Goals for Pretrial Diversion*. Wauwatosa, WI: National Association of Pretrial Services Agencies, 1995.
- _____. *Performance Standards and Goals for Pretrial Release*. Wauwatosa, WI: National Association of Pretrial Services Agencies, 1998.
- National Center on Institutions and Alternatives. "Model Suicide Prevention Programs: Part I." *Jail Suicide/Mental Health Update* 7, no. 3 (1998): 1-9.
- National Center for Victims of Crime. *Crime Victims Source Book*. Washington, DC: National Center for Victims of Crime.
- National Commission on Correctional Health Care. *Standards for Health Services in Jails*. Chicago: National Commission on Correctional Health Care, 1996.
- National Council for Community Behavioral Healthcare. *Principles for Behavioral Healthcare Delivery*. Rockville, MD: National Council for Community Behavioral Healthcare.
- National District Attorneys Association. *National Prosecution Standards*. Second edition. Alexandria, VA: National District Attorneys Association, 1990.
- National GAINS Center for People with Co-Occurring Disorders in the Justice System. "Blending Funds to Pay for Criminal Justice Diversion Programs for People with Co-Occurring Disorders." Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System, fall 1999.
- _____. "Creating Integrated Service Systems for People with Co-Occurring Disorders Diverted from the Criminal Justice System: The King County (Seattle) Experience." Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System, Summer 2000.
- _____. *Drug Courts as a Partner in Mental Health and Co-Occurring Substance Use Disorder Diversion Programs*. Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System, 1999.
- _____. "Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders." Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System, summer, 1999.
- _____. *The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System*. Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System, December, 1999.
- _____. *Treatment of People With Co-Occurring Disorders in the Justice System*. Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System, 2000.
- National Institute of Corrections. *Effectively Addressing the Mental Health Needs of Jail Detainees*. Henry J. Steadman, ed., Boulder, CO: U. S. Department of Justice, National Institute of Corrections, 1990.
- National Institute of Mental Health. *Somatization: Disorder in the Medical Setting*. Bethesda, MD: Department of Health and Human Services, National Institute of Health, National Institute of Mental Health, 1990.
- National Technical Assistance Center for State Mental Health Planning. *Building Bridges Between Mental Health and Criminal Justice: Strategies for Community Partnerships*. Alexandria, VA: National Technical Center for State Mental Health Planning, Spring, 1998.

- Nieto, M. *Mentally Ill Offenders in California's Criminal Justice System*. Report prepared for the Assembly Select Committee on Mental Health by the California Research Bureau, 1999.
- Office of Rural Health Policy. *National Rural Health Policy: Recommendations from the First Eight Years of the National Advisory Committee on Rural Health*. Rockville, MD: Office of Rural Health Policy, 1997.
- O'Hara, Ann and Emily Miller. *Priced Out in 2000: The Crisis Continues*. Boston: Technical Assistance Collaborative, June 2001.
- On Our Own of Maryland, Inc. *Disability, Entitlements and Employment: A Reference Guide for Individuals on Disability Entitlements Desiring to Work*. Baltimore: On Our Own of Maryland, January 1994.
- Osher, F. and R. Drake. "Reversing a History of Unmet Needs: Approaches to Care to Persons with Co-Occurring, Addictive and Mental Disorders." *American Journal of Orthopsychiatry* 66, no. 1 (1996).
- Peters, R.H. and M. Green Bartoi. *Screening and Assessment of Co-Occurring Disorders in the Justice System*. Tampa, Florida: Louis de la Parte Florida Mental Health Institute, University of South Florida, Department of Mental Health Law and Policy, 1997.
- Peters, R.H. and H.A. Hills. "Intervention Strategies for Offenders with Co-Occurring Disorders: What Works?" Delmar, NY: National GAINS Center for People with Co-Occurring Disorders in the Justice System, 1997.
- Phipps, Polly and Gregg Gagliardi. *Implementation of Washington's Dangerous Mentally Ill Offenders Law: Preliminary Findings*. Olympia, WA: Washington Institute for Public Policy, March 2002.
- Pion, G. and H. McCombs. *Mental Health Providers in Rural and Isolated Areas: Final Report of the Ad Hoc Rural Mental Health Provider Work Group*. Rockville, MD: U.S. Department of Health and Human Services, Center for Mental Health Services, 1997.
