The Sequential Intercept Model: A Systematic Approach to Keeping People with Mental Illness Out of the Criminal Justice System

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Acknowledgements:

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Director of Health Systems and Services

Justice Center, Council of State Governments

Corey Schaal, Supreme Court of Ohio

Overview of Presentation

- Briefly review the problem of "criminalization of the mentally ill"
  - In the context of U.S. trends in incarceration
- Review the Sequential Intercept Model, a conceptual approach to support decriminalization
  - Its history
  - Its use in Ohio's statewide jail diversion
  - Its potential application in addressing the findings of the CSG Justice Reinvestment Initiative
  - Its use in other statewide planning

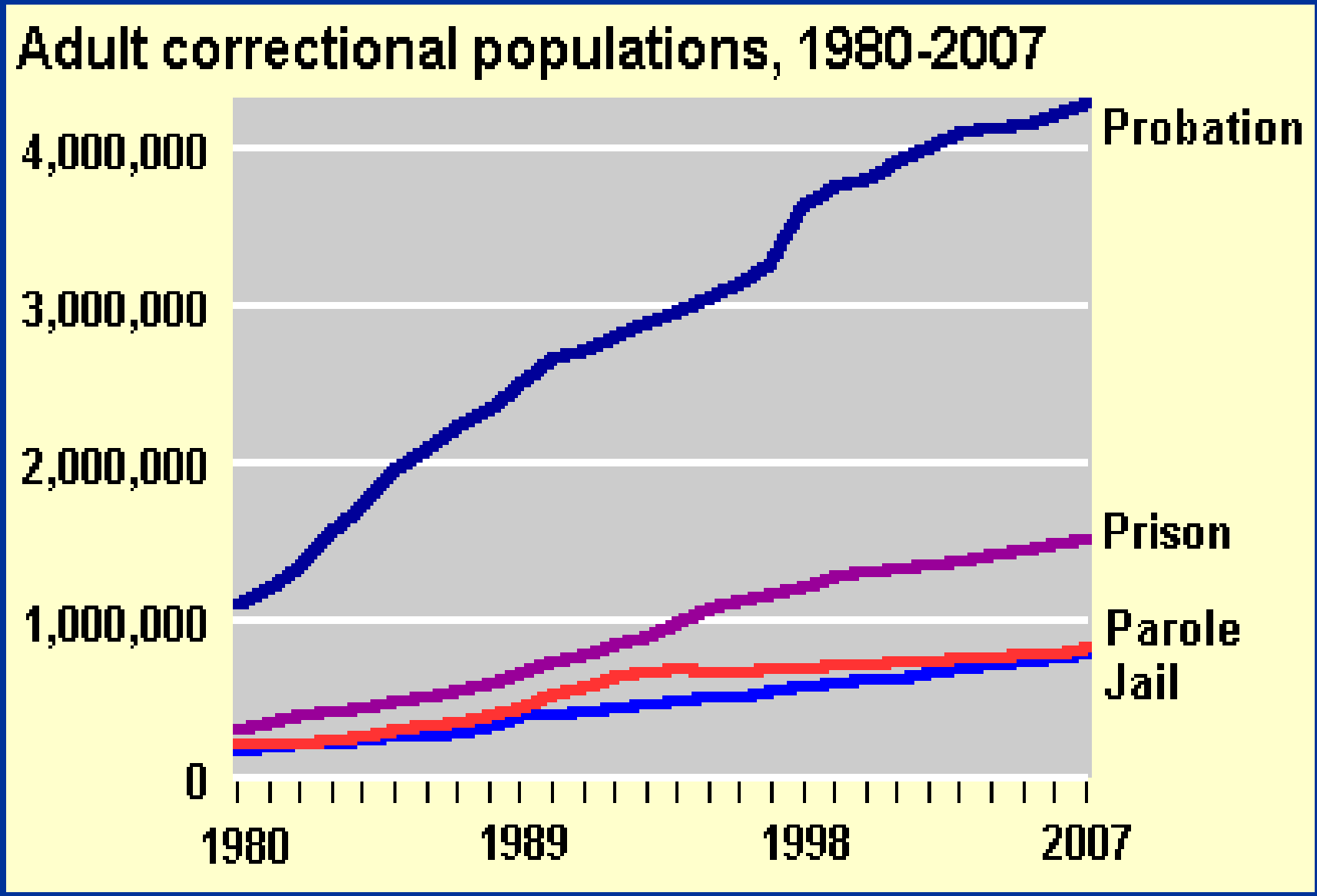
"He's been in a marvellous mood ever since he learned one out of every hundred and fifty Americans is in jail."

The growing corrections system

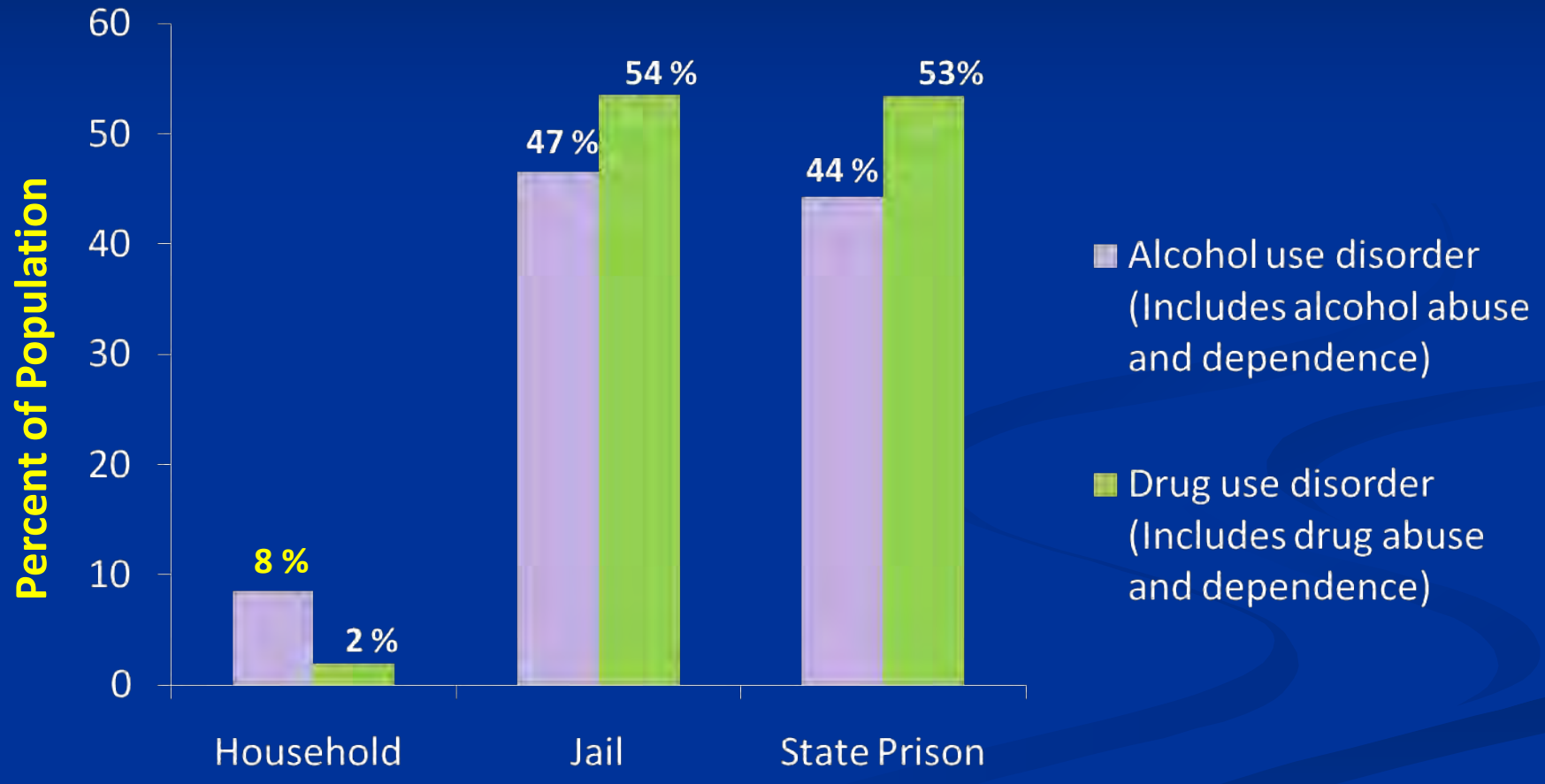
Source: Bureau of Justice Statistics

- In 2005, over 7 million people were on probation, in jail or prison, or on parole at yearend
  - 3.2% of all U.S. adult residents or 1 in every 32 adults.
- State and Federal prison authorities had in custody 1,446,269 inmates at yearend 2005:
  - 1,259,905 in State custody
  - 179,220 in Federal custody
- Local jails held 747,529 persons awaiting trial or serving a sentence at midyear 2005.
- In 2001 the U.S. incarceration rate of 690 per 100,000 overtook Russia (670/100,000) to lead the world
- By 2005 the rate had risen to 726/100,000
- 2009 report showed decrease in state prison population for first time since 1972; jail populations also showed decline as of June 30, 2009

The growing corrections system



Alcohol and Drug Use Disorders

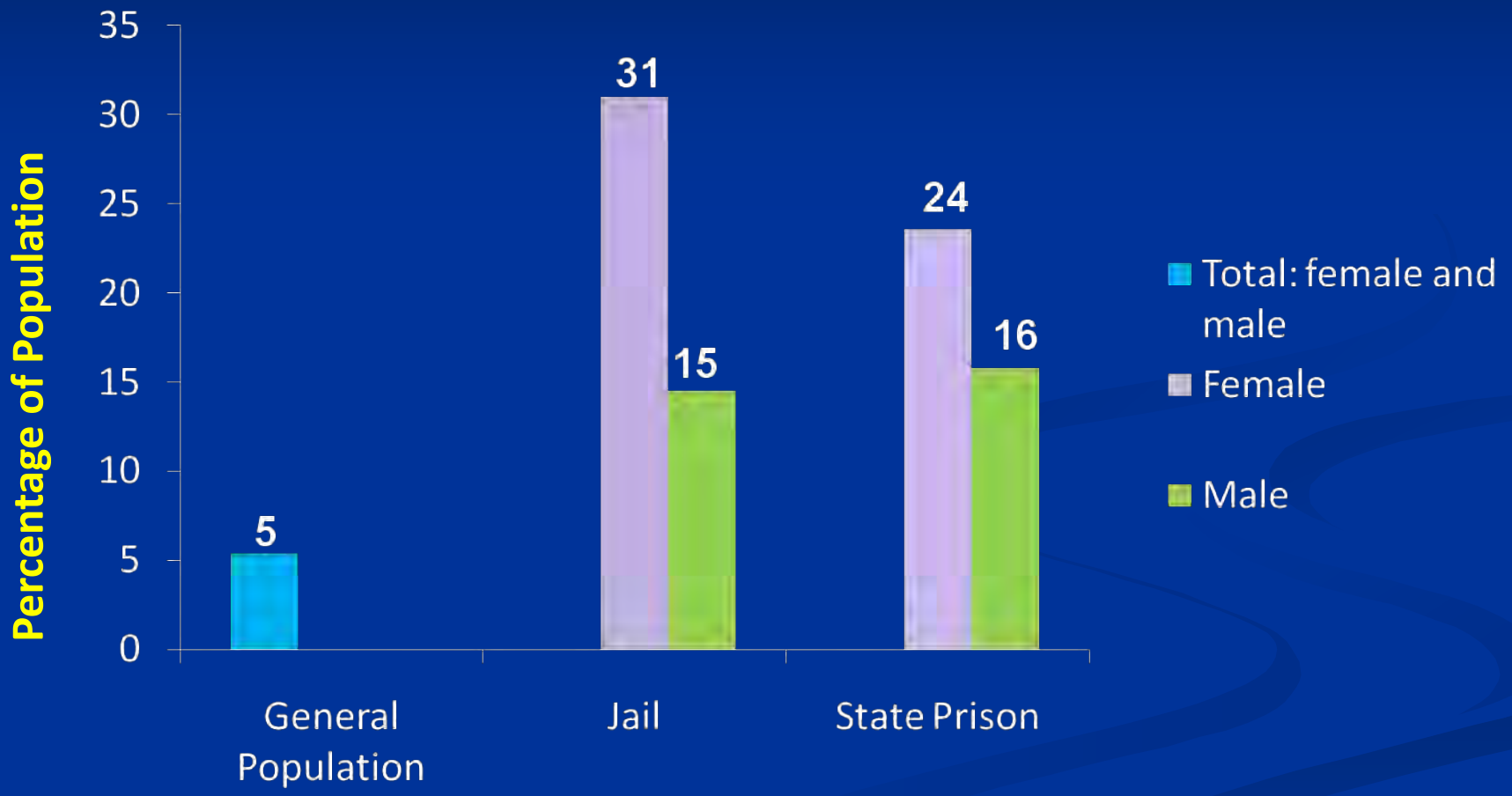


Source: Am J. Psychiatry 167:4, April 2010;
slide provided by Fred Osher, M.D.

Dorothea Dix:

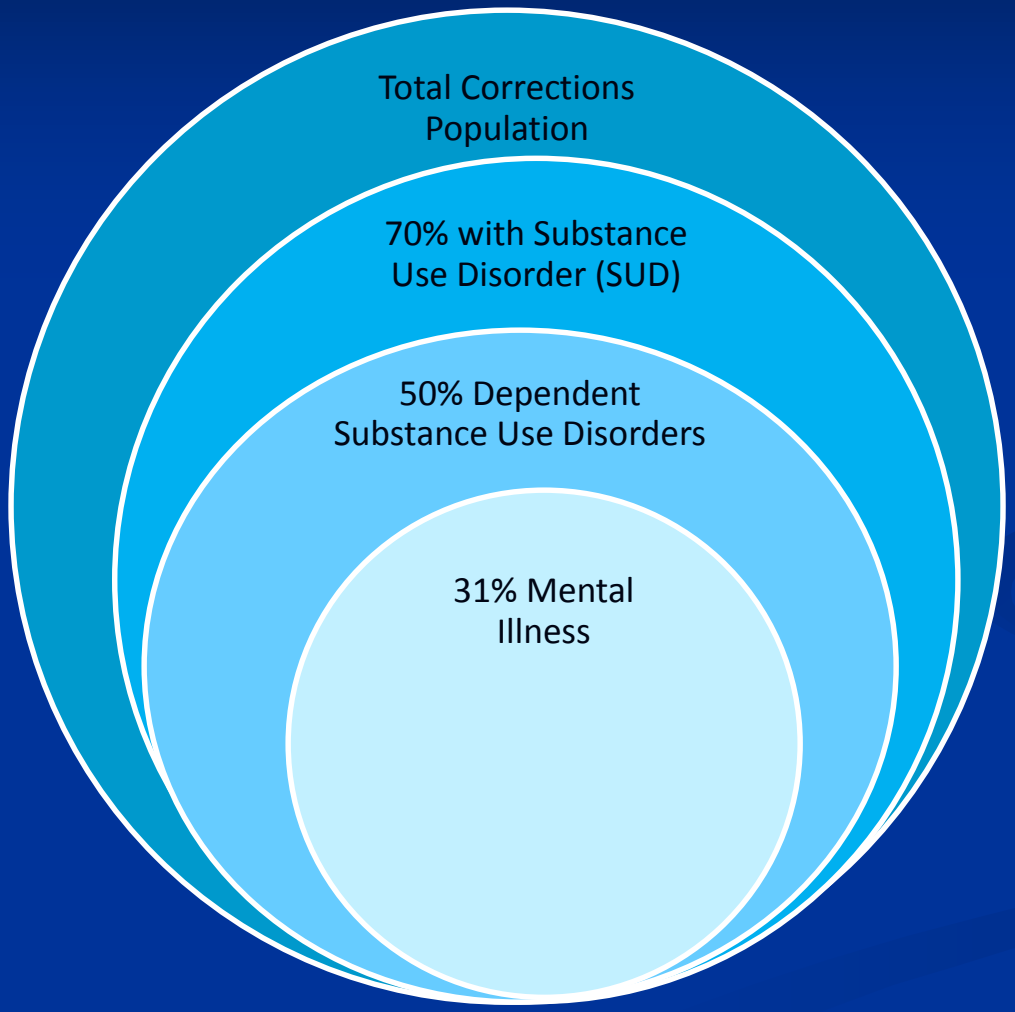
Finding People with Mental Illness in Jails

Serious Mental Illness (SMI)

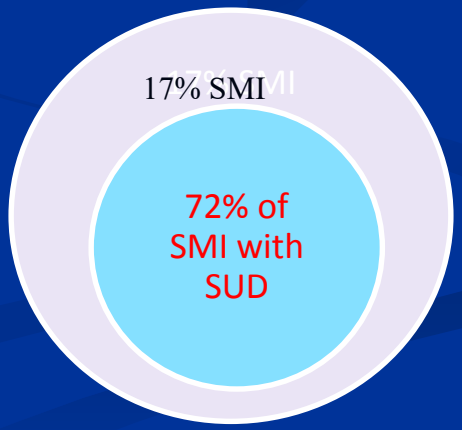


Source: General Population (Kessler et al. 1996), Jail (Steadman et al, 2009), Prison (Ditton 1999) Slide provided by Fred Osher, M.D.

Prevalence of Behavioral Health Disorders in Corrections Population

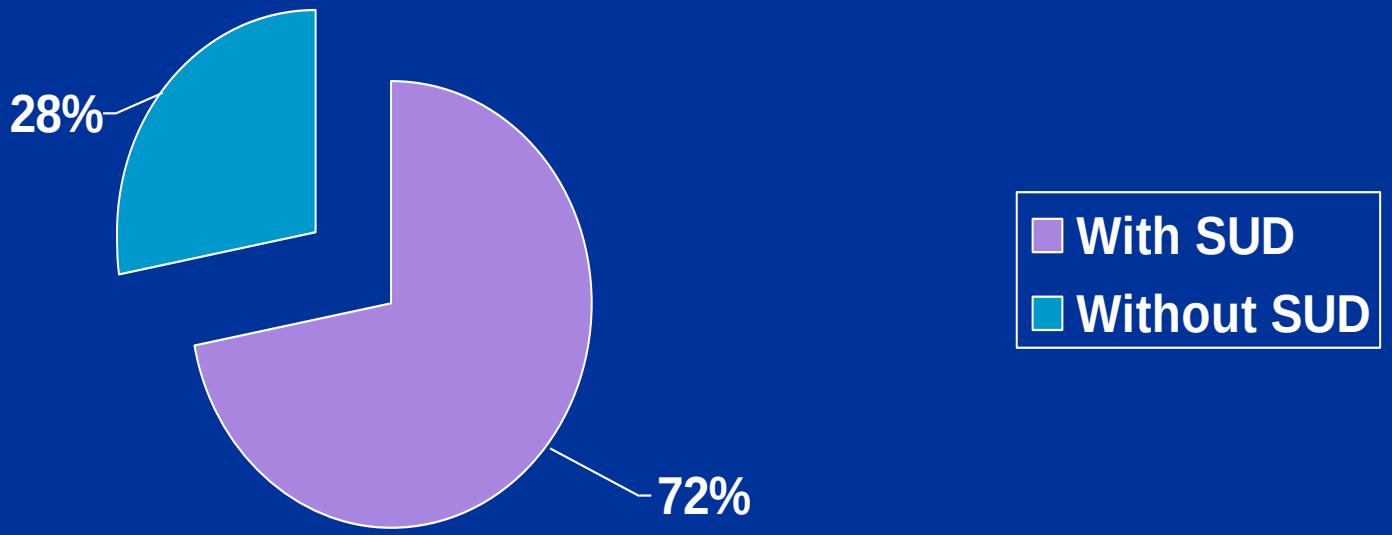


- **Prevalence fairly consistent across prison, jail and community corrections**
- **Rates of dependency and mental illness higher among women**



Slide provided by Fred Osher, M.D.

Substance Use Disorders Among People with Severe Mental Illness at Admission to Jail (Teplin, et al)



Criminalization of People with Mental Illness: The Ohio Story

- In Ohio prisons
  - >8000 inmates with mental illness (~16%)
    - ~ 4000 severely mentally disabled (~8%)
- In Ohio psychiatric hospitals
  - As of 7/31/10
    - 1008 individuals
    - 64.1%% are "forensic patients"
      - NGRI
      - IST

The Summit County Story

- Late 1990's
  - Study of individuals with SPMI in SCJ
    - 1 in 12 of individuals with an SMD in Summit County had at least one incarceration in the SCJ in 1996
      - most were also substance abusers
      - half appeared to be candidates for diversion
- Community-wide consultation from National GAINS Center
  - Patty Griffin, Ph.D. was consultant

Diversion

The Summit County Story

- Community-wide consultation from National GAINS Center
  - Led to development of a MH/CJ Community Forum held at the County ADM Board
  - Led to evolution of a conceptual model to approach diversion/de-criminalization in ongoing consultation with Drs. Griffin and Steadman

Jail Diversion

Diverting people with mental illness to treatment instead of incarceration

Calls for Diversion

- National Alliance on Mental Illness
- Bazelon Center
- Mental Health America
- Criminal Justice – Mental Health Consensus Report
- Every sheriff or jail administrator you ever met

Understanding Diversion (Before):
(Steadman, et al, 1994)

- Mail survey of every jail in country with more than 50 inmates; Followed by phone and site visits

- Estimated 52 formal diversion programs in entire U.S.

A diversion of a different sort:

What is a Coordinating Center of Excellence?

ODMH created CCoEs

- To provide excellent resources to local systems to:
  - Assist in developing the capacity to identify and implement Best Practices
  - Promote the utilization of procedures required to implement Best Practices
  - Develop education and training materials
  - Utilize and share fidelity scales or other measures to evaluate implementation
  - Promote cross system sharing

Tools for Transformation: A Guide to Ohio's Coordinating Centers of Excellence and Networks

- Integrated Dual Disorder Treatment/SAMI CCoE
- Supported Employment/SE CCoE
- Cluster-Based Planning Alliance CCoE
- Mental Illness/Mental Retardation/Developmental Disabilities CCoE
- **Criminal Justice CCoE**
- Center for Learning Excellence (CLEX) CCoE
- Center for Innovative Practices (CIP) CCoE
- Wellness Management and Recovery CCoE
- Consolidated Culturalogical Assessment Tools (C-CAT) CCoE
- Adult Recovery Network (ARN) Mental Health
- Network for School Success
- Assertive Community Treatment (ACT) Coordinating Center
- Mental Health Housing Leadership Institute

Criminal Justice Coordinating Center of Excellence (CJ/CCoE)

- In May 2001 the Summit County ADM Board was designated by ODMH to be a CCoE to help in the state-wide elaboration of Jail Diversion programs
- The Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOUCOM) operates the Center

CCOE
OHIO CRIMINAL JUSTICE
COORDINATING CENTER
OF EXCELLENCE

Major CJ/CCoE partners

KENT STATE UNIVERSITY

GAINS The National GAINS Center for People with Co-Occurring Disorders in the Justice System

Criminal Justice | Mental Health CONSENSUS PROJECT coordinated by the Council of State Governments

Justice Evelyn Stratton

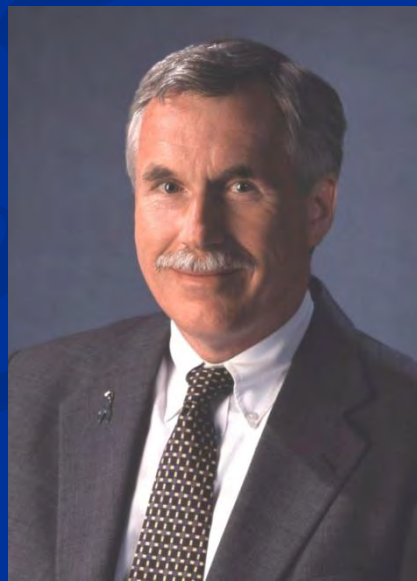
AKRON POLICE

State of Ohio OCJS Office of Criminal Justice Services

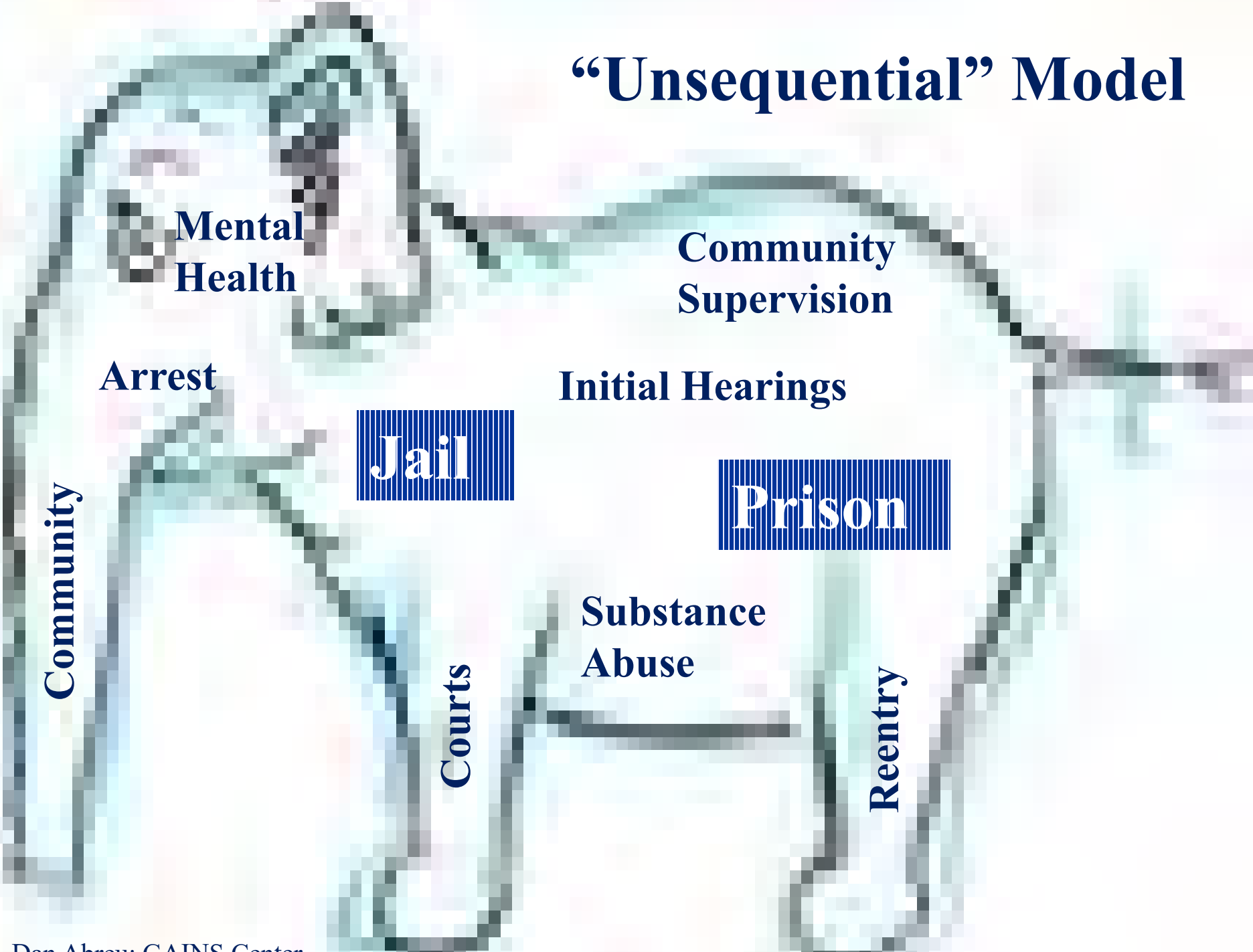
NAMI Ohio

The need for a conceptual model

- In awarding Summit County the CJ CCoE, ODMH Director Michael Hogan "requested" that we develop a conceptual model to approach jail diversion.