- Police Executive Research Forum*. The Police Response to People with Mental Illnesses: Trainers Guide. *Washington, D. C.: Police Executive Research Forum, 1997*.
- Policy Research Associates. *Applying the Research to Improve Mental Health Services in Jails: A Workshop Summary*. Delmar, NY: Policy Research Associates, 1994.
- _____. *Blueprint for Contracting for Mental Health Services for Jail Detainees with Mental Illnesses*. Delmar, NY: Policy Research Associates, 1995.
- _____. *Jail Diversion: Creating Alternatives for Persons with Mental Illnesses*. Delmar, NY: Policy Research Associates.
- Pollack, L., G. Stuebben, K. Kouzekanani, and K. Krajewski. "Aftercare Compliance: Perceptions of People with Dual Diagnosis." *Substance Abuse* 19, (1998).
- "Prevention of Jail and Hospital Recidivism Among Persons With Severe Mental Illness: Project Link, Department of Psychiatry, University of Rochester, Rochester, New York." *Psychiatric Services* 50, no. 11 (November 1999): 1477-80.
- Psychiatric News*. "Cook County Pilot Program Prevents Recidivism Among Mentally Ill." 7 January, 2001.
- Psychiatric News*. "Substance Abuse Treatment Found Lacking in Correctional Facilities." 2 June, 2000.
- Raider, E. and B. L. Arthur. *Using Management Information Systems to Locate People with Serious Mental Illnesses and Co-Occurring Substance Use Disorders in the Criminal Justice System for Diversion*. Delmar, New York: National GAINS Center for People with Co-Occurring Disorders in the Justice System, 1999.
- Regina, Judith L. "The Mental Health Initiative: Maine Sheriff's Associations Response to a Growing Problem." *Jail Suicide/Mental Health Update* 6, no. 4 (1996): 11-16.
- Rhine, E. *Best Practices: Excellence in Corrections*. Lanham, MD: American Correctional Association, 1998.
- Robertson, James E. "Jailers' Liability for Custodial Suicide after *Farmer v. Brennan*." *Jail Suicide/Mental Health Update* 6, no. 3 (1996): 1-5.
- Robins, L. and D. Regier. *Psychiatric Disorders in America: The Epidemiologic Catchment Area Study*. New York: Free Press, 1991.
- Roskes, Erik and Richard Feldman. "A Collaborative Community-Based Treatment Program for Offenders with Mental Illness." *Psychiatric Services* 50, no. 1 (1999): 1614-19.
- Rowan, Joseph R. and Lindsay M. Hayes. *Training Curriculum on Suicide Detention and Prevention in Jails and Lockups*. Mansfield, MA: National Center on Institutions and Alternatives, 1995.

- Sacramento Bee*. "Treatment Not Jail: A Plan to Rebuild Community Mental Health." 17 March, 1999, Section B, p. 6.
- Samber, S. "New Study Calls for More Substance Abuse Treatment for Prisoners." *The NCADI Reporter*, January 8, 1998.
- Severson, Margaret M. "Back to Basics in Jail Mental Health Programming: Combining Knowledge, Common Sense, Creativity and Community." *Jail Suicide/Mental Health Update* 6, no. 1 (1995): 8-12.
- Sorensen, D. D. "The Invisible Victims." National Center for Victims of Crime. Available at: www.ncvc.org/newsltr/disabled.htm.
- Slyter, Thomas. "Addicts in Our Jails: Do We Warehouse, Punish, or Treat Them?" *American Jails* XII, no. 3 (July/August 1998): 41-43.
- Steadman, Henry J. "Boundary Spanners: A Key Component for the Effective Interactions of the Justice and Mental Health Systems." *Law and Human Behavior* 16, no. 1 (1992): 75-86.
- Steadman, Henry J. et al. "The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968-1978." *Journal of Criminal Law & Criminology* 75, no. 2 (1984): 474-90.
- Steadman, Henry J. and Bonita Veysey. "Providing Services for Inmates with Mental Disorders." *American Jails* XI, no. 2 (May/June 1997): 11-23.
- Steadman, Henry J., Deborah L. Dennis, and Suzanne M. Morris. "The Diversion of Mentally Ill Persons from Jails to Community-Based Programs: A Profile of Programs." *American Journal of Public Health* 85, no. 12 (1995): 1630-5.
- Steadman, Henry J., Dennis W. McCarty, and Joseph P. Morrissey. "Developing Jail Mental Health Services: Practices and Principles." Bethesda, MD: Department of Health and Human Services, National Institute of Health, National Institute of Mental Health, 1986.