“Unsequential” Model

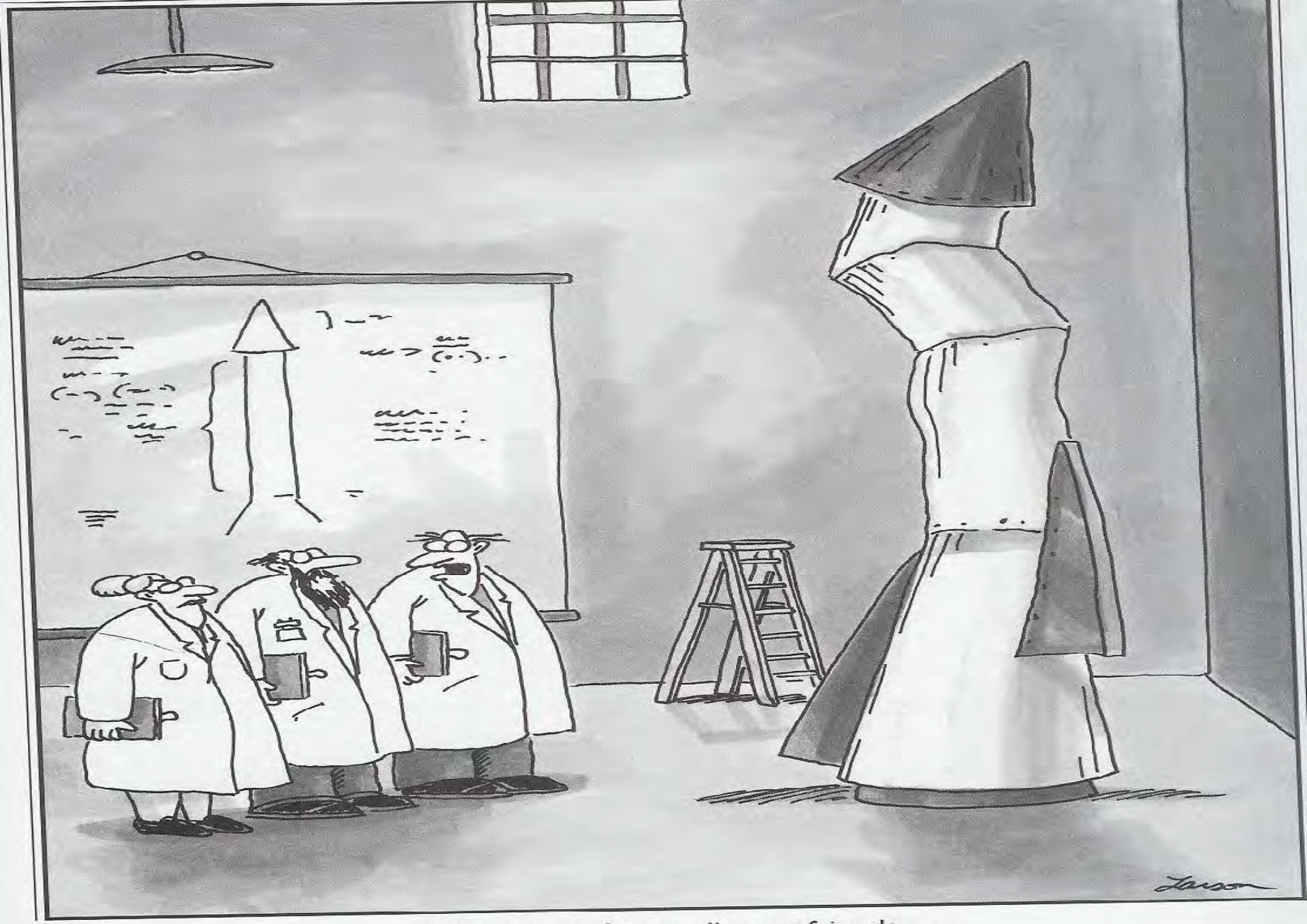


A systematic approach to the criminalization problem

- There is no single solution to the problem we are calling "criminalization of people with mental illness"
  - People move through the criminal justice system in predictable ways
  - The problem must be attacked from multiple levels
  - The "Sequential Filters" Model
    - We conceptualized a series of filters. Each filter provides a point to "catch" an individual with mental illness. Over time the filter rate should increase earlier in the sequence.

From filters to intercepts:

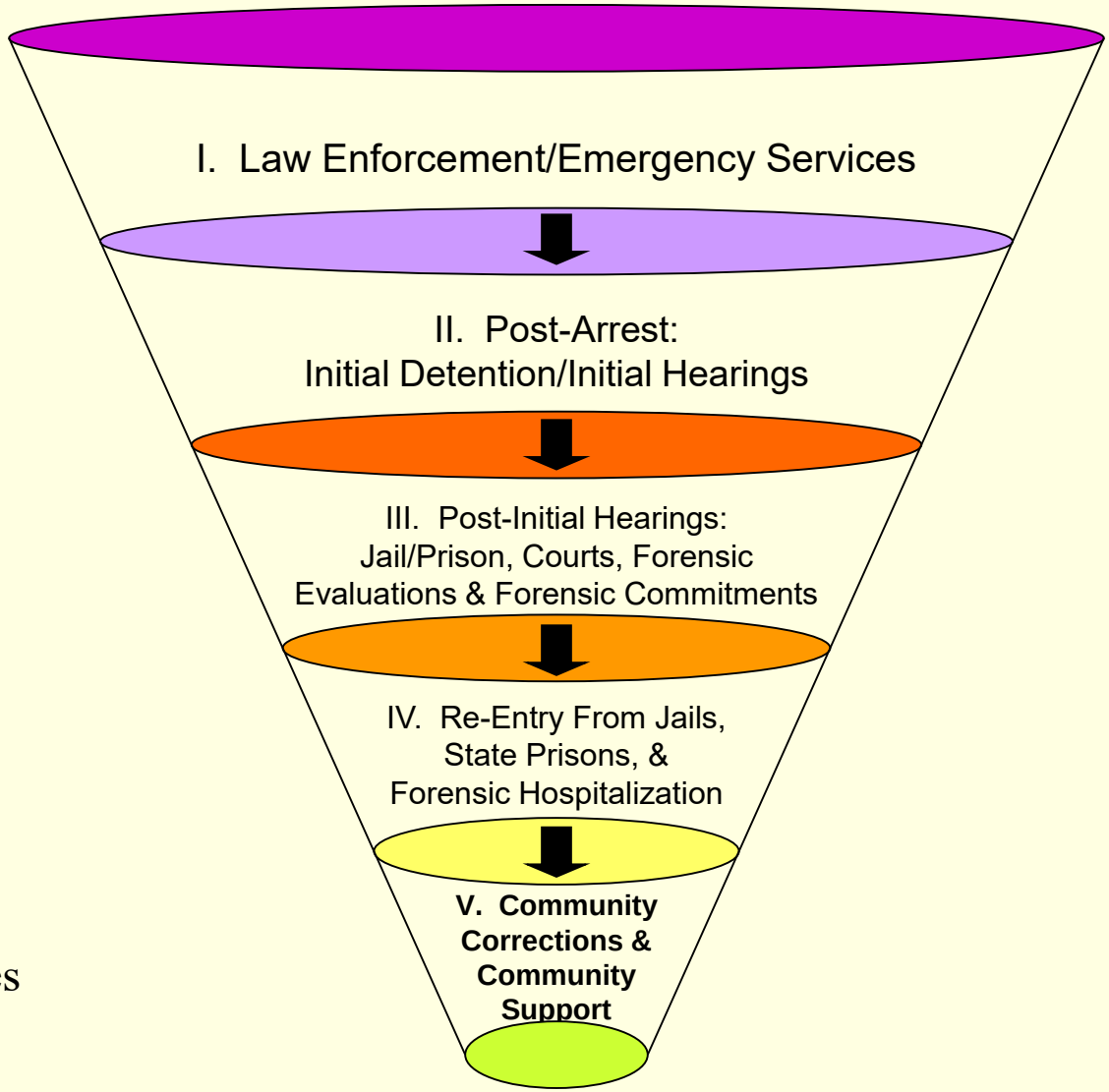
- GAINS Center Director, Dr. Henry Steadman suggested that we call the model the "Sequential Intercept Model" because it better captured the goals of the model.



"It's time we face reality, my friends. . . .
We're not exactly rocket scientists."

Sequential Intercepts

Best Clinical Practices: The Ultimate Intercept



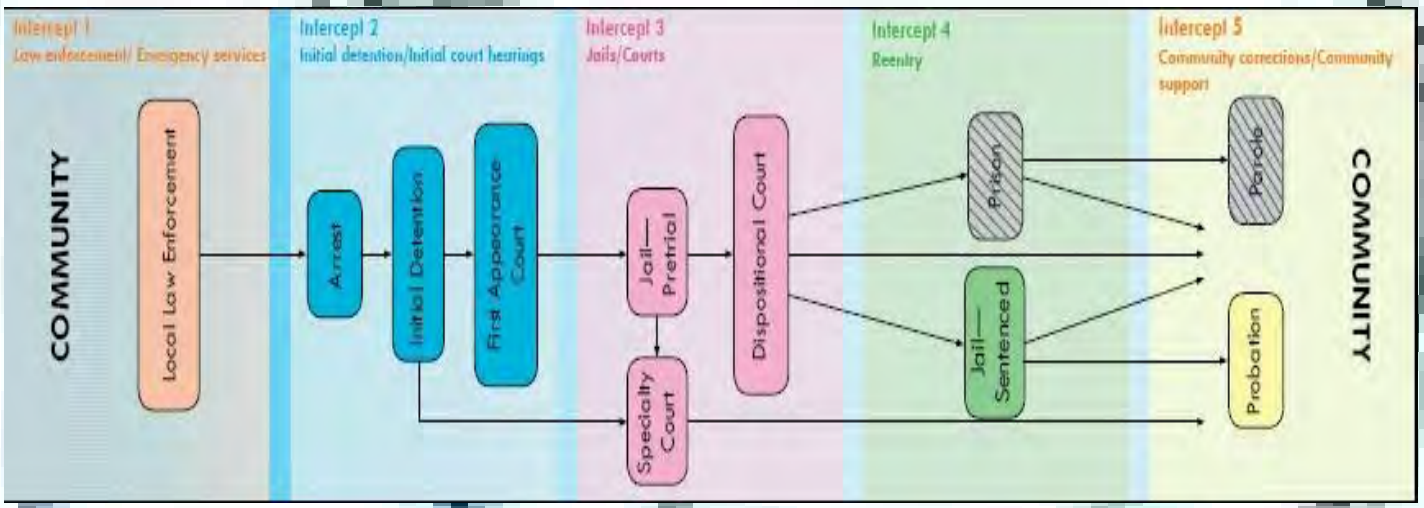
Munetz & Griffin:

Psychiatric Services
57: 544–549, 2006

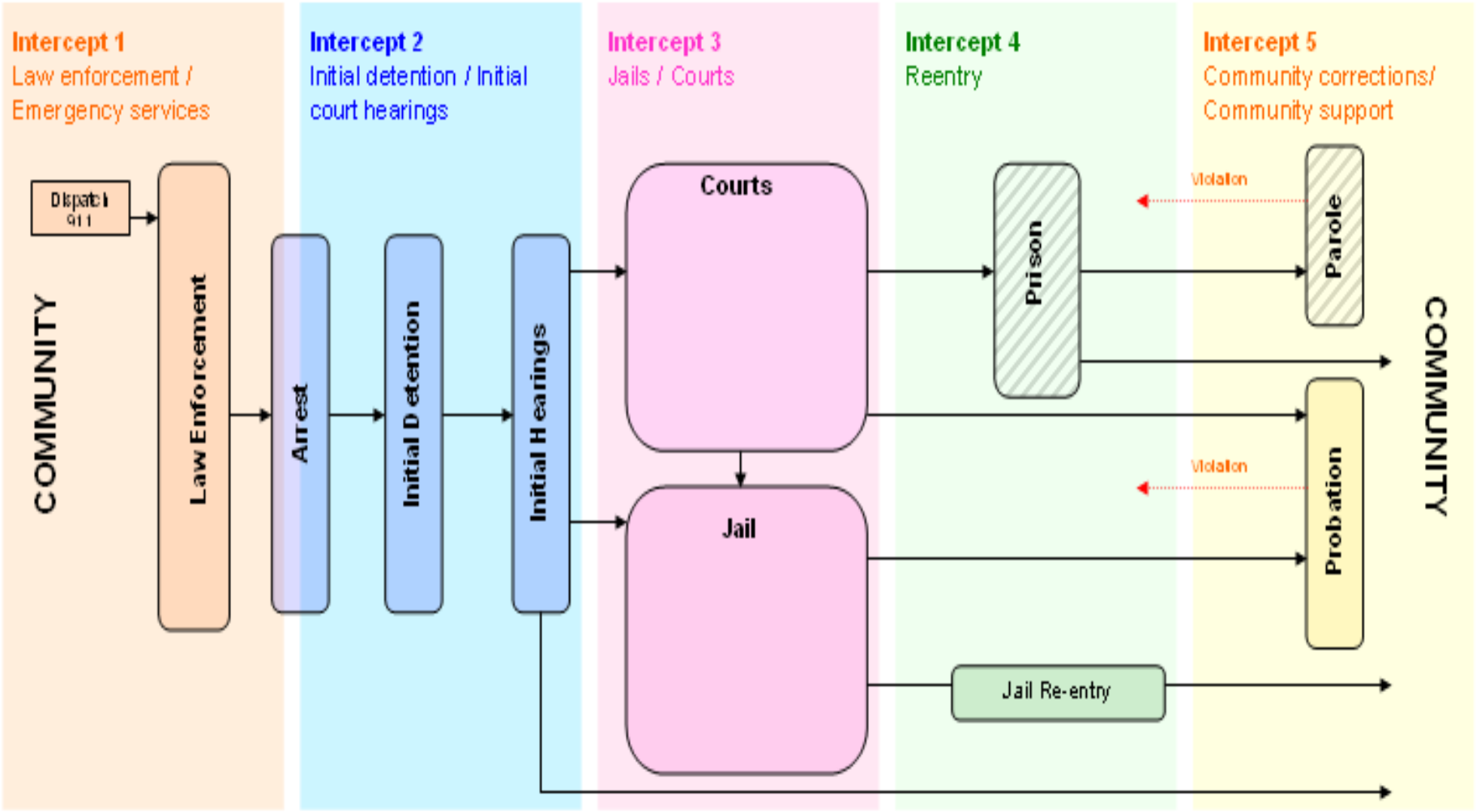
Sequential Intercept Model: The Revolving Door Approach

Munetz & Griffin:
Psychiatric Services
57: 544–549, 2006

Sequential Intercept Model



Sequential Intercepts for Change: Criminal Justice - Mental Health Partnerships



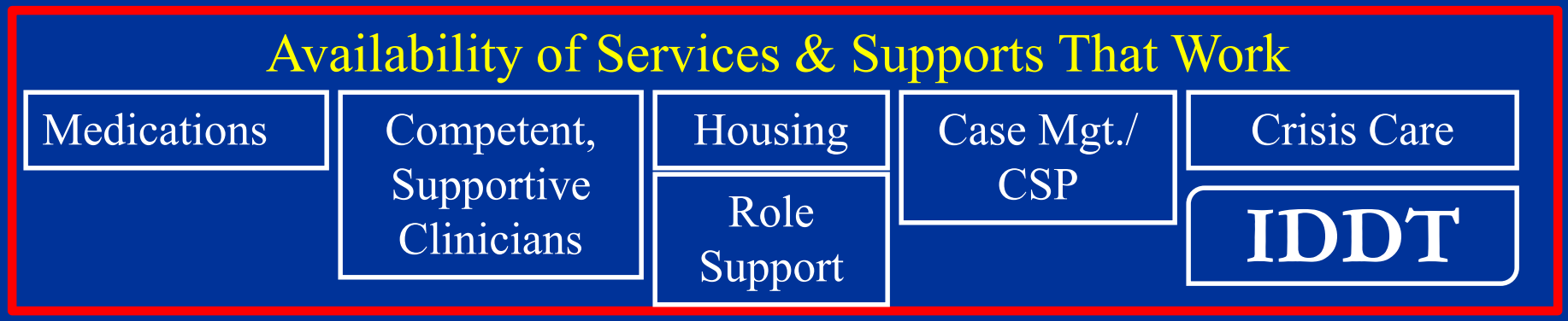
Policy Research Associates, Inc.
Adapted from Munetz & Griffin 2006

Diversion

- Before talking about diversion the question has to be answered:

DIVERSION TO WHAT?