- _____. *The Mentally Ill in Jail: Planning for Essential Services*. New York: Guilford Press, 1989.
- Steadman, Henry J., E. Mulvey, J. Monahan, P. Robbins, P. Appelbaum, T. Grisso, L. Roth, and E. Silver. "Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods." *Archives of General Psychiatry* 55 (1998): 393-401.
- Steadman, Henry J., M. Williams, R. Borum, and J. P. Morrissey. "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies." *Psychiatric Services* 51, no. 5 (2000): 645-9.
- Steadman, Henry J., S. Davidson, and C. Brown. "Mental Health Courts: Their Promise and Unanswered Questions." *Psychiatric Services* 52, no. 4 (2001).
- Stojkovic, Stan and Rick Lovell. *Corrections: An Introduction*. Cincinnati, OH: Anderson, 1992.
- Swartz, M., D. Blazer, L. George, and I. Winfield. "Estimating the Prevalence of Personality Disorder in the Community." *Journal of Personality Disorders* 4, (1990): 257-72.
- Teplin, Linda A. "Detecting Disorder: The Treatment of Mental Illness Among Jail Detainees." *Journal of Consulting and Clinical Psychology* 2 (1990): 233-36.
- _____. *Keeping the Peace: Police Discretion and Mentally Ill Persons*. Washington, DC: U.S. Department of Justice, National Institute of Justice, July 2000.
- _____. "The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees: Comparison with the Epidemiologic Catchment Area Program." *American Journal of Public Health* 80, no. 6 (1990): 663-69.
- _____. "Psychiatric and Substance Abuse Disorders Among Urban Male Jail Detainees." *Journal of Public Health* 84, no. 2 (1994): 290-93.
- Teplin, Linda and Karen Abram. "Co-Occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy." *American Psychologist* 46, no. 10, 1036-45.
- Teplin, Linda, Karen Abram, and Gary McClelland. "Prevalence of Psychiatric Disorders Among Incarcerated Women." *Archives of General Psychiatry* 53 (1996): 505-12.
- Thompson, Tommy. Letter to Congressman Charlie Rangel. Washington, DC, 11 October 2001.
- Travis, J., A. L. Solomon, and M. Waul. *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry*. Washington, DC: The Urban Institute, June, 2001.
- Tyiska, C. G. "Working with Victims of Crime with Disabilities." Washington, DC.: U.S. Department of Justice. Office of Justice Programs, Office for Victims of Crime, *OVC Bulletin*, NCJ 172838, 1998.

- U. S. Bureau of Justice Statistics. *Correctional Populations in the United States, 1997*. Washington D. C.: U. S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 1997.
- U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U. S. Department of Health and Human Services, Office of the Surgeon General, 1999.
- _____. *Blueprints for Managed Care: Mental Healthcare Concepts and Structure*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 1995.
- _____. *Double Jeopardy: Persons with Mental Illnesses in the Criminal Justice System: Report to Congress from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration*. Rockville, MD: U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1995.
- _____. *Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, Office of the Surgeon General, 2001.
- _____. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U. S. Department of Health and Human Services, 2001.
- U.S. House Committee on the Judiciary, Subcommittee on Crime, Terrorism, and Homeland Security. *The Impact of the Mentally Ill on the Criminal Justice System*. 107th Congress, 21 September 2001.
- Ventura, Lois A., Charlene A. Cassel, Joseph E. Jacoby, and Bu Huang. "Case Management and Recidivism of Mentally Ill Persons Released From Jail." *Psychiatric Services* 49, no. 10 (October 1998): 1330-37.
- Vickers, Angela D. "Saving Lives: Creating Partnerships with your Legal Communities." Presentation at 2001 National Mental Health Association Conference.
- Victims of Mentally Ill Offenders: Helping Family Caregivers and Strangers At Risk of Assault*. New York: New York University, Ehrenkranz School of Social Work, Institute Against Violence, New York, 2000.
- Weissman, M., M. Bruce, P. Leaf, L. Floria, and C. Holzer. "Affective Disorders." In *Psychiatric Disorders in America*. Edited by L. Robins and D. Reiger. New York: Macmillan, 1992.
- Wilson, N. "Breaking Out of the Big House." *Open Door* (Summer 1999): 2-4.

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