Treatment Engagement: Building Blocks



Treatment Engagement: Building Blocks

Clear & Coordinated Access to Services

Availability of Services & Supports That Work

- Medications
- Competent, Supportive Clinicians
- Housing
- Role Support
- Case Mgt./ CSP
- Crisis Care
- **IDDT**

Treatment Engagement: Building Blocks

High Engagement Services/Supports

Homeless Outreach

Consumer Operated Services

Jail Diversion

Clear & Coordinated Access to Services

Availability of Services & Supports That Work

- Medications
- Competent, Supportive Clinicians
- Housing
- Role Support
- Case Mgt./ CSP
- Crisis Care
- **IDDT**

Treatment Engagement: Building Blocks

Legal & Clinical Activities to Sparingly "Force Engagement"

IOC

Guardianship

Criminal Court

High Engagement Services/Supports

Homeless Outreach

Consumer Operated Services

Jail Diversion

Clear & Coordinated Access to Services

Availability of Services & Supports That Work

- Medications
- Competent, Supportive Clinicians
- Housing
- Role Support
- Case Mgt./ CSP
- Crisis Care
- **IDDT**

Intercept 1: Intercepting at First Contact Police & Emergency Services (Deane, et al, 1999)

- Police-based specialized police response
  - Front line police response
  - Specialized training/support system
  - Example: Memphis Crisis Intervention Team (CIT)
- Police-based specialized mental health response
  - MH professionals employed by police dept.
  - Example: Community Service Officers in Birmingham AL
- Mental Health-based specialized response
  - Mobile crisis teams
  - Examples: Montgomery County Emergency Services (PA); Knoxville TN; Butler County, Ohio


CCOE
OHIO CRIMINAL JUSTICE
COORDINATING CENTER
OF EXCELLENCE
Promoting Jail Diversion Alternatives for People with
Ohio's Crisis Intervention Team (CIT) Initiative
Run Time: 14 minutes
©2009 Northeastern Ohio Universities Colleges of Medicine and Pharmacy

Memphis Crisis Intervention Team Model (CIT)

- Intensive training to volunteer patrol officers
- CIT officers then respond 24/7 to calls involving individuals with mental illness
- Officers are encouraged to refer people to treatment when it is an appropriate alternative to incarceration

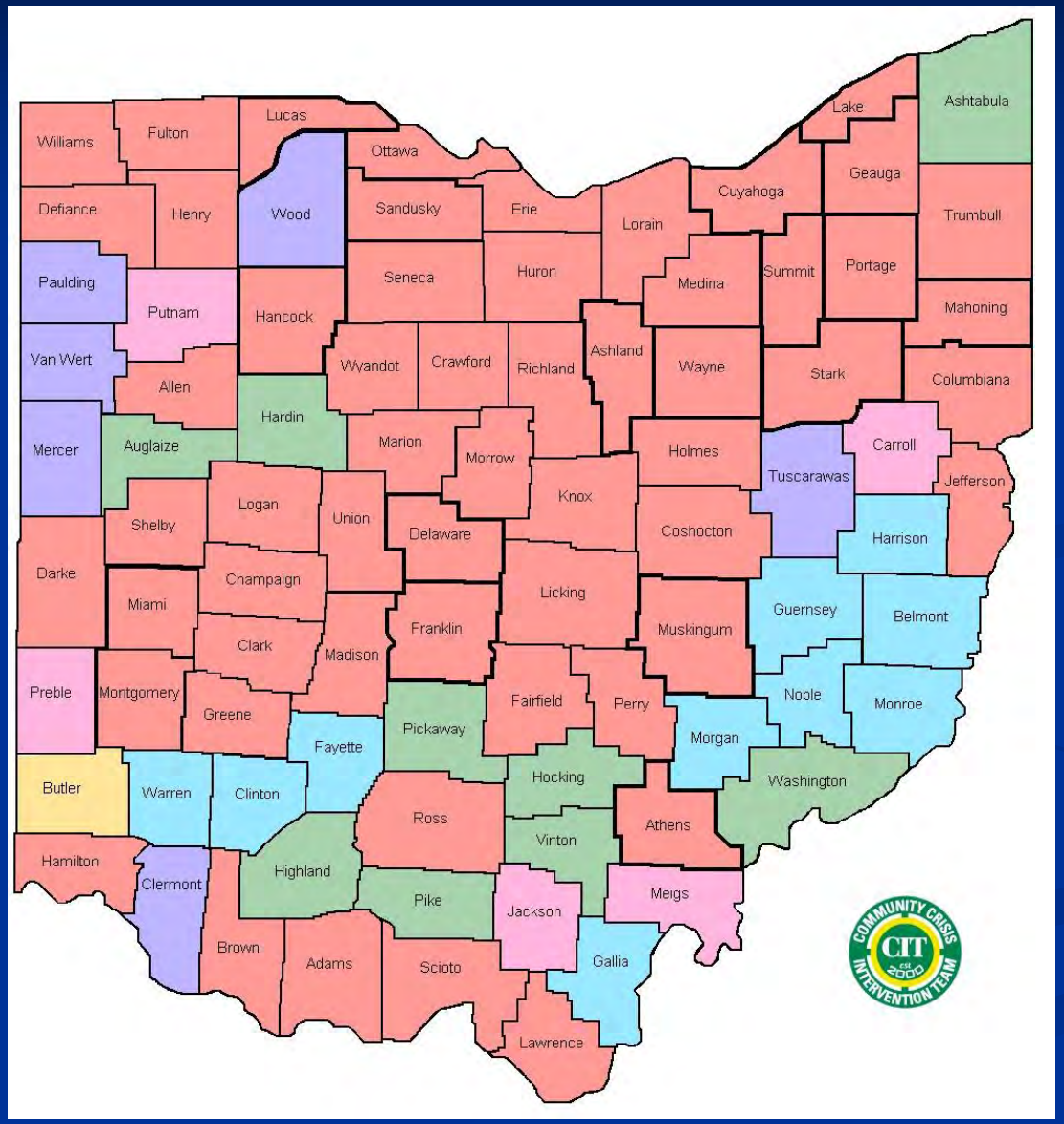
CIT

- A police officer safety program
- A mental health consumer safety program
- A unique community partnership
  - A different way of doing business for law enforcement, the mental health system, consumers and their families
- A pre-arrest jail diversion program

Memphis CIT

- According to Dupont and Cochran CIT in Memphis resulted in:
  - Reduction in officer injuries (85%)
  - Reduction in injuries to mental health consumers
  - Less need for lethal force
    - 55% reduction in SWAT calls
  - Improved community relations
- Reduction in ER recidivism
- Reduction in involuntary commitments
- JAIL DIVERSION
  - Lower percentage of individuals in custody with mental illness
  - Lower arrest rates in mental illness calls
    - 2% vs. 20%

CIT in Ohio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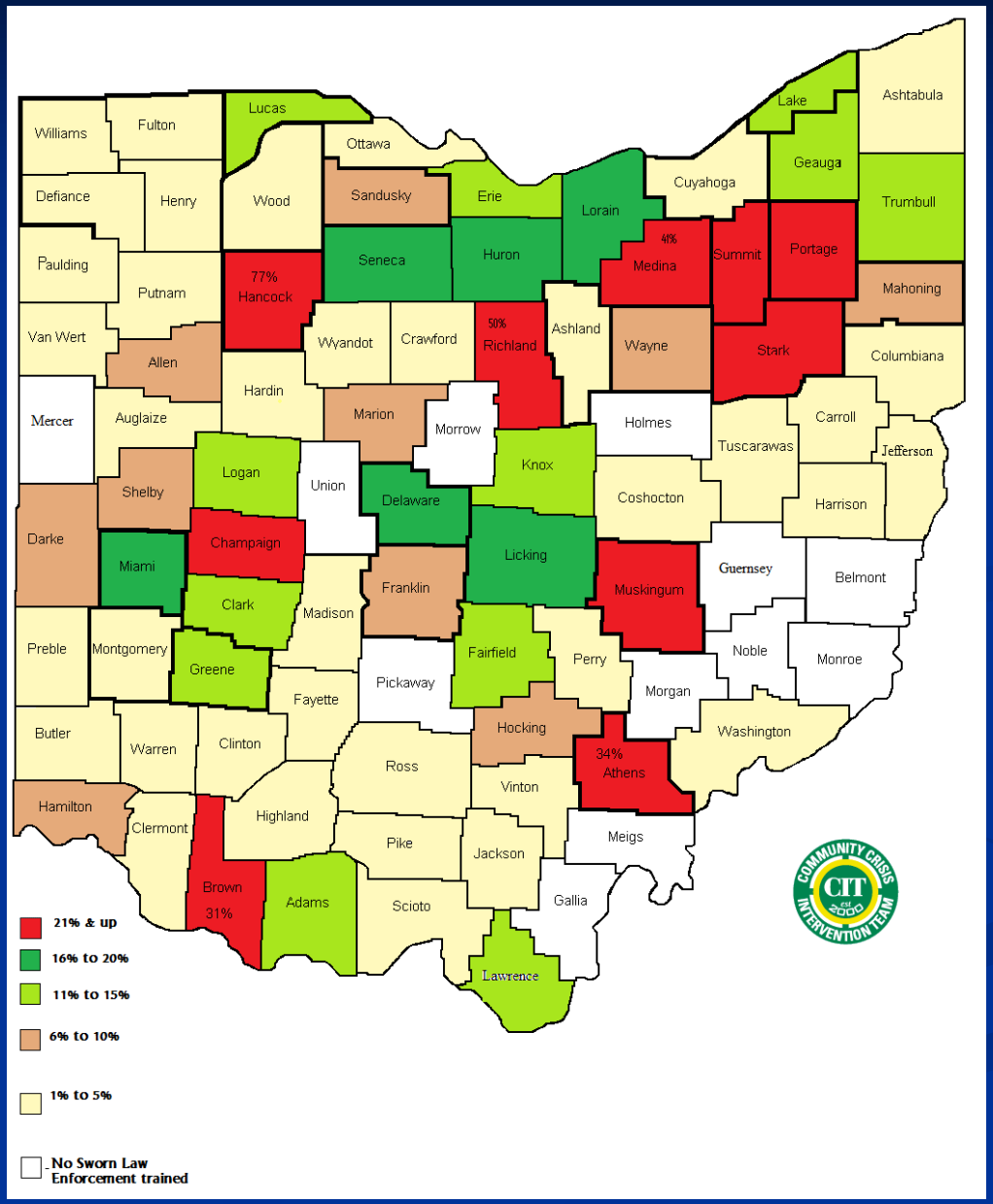
Paulding
Putnam
Hancock
Seneca
Huron
Medina
Summit
Portage
Mahoning
Van Wert
Allen
Wyandot
Crawford
Richland
Ashland
Wayne
Stark
Columbiana
Mercer
Auglaize
Hardin
Marion
Morrow
Holmes
Tuscarawas
Carroll
Jefferson
Shelby
Logan
Union
Delaware
Knox
Coshocton
Harrison
Darke
Champaign
Miami
Clark
Madison
Franklin
Licking
Muskingum
Guernsey
Belmont
Preble
Montgomery
Greene
Fayette
Pickaway
Fairfield
Perry
Morgan
Noble
Monroe
Butler
Warren
Clinton
Ross
Hocking
Athens
Washington
Hamilton
Clermont
Highland
Pike
Vinton
Jackson
Meigs
Brown
Adams
Scioto
Gallia
Lawrence
COMMUNITY CRISIS INTERVENTION TEAM
CIT
est 2000
–Active CIT
–CIT in Active Planning
–CIT in planning - Team Attended a CIT Course
–CIT Considered - Heard One or More Presentations from CCoE/NAMI
–CIT Considered - One or More Discussions with CCoE or NAMI Staff
–Other specialized law enforcement approach

Status of CIT in Ohio



Summary of Ohio CIT Research

Quality of Life of People with Mental Illness Team

Christian Ritter, Ph.D.

Mark R. Munetz, M.D.

Jennifer Teller, Ph.D.

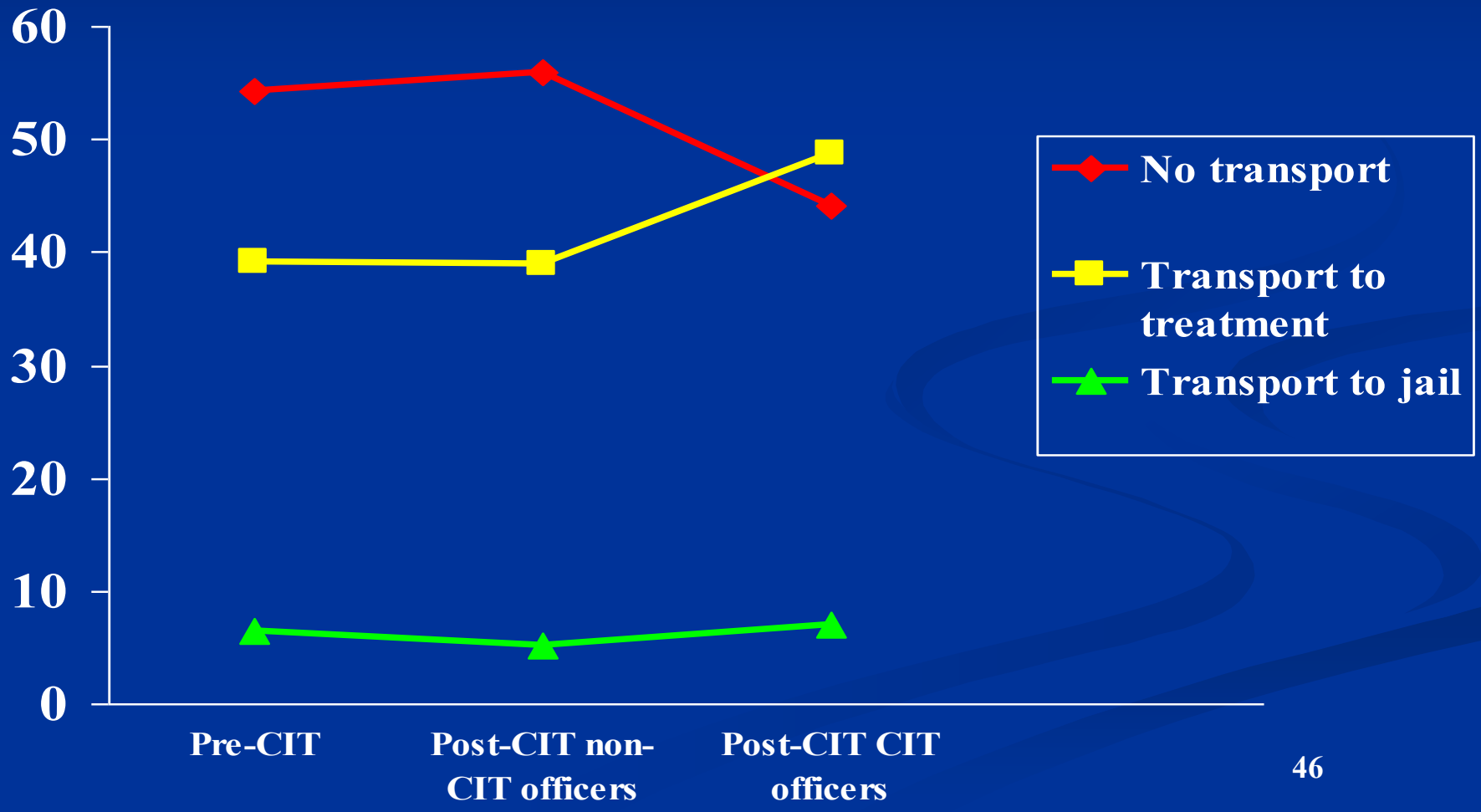
Natalie Bonfine, M.A.

CIT connects individuals with mental illness in crisis to mental health services*

- CIT officers are significantly more likely than non-CIT officers to transport people with mental illness to psychiatric emergency services
- CIT officers are more likely to transport people in crisis to treatment on a voluntary basis
- A CIT encounter is far more likely to result in transport to treatment (62%) than arrest (4%)

* Teller, J.L.S., Munetz, M.R., Gil, K.G., and Ritter, C. "Crisis Intervention Team training for Police Officers Responding to Mental Disturbance Calls." *Psychiatric Services 57L 232-237, 2006.*

Dispositions of Calls by Time and Training (Teller, Munetz, Gil & Ritter: Psychiatric Services, 57:232-237, 2006)



CIT officers use their training and experience to inform their decisions about dispositions*

- Officers are more likely to take individuals to a mental health treatment facility if the officer perceives signs of substance abuse, violence towards self or others, signs and symptoms of mental or physical illness or non-adherence to medication
- Dispatch training is an important element of a CIT program to prepare officers before arriving on-scene
- CIT officers are able to identify individuals in crisis in need of mental health treatment regardless of how calls are dispatched

*

Ritter, C., Teller, J.L.S., Marcussen, K., Munetz, M.R. and Teasdale, B. (in press). "Crisis Intervention Team Officer Dispatch, Assessment, and Disposition: Interactions with Individuals with Severe Mental Illness." *International Journal of Law and Psychiatry*

CIT prepares officers to better respond to calls involving people with mental illness in crisis*

- Before CIT, officers who volunteered for CIT felt significantly less prepared to respond to calls involving persons with mental illness in crisis when compared to officers who have not participated in CIT
- CIT training and experience in the field prepares CIT officers to feel better equipped when responding to such calls (26% before CIT compared to 97% after feeling at least moderately prepared)

*Ritter, C., Teller, J.L.S., Munetz, M.R. and Bonfine, N. "Crisis Intervention Team (CIT) Training: Selection Effects and Long-Term Changes in Perceptions of Mental Illness and Community Preparedness." *Journal of Police Crisis Negotiation* 10:133–152, 2010

CIT has improved community partnerships

Focus groups throughout the state reveal that:

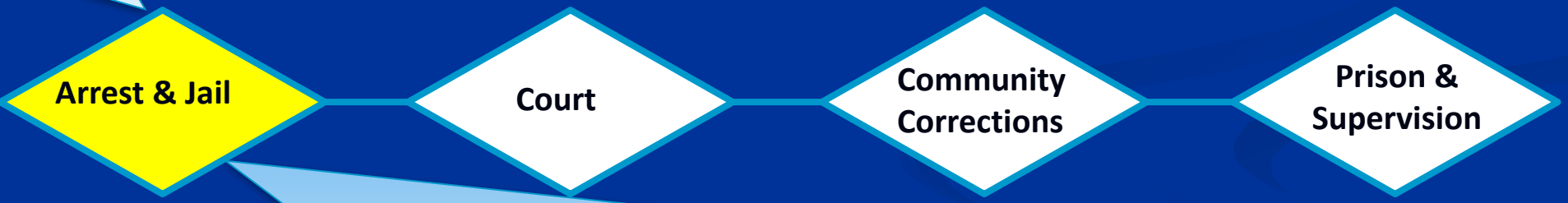
- In many Ohio communities, CIT has helped develop a sustainable, cross-system steering group for jail diversion efforts
- CIT has led to cross-system understanding and awareness of issues between law enforcement and mental health providers
- Improved communication between criminal justice and mental health has increased trust and improved efficiency in working across systems

CIT has improved community partnerships

- CIT has positively impacted the ways that police officers and jail administrators interact with individuals with mental illness
- Consumers and family members help spread awareness of the CIT program throughout the community

Current Practices in Ohio: Law Enforcement

Specialized Police-Based Responses



Ohio's Criminal Justice Center of Excellence

- Officers from 74 counties have received Crisis Intervention Team (CIT) training
- 3,739 CIT Law Enforcement (LE) Officers Trained
- 350 LE agencies have had 25% or more of officers trained within each agency

Justice Center Report

SPR/CIT Responses More Effective When Local BH Services and Treatment Are Available

De-escalation is effective

- A CIT encounter is far more likely to result in transport to treatment (62%) than arrest (4%)

However, the effectiveness of these specialized responses is compromised by . . .

On June 8, the US Attorney's Office, Northern District Hosted a focus group of approximately 25 chiefs and sheriffs from northern Ohio

Community restrictions on who and when services are delivered

- History of violence
- Intoxication at time of arrest
- Reduction in reception center hours

CIT worked better when local BH budgets were more robust

"No matter how much CIT or de-escalation you do, you still rely on the medical institutions to wrap it up, and we can't seem to do that anymore."

What are Mental Health Courts?

(Petrila & Poythress, 2002)

- Limited docket
- Specially assigned judge
- Problem-solving
  - Expanded scope of non-legal issues
  - Hope for outcomes beyond law's application
  - Foster collaboration among many parties
- New roles for judge, attorneys, and treatment system

Mental Health Court vs. Mental Health Docket: Potato vs. Potato

Source: Corey Schaal, Mental Health Court Program Manager Supreme Court of Ohio

- Mental Health Court – a specialty docket – not a separate, special court.
- Definition – Specialized Dockets:
  - "A therapeutically oriented judicial approach to provide court supervision and appropriate treatment for offenders"

First Mental Health Court

- Based on the success of the drug court model, several jurisdictions across the country have developed specialized courts to address mental illness.
- Like drug courts, the central goal of mental health courts is to reduce the recidivism of defendants by providing them with court-monitored treatment.
- One of the first of these courts opened in June 1997 in Broward County, Florida.
  - Marion County Indiana (Indianapolis) had opened previously

Supervision

- Wide variation in frequency of court review
  - Weekly to "as needed"
  - Driven primarily by limited court resources
- Three approaches to supervision
  - Existing community treatment providers who report to court on a regular basis or when difficulties
  - MH Court staff or probation officer
  - Team of probation and mental health staff

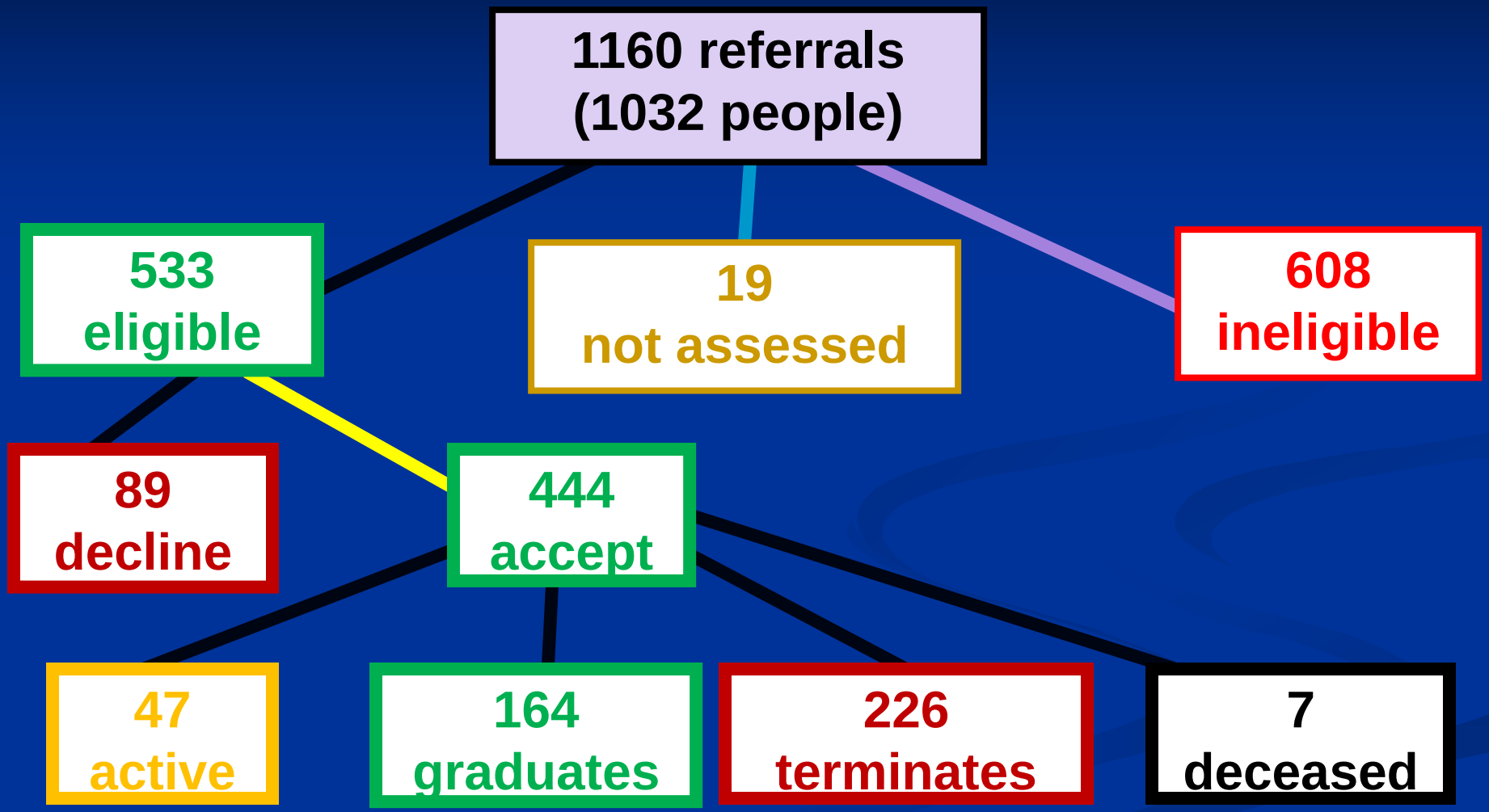
Specialized Dockets in Ohio

- In 1995, Hamilton County established the first drug court in Ohio. This court is the only therapeutic court mandated by an act of the Ohio legislature.
- 2001 was a red-letter year in Ohio: Akron Municipal Court started a mental health docket under Judge Elinore Marsh Stormer and Justice Evelyn Lundberg Stratton organized and began chairing the Supreme Court's Advisory Committee on Mentally Ill in the Courts (ACMIC).
- Today, 59 drug courts in Ohio ranks us second in the nation per capita. 35 recognized mental health courts out of ~150 in the nation ranks Ohio as number 1. There are also DUI, Re-entry and Domestic Violence Courts in Ohio with other variations under consideration

Akron Mental Health Court

- For those who get past CIT officers
  - Individuals who have an SMD
  - Who have been charged in lieu of jail time
- Voluntary offer of treatment in lieu of jail time
  - Two year program of community supervision by judge, probation officer and case
  - Carrot and stick approach
    - Graduated sanctions and rewards

Akron Mental Health Court



As of January 2010

Preliminary MH Court Research Findings
(Ritter, Munetz, Teller, & Bonfine)

Mental health court reduces incarceration

- Mental health court graduates experiences a significant decline in the proportion of time spent incarcerated after participating in the program compared to other individuals with mental illness living in the community
- Fewer mental health court graduates experienced a new incarceration after leaving the program compared to those who declined participation
- Mental health court graduates had fewer incarcerations after the program than before

Preliminary MH Court Research Findings
(Ritter, Munetz, Teller, & Bonfine)

Mental health court reduces recidivism rates

- When comparing mental health court graduates with 1) those who were eligible for the program but declined and 2) other individuals with mental illness living in the community, research has found that:
  - Mental health court graduates had a lower rate of recidivism when compared to the other groups
  - When mental health court graduates did recidivate, they had been in the community for a longer period of time before being arrested compared to the control groups

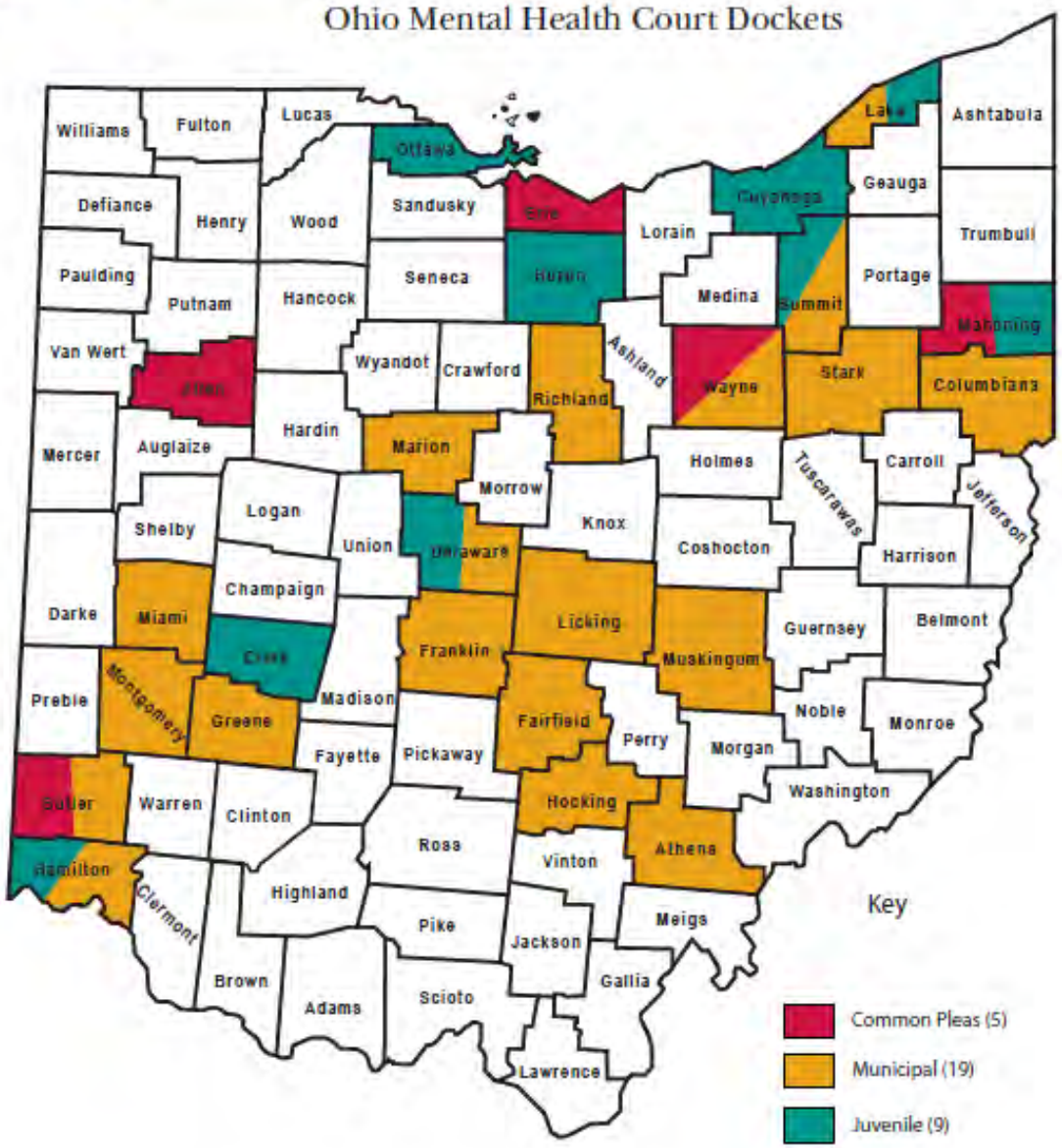
Preliminary MH Court Research Findings

Proportion days hospitalized:

- There were no differences in the proportion of days hospitalized after the index date when comparing those who graduated and those who declined to participate in the MHC
- The proportion of days hospitalized prior to the index date was a statistically significant predictor of the proportion of days hospitalized after the index date

THE SUPREME COURT of OHIO

Mental Health Courts in Ohio



The Back Door:

Linkages Between Institutions and the Community

Intercept 4

Allegheny County Pennsylvania Reentry Efforts

- In-reach into state prison in advance of discharge
  - Develop a relationship
- Meets released person at the bus station
- Arranges for temporary housing, bus passes, appointments for aftercare
- Takes person shopping for $200 worth of clothing and toiletries

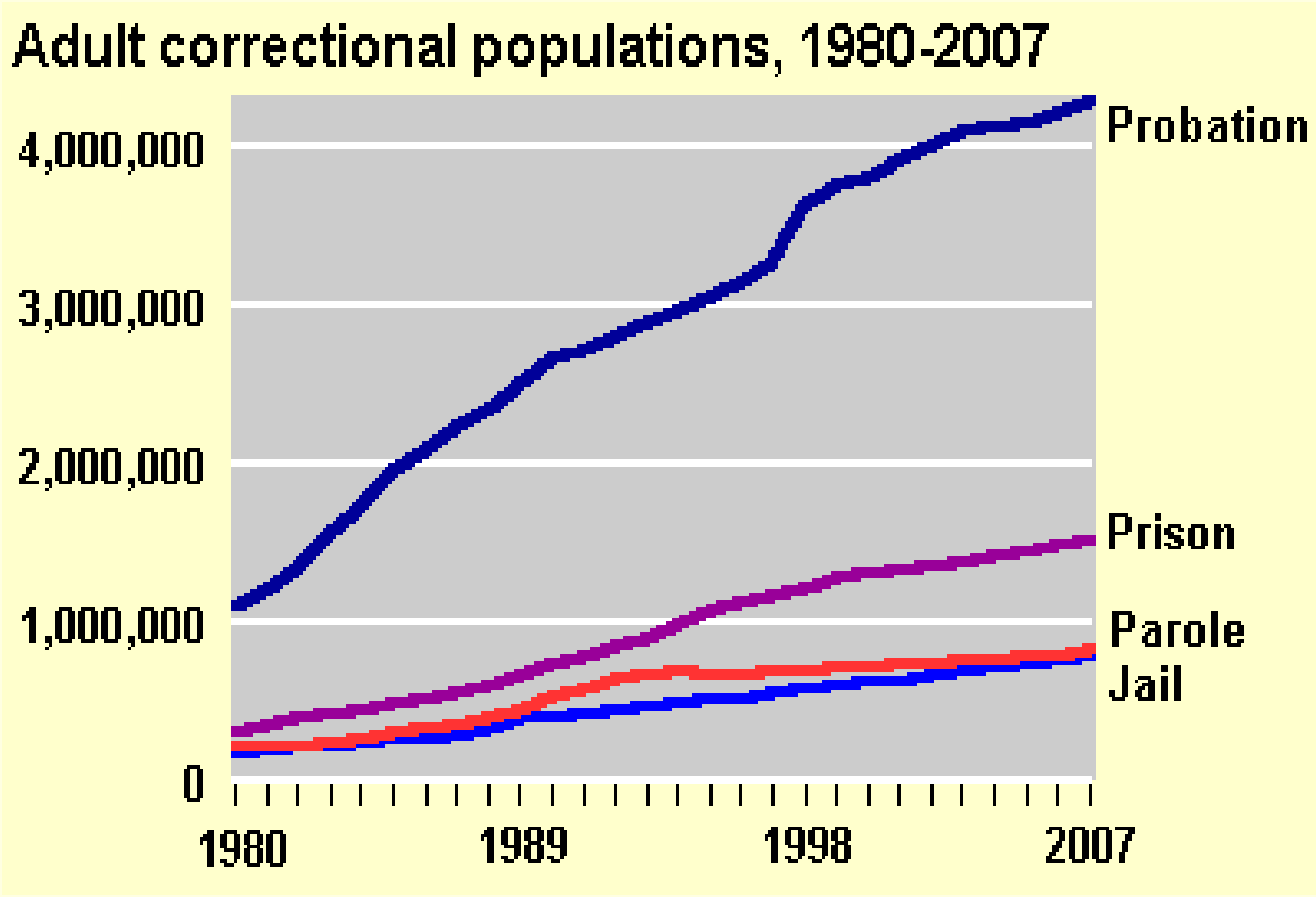
Allegheny County

State Justice Related Support Services

Developed in 1998

2005 Winner of the Innovation in American Government Award: a Program of the Ash Institute for Democratic Governance and Innovation

- ½ Time Supervisor and 1 Justice Related Services Specialist
- Works with Consumers with Mental Illness Maxing Out of State Correctional Institutions
- Follows 60-90 Days in the Community
- Voluntary Program
- Average Caseload = 45
- Recidivism Rate for 2006 = 14.6%



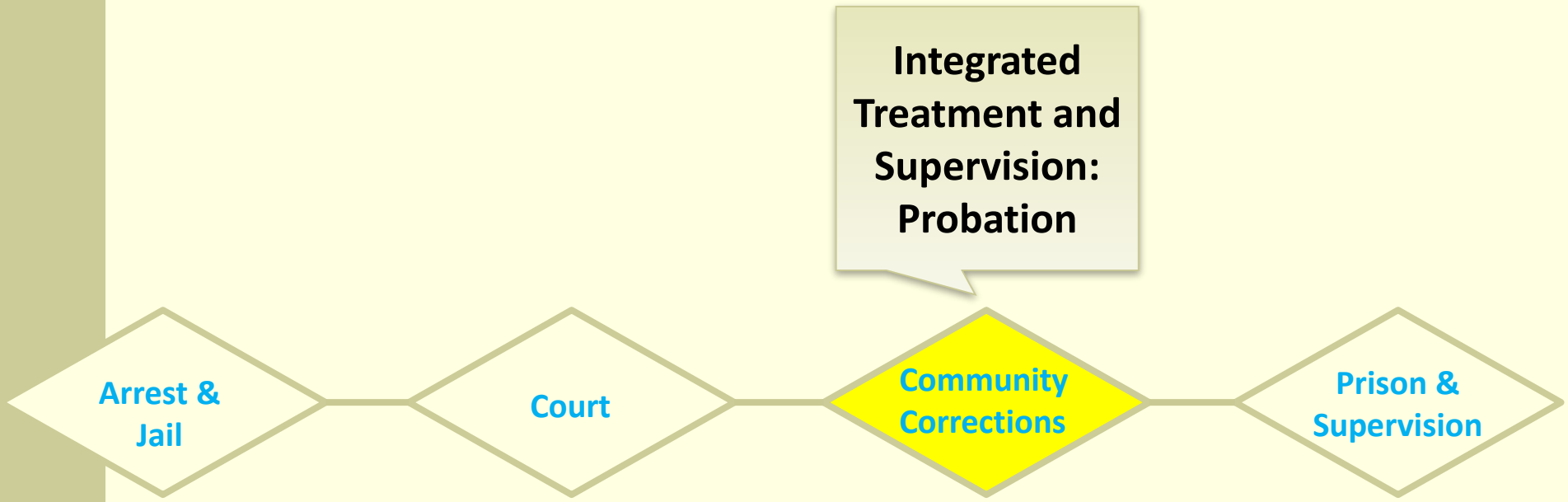
Bureau of Justice Statistics

People with severe mental illness are less likely to succeed on probation

- Probationers with mental illness were:
  - ***Less*** likely to have had their probation revoked because of a new arrest,
  - ***Equally*** likely to have had their probation revoked because of a new felony conviction, and
  - ***More*** likely to have had their probation revoked because of a new misdemeanor conviction.
- Probationers with mental illness are ***more*** likely to have their probation revoked because of failure to pay fine or fees, and "other" violations (e.g., failure to work).
- Why?
  - Functional impairments that complicate their ability to follow standard conditions of probation (e.g., paying fees).
  - Different revocation thresholds set by judges or probation officers.

Dauphinot (1996)

Current Practices in Ohio: Community Corrections



2/3 don't have specialized probation officers for probationers with mental illnesses

2/3 said there are insufficient mental health services in the community for probationers

Effectiveness of Behavioral Health Services at Improving Probation Outcomes

How effective would more substance abuse and/or mental health services be in increasing the number of probationers who successfully complete their term of supervision?

32 % Very Effective

37 % Effective

14 % Somewhat Effective

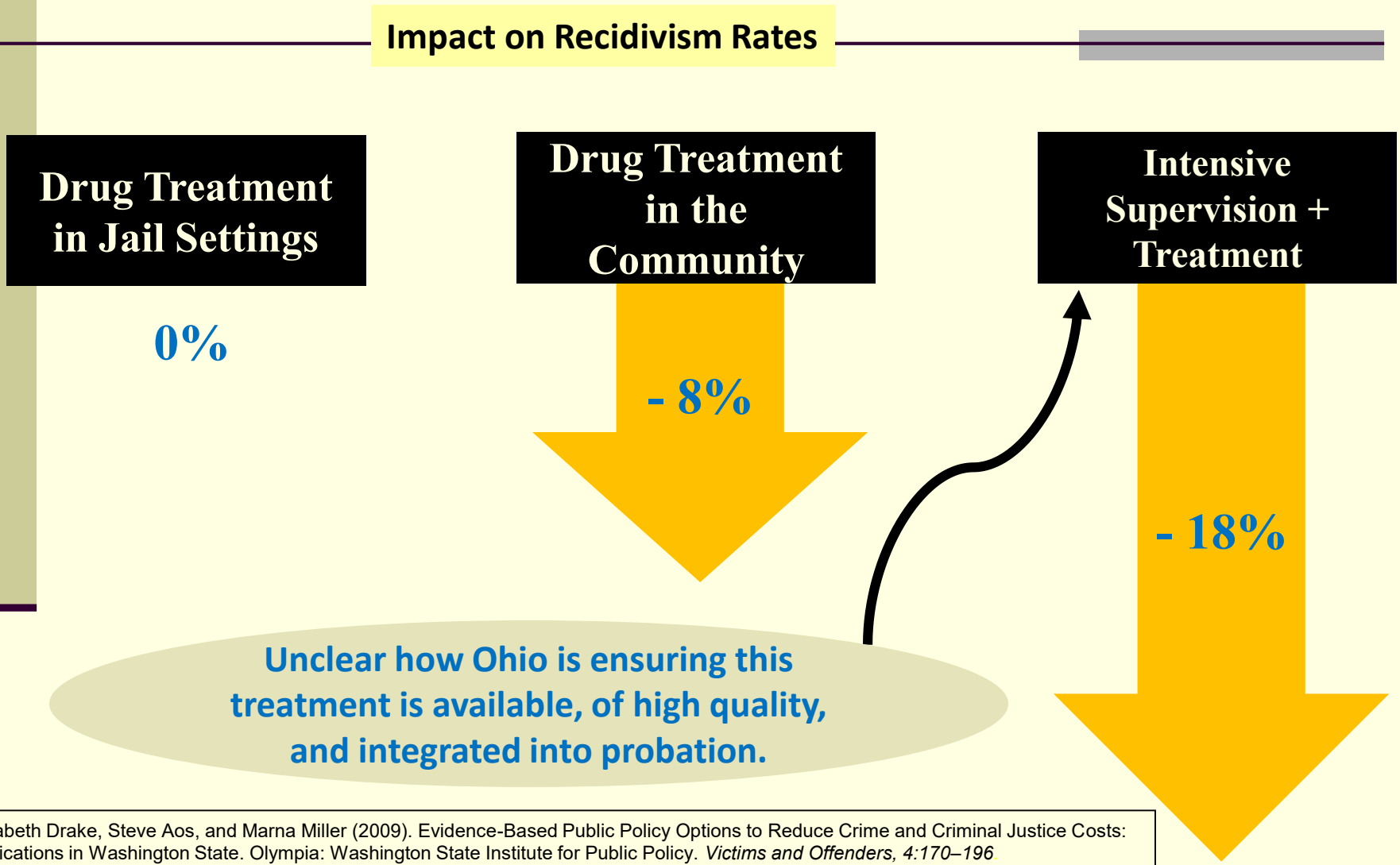
2 % Not Effective

69 % of judges said BH services were <u>effective or very effective</u> at improving probation outcomes

* Internet based survey conducted from
May 31 to June 11, 2010 with assistance from the administrative office of the Judicial Conference
** Not a random design that allows for generalization to the full population

CSG Report

Probation + Community-Based Treatment is Most Effective at Reducing Recidivism



Elizabeth Drake, Steve Aos, and Marna Miller (2009). Evidence-Based Public Policy Options to Reduce Crime and Criminal Justice Costs: Implications in Washington State. Olympia: Washington State Institute for Public Policy. *Victims and Offenders, 4:170–196*.

Bottom Line Summary

CSG Justice Center Report

1

Revolving Door

More than 10,000 F4 and F5 property and drug offenders are sentenced to prison, stay about 9 months in prison and then 72% are released to no supervision

Instead of short prison sentences, treatment + supervision in the community would reduce crime, recidivism, and prison costs, but requires dedicated reinvestment

Bottom Line Summary:
CSG Justice Center Report

2

No Admission Criteria for Diversion Programs
Ohio has invested heavily in a wide range of community corrections programs to divert these offenders from prison, but no criteria or consensus exists about which offenders (by offense & risk level) should utilize these programs

Use CBCF and HWH programs to address risk, not treatment needs

Any treatment received in a CBCF/HWH will have little impact unless matched with community treatment and supervision upon release

Bottom Line Summary

3

Patchwork of Probation Supervision
Most criminal offenders are sentenced to probation supervision, which is an uncoordinated tangle of municipal, county, and state agencies with wide variations in policies, training, supervision standards, and outcomes, with no data being collected statewide

Without community-based treatment, probation will be less effective.

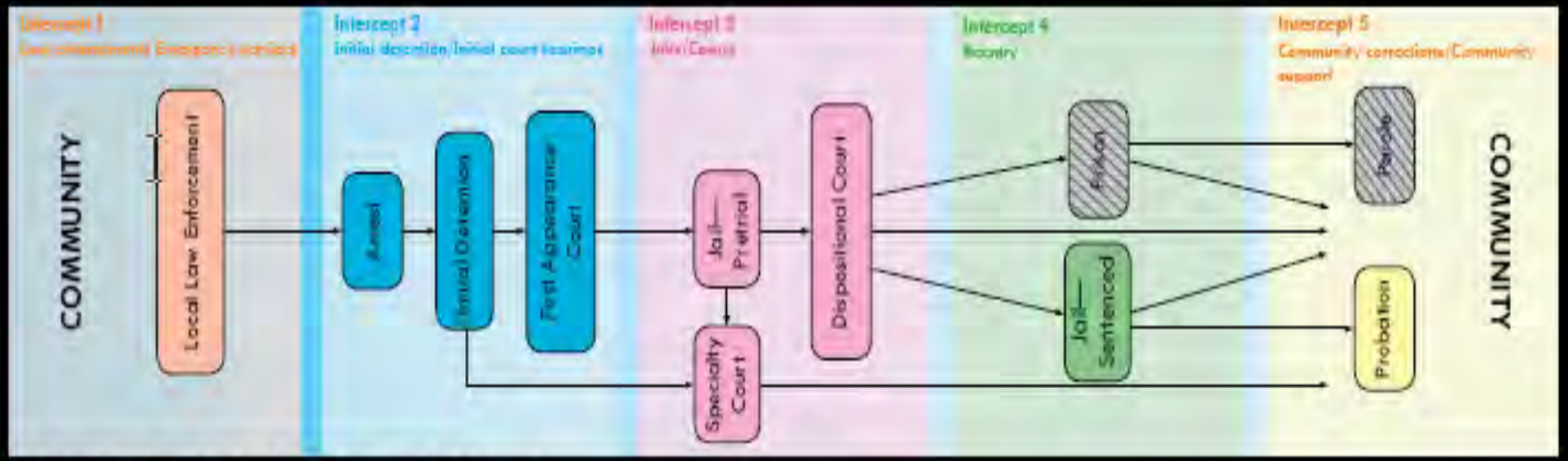
Without effective probation supervision, treatment will be less effective.

Evidence-based treatment and probation supervision must both be in place to achieve reductions in recidivism.

Sequential Intercepts for Change: CJ–MH Partnerships

Actions for State Level Change...

- Develop a statewide effort to provide Crisis Intervention Training for police as done in OH, AZ
- Pass legislation encouraging jail diversion programs as done in FL, MI, IN, CT, TX
- Facilitate changes at the State level to allow the retention of Medicaid or SSI eligibility via suspension in jail rather than termination, as done in Lane County, OR
- Remove constraints that exclude persons formerly incarcerated from housing or services; make criminal justice clients a priority for housing, as done in MD
- Expand access to evidence-based programs in community-based services for people with mental illness in contact with the justice system
- Create criminal justice priority eligibility group without "net-widening" or limiting services to others, for instance, by using HUD funds for housing and Justice Assistance Grants (JAG)
- Provide access to comprehensive and integrated treatment programs for persons with mental illness and co-occurring substance use disorders diverted or released from the criminal justice system
- Legislate task forces/commissions made up of mental health, substance abuse, and criminal justice stakeholders to legitimize addressing the issues as done in TX, AZ, CA
- Utilize the State planning process to integrate mental health, substance abuse, and criminal justice; identify incentives to get stakeholders in each system to the table
- Support training programs that focus on cross-systems collaboration and provide opportunities for using people with mental illness as cross-trainers



Action Steps for Service Level Change by Intercept...

- *Request for Police Service:* Train dispatchers to identify calls involving persons with mental illness and refer to designated, trained responders
- *On-Scene Assessment:* Train officers with de-escalation techniques to effectively assess and respond to calls where mental illness may be a factor
- *Incident Documentation:* Document police contacts with calls involving a person with mental illness to promote use of available services and ensure accountability
- *Police Response Evaluation:* Collaborate with mental health partners to identify available services and reduce frequency of subsequent contacts by individuals with histories of mental illness and with prior arrests

Source: Policy Statements 2-6, Consensus Project (2002)

- *Appointment of Counsel:* Provide defense attorneys with earliest possible access to client mental health history and service needs, available community mental health resources, and legislation and case law impacting the use of mental health information in case resolution
- *Prosecutorial Review of Charges:* Maximize the use of alternatives to prosecution through pretrial diversion in appropriate cases involving people with mental illness
- *Pretrial Release & Modification of Pretrial Diversion Conditions:* Maximize the use of appropriate pretrial release options and assist defendants with mental illness in complying with conditions of pretrial diversion

Source: Policy Statements 7-11, Consensus Project (2002)

- *Intake Procedure:* Establish a comprehensive, standardized, objective, and validated intake procedure to assess individuals' strengths, risks, and needs upon admission
- *Individualized Programming Plan:* Using information obtained from assessments, identify programs necessary during incarceration to ensure safe and successful transition to the community
- *Physical Health Care & Mental Health Care:* Facilitate community-based providers' access to prisons and jails and promote service delivery consistent with community and public health standards
- *Substance Abuse Treatment, Children & Families, Behaviors & Attitudes, Education & Vocation Training:* Provide effective substance abuse treatment, services for families and children of inmates, educational and vocational programs, peer support, mentoring, and basic living skills

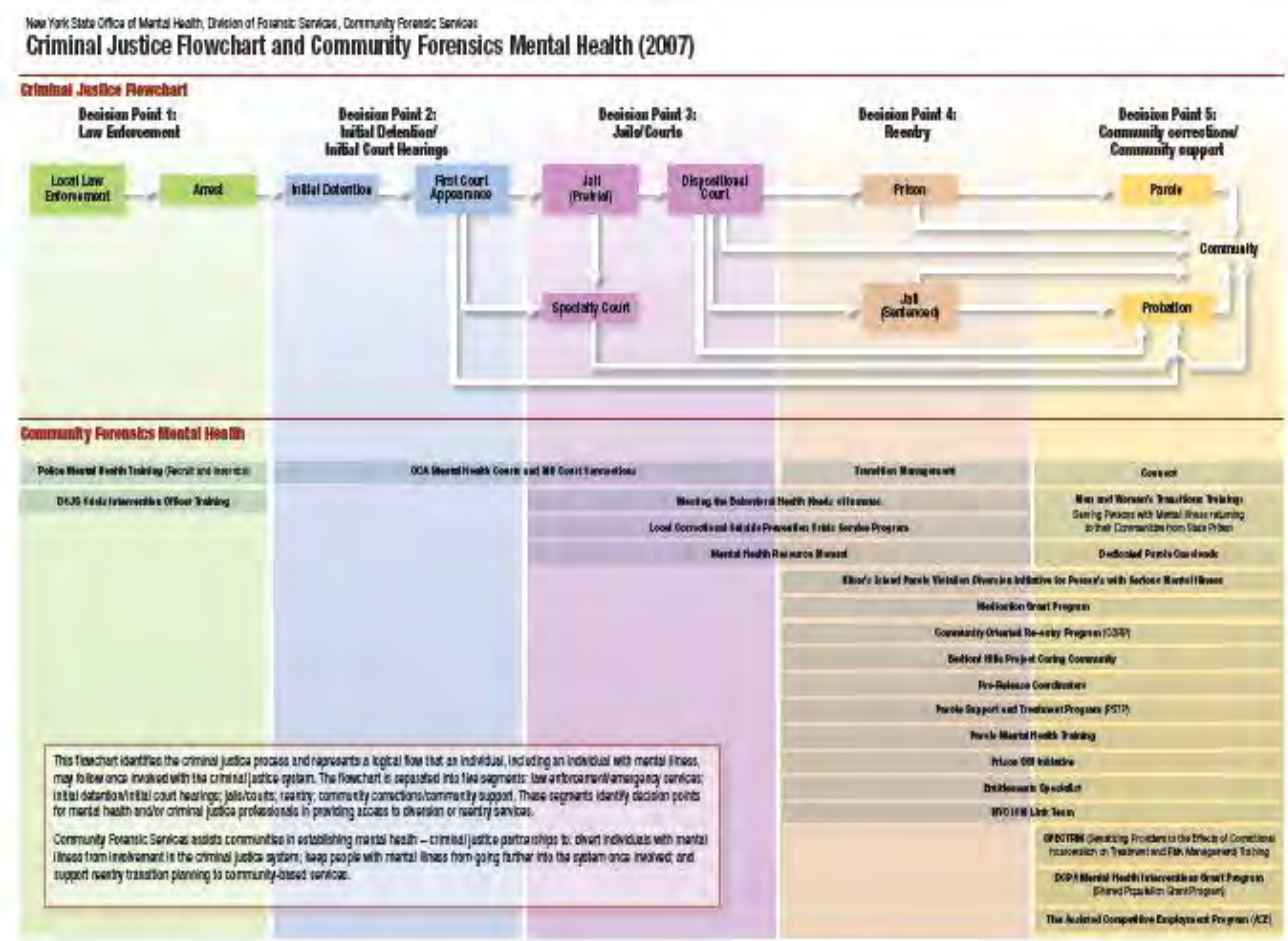
Source: Policy Statements, 8-13, Re-Entry Policy Council (2004)

- *Subsequent Referral for Mental Health Evaluation:* Identify individuals not identified in screening and assessment process who show symptoms of mental illness after their intake into the facility and ensure appropriate action is taken
- *Development of Transition Plan:* Effect the safe and successful transition of people with mental illness from prison or jail to the community
- *Transition Planning:* Facilitate collaboration among corrections, community corrections, and community providers and utilize a transition Checklist to identify service needs and provide effective linkage to services
- *Identification & Benefits:* Ensure releasees exit prison or jail with ID and prior determinations of eligibility and linkage to public benefits to ensure immediate access upon release from prison or jail

Source: Policy Statement 19-21, Consensus Project (2002); APIC Re-Entry Report; SAMHSA Gaining Ground; 18 & 24, Re-Entry Policy Council (2004)

- *Implementation of Supervision Strategy:* Concentrate community supervision resources on the period immediately following the person's release from prison or jail, and adjust supervision strategies as the needs of releasees, victim, community, and family change
- *Maintaining a Community of Care:* Connect inmates to employment, including supportive employment services, prior to release. Facilitate releasees' sustained engagement in treatment, mental health and supportive health services, and stable housing
- *Graduated Responses & Modification of Conditions of Supervised Release:* Ensure a range of options for community corrections officers to respond to reinforce positive behavior and effectively address violations or noncompliance with conditions of release

Source: Policy Statements 24-29, Re-Entry Policy Council (2004); 22, Consensus Project (2002)


New York State Office of Mental Health, Division of Forensic Services, Community Forensic Services
Criminal Justice Flowchart and Community Forensics Mental Health (2007)
Criminal Justice Flowchart
Decision Point 1: Law Enforcement
Decision Point 2: Initial Detention/ Initial Court Hearings
Decision Point 3: Jails/Courts
Decision Point 4: Reentry
Decision Point 5: Community corrections/ Community support
Local Law Enforcement
Arrest
Initial Detention
First Court Appearance
Jail (Pretrial)
Dispositional Court
Prison
Parole
Community
Specialty Court
Jail (Sentenced)
Probation
Community Forensics Mental Health
Police Mental Health Training (Recruit and In-service)
Transition Management
Mental Health Resource Manual
Medication Grant Program
Community Oriented Re-entry Program (CORP)
Bedford Hills Project Caring Community
Pre-Release Coordinators
Parole Support and Treatment Program (PSTP)
Parole Mental Health Training
Entitlements Specialist
The Assisted Competitive Employment Program (ACE)
This flowchart identifies the criminal justice process and represents a logical flow that an individual, including an individual with mental illness, may follow once involved with the criminal justice system. The flowchart is separated into five segments: law enforcement/emergency services; initial detention/initial court hearings; jails/courts; reentry; community corrections/community support. These segments identify decision points for mental health and/or criminal justice professionals in providing access to diversion or reentry services.
Community Forensic Services assists communities in establishing mental health – criminal justice partnerships to: divert individuals with mental illness from involvement in the criminal justice system; keep people with mental illness from going further into the system once involved; and support reentry transition planning to community-based services.

State of Washington
Sequential Intercept Planning Outline

Intercept	Problems	Possible Solutions	Issues to be Resolved
I: Law Enforcement & Emergency Svcs	•Erratic behavior evokes police response •Police feel unprepared •Emergency rooms take time, return offender quickly to streets	•Specialized & trained response teams •Specialized crisis response sites ▪[This section should, but does not, match the corresponding narrative above about sequential intercepts on page 7, item #1]	•Ability of specialized response teams to respond over large geographic areas on a 7/24 basis •Legal constraints on no-refusal and commitment authority of crisis stabilization centers •Expense of constructing and staffing secure facilities, duplication of nearby jail operations
II: Pre-Booking Diversion	•High flow of detainees with short stays requiring individualized responses •Stress on jail intake systems, e.g. restraint & suicide issues	•MH screening & diversion •Partial confinement pre-trial •Collaboration, jails & social service/mh providers	•Consent & privacy issues re information sharing between jail and mh agencies •Jail staff resources, training, and cultural resistance to incorporating clinical need into decisions
III: Jails & Courts	•Same as above, plus: standard sentences lack deterrent value	•Crisis intervention training for correctional staff •Mental health courts •Mental health professionals advise regular courts ▪[This section should, but does not, match the corresponding narrative above about sequential intercepts on page 7, item #3]	•Interaction of public safety, accountability, and clinical needs •Use of court orders to circumvent restrictions on community treatment or hospital admission •Post-adjudication sentencing alternatives for felonies/ violent offenses
IVA: Transition from Jails	•Short stays + high traffic→ pre-release planning↓ •Laws & agency policies restricting service eligibility upon release	•Interagency collaborative planning begins @ intake •Expedited eligibility programs & policies	•Policy vs. resource issues affecting eligibility & transition planning •Federal vs. state rules & regulations
IVB: Transition from Prisons	•Delays & low intensity of svc, limited housing options •Restrictive Medicaid eligibility rules •Walls between prison & comm. mh staff	•Funding for pre-release planning & engagement •Medicaid eligibility waiting period waivers •Interagency collaboration	•Expense of intensive treatment & housing for persons with mental health stigma, extensive or violent records •Prison staffing & administrative resources for assessment, treatment, & pre-release planning
V: Community Services & Supervision	•Incentives to preserve resources for existing clientele •correctional vs. social service methods	•Collaboration policies, local staff relationships	•Distinct authority & practices of correctional, social services, statewide and local agencies

ACTION: Cross-Systems Mapping

Cross-Systems Mapping

Creating a Local Cross-Systems Map

- This 1-day workshop visually depicts how people with mental illness come in contact with and flow through the criminal justice system
- It brings together key stakeholders to tap into local expertise
- A local map is created using the Sequential Intercept Model developed through the CMHS National GAINS Center at PRA
- Opportunities and resources are identified for diverting people to treatment
- Gaps in services are summarized

Cross-Systems Mapping Exercise

- Reflects how individuals move through the local criminal justice system
- Indicates points for intervention or diversion of people with mental illness
- Provides a visual depiction of the ways in which treatment systems interact with the local criminal justice system

Priorities for Change

- PRA provides examples of successful systems integration, promising programs, and emergent collaborations from around the U.S.
- Participants determine areas where immediate steps will effect a more cohesive, integrated approach to service delivery
- A local set of priorities for change

Additional Benefits

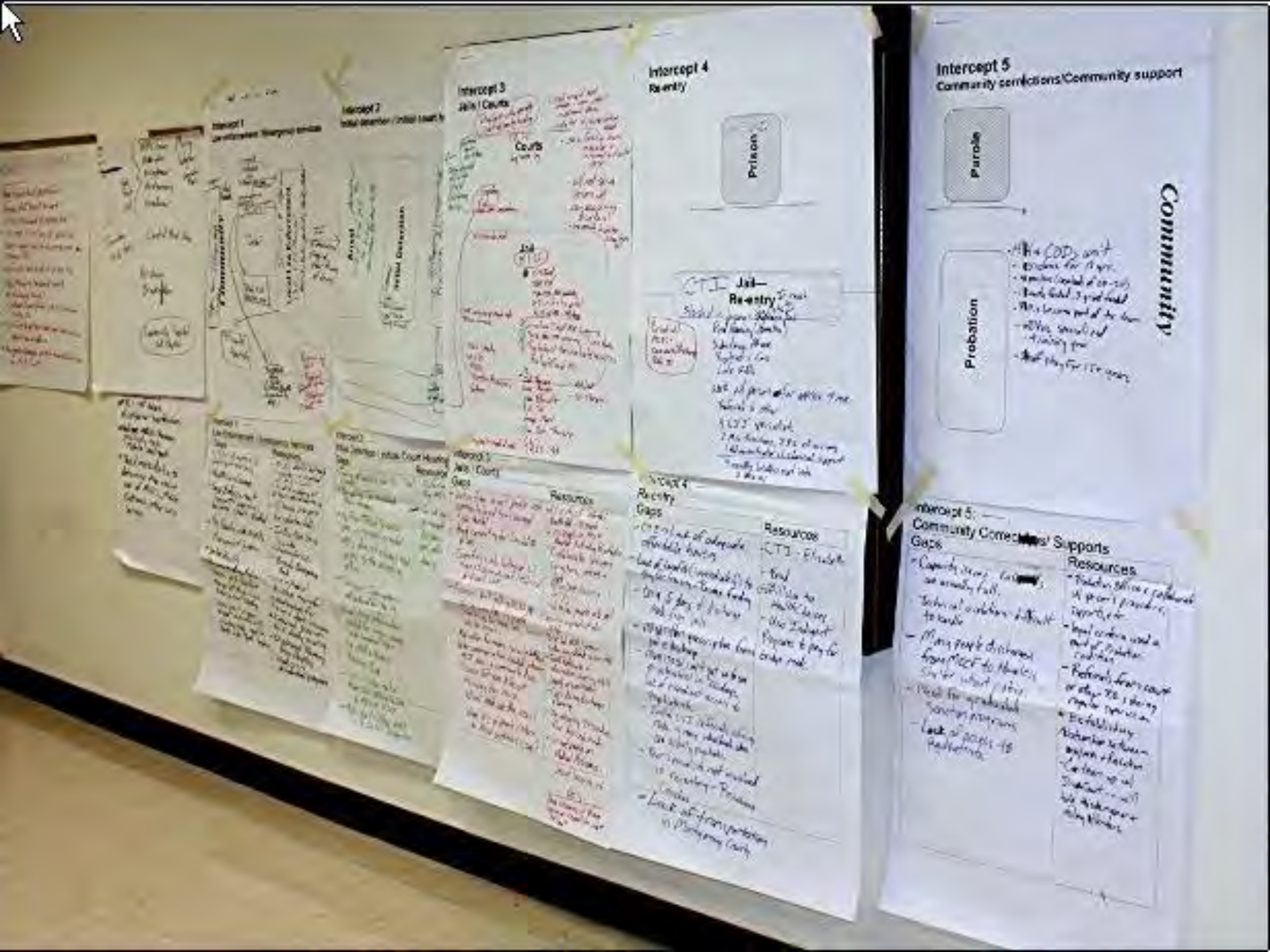
- This workshop facilitates cross-system communication
- The Cross-Systems Mapping Exercise facilitates cross-system collaboration
- This collaboration in turn improves the early identification of people with co-occurring disorders coming into contact with the criminal justice system, increases effective service linkage, reduces the likelihood of recycling through the criminal justice system, enhances community safety and improves quality of life

For information & pricing, contact PRA Training

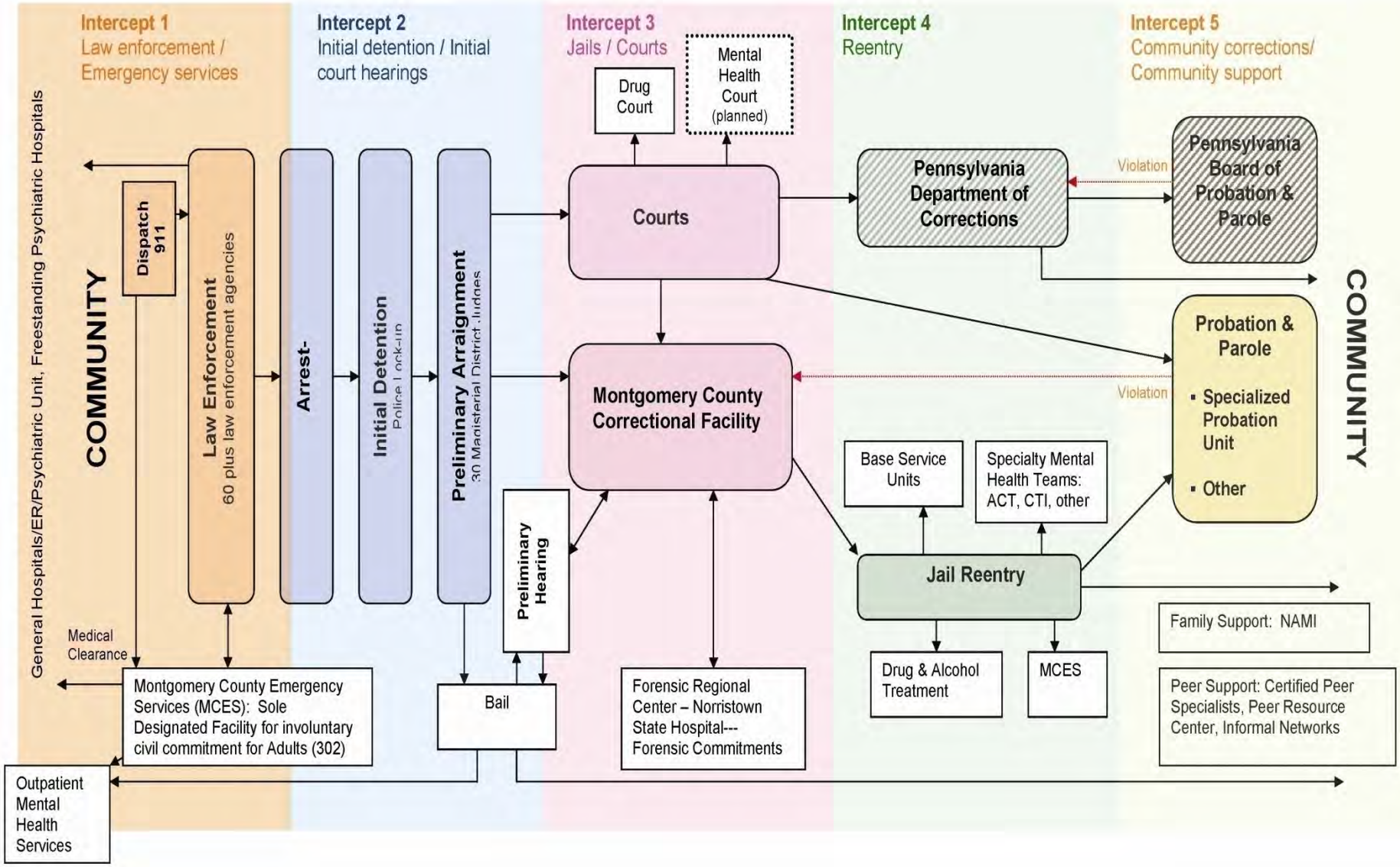
Policy Research Associates, Inc. • 345 Delaware Avenue • Delmar, NY 12054
518.439.7415 • training@prainc.com

Policy Research Associates, Inc.—a national leader in mental health research and its application to social change since 1987, providing assistance to over 100 communities nationwide through a broad range of services to guide policy and practice.

Policy Research Associates
www.prainc.com


Intercept 3
Jails / Courts
Courts
Jail
Intercept 4
Re-entry
Prison
Jail—
Re-entry
Intercept 5
Community corrections/Community support
Parole
Probation
Community
Intercept 3
Jails / Courts
Gaps
Resources
Intercept 4
Re-entry
Gaps
Resources
Intercept 5:
Community Corrections/ Supports
Gaps
Resources

Montgomery County, PA, 2008 – Sequential Intercepts for Change: Criminal Justice - Behavioral Health Partnerships



"I also saw how bringing disparate groups together --- even those with conflicting missions --- could often be effective ..... The power of proximity --- spending time side-by-side --- had pulled us all to compromise in our efforts to help ..... People, not programs, change people. The cooperation, respect, and collaboration we experienced gave us hope that we could make a difference …"

- Bruce Perry & Maia Szalavltz, 2007

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