NEW FREEDOM COMMISSION ON MENTAL HEALTH

Subcommittee on Criminal Justice:

BACKGROUND PAPER

June 2004

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The content of this publication reflects the views and opinions of the Subcommittee on Criminal Justice. Therefore, this paper is a product of the process that advised the full Commission and as such does not reflect the position of the President's New Freedom Commission on Mental Health or any agency of the United States Government.

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Preface

The President's New Freedom Commission on Mental Health appointed 15 subcommittees to assist in its review of the Nation's mental health service delivery system. The full Commission appointed a Chair for each subcommittee. Several other Commissioners served on each subcommittee, and selected national experts provided advice and support. The experts prepared initial discussion papers that outlined key issues and presented preliminary policy options for consideration by the full subcommittee. The subcommittee reported to the full Commission only in summary form. On the basis of this summary, the full Commission reached consensus on the policy options that were ultimately accepted for inclusion in the Final Report, *Achieving the Promise: Transforming Mental Health Care in America*. Therefore, this paper is a product of the subcommittee only and does not necessarily reflect the position of the full Commission or any agency of the United States Government.

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Introduction

Scope of the Problem

Remarkably, there are approximately 1.3 million people in U.S. State and Federal prisons (Beck, Karberg and Harris, 2002), another 631,000 people in local jails (resulting from 13 million jail admissions annually) (Beck, 2002), and 4.6 million people under correctional supervision in the community (Bureau of Justice Statistics, 2001).

The rates of serious mental illnesses for all of these people are about three to four times that of the general U.S. population (Teplin, 1990). This means that about 7% of all incarcerated people currently have serious mental illnesses; the proportion with any type of mental illness is substantially higher. An estimated 93,000 people with mental illnesses are in prisons, 44,000 are in jail, and another 320,000 are under corrections supervision in the community on a given day (Teplin, 1990).

The people with serious mental illnesses who come in contact with the criminal justice system are typically poor and uninsured, are disproportionately members of minority groups, and often are homeless and have co-occurring substance abuse and mental disorders. They cycle in and out of homeless shelters, hospitals, and jails, occasionally receiving mental health, substance abuse services, but most likely receiving no services at all (APA, 2000). The majority of these individuals has committed misdemeanor crimes and do not belong in the criminal justice system (National GAINS Center for People with Co-Occurring Disorders in the Justice System, n.d.).

The problem is inescapable in almost every urban community. It has frustrated judges, prosecutors, criminal justice system administrators, families, and consumers alike. Advocates from across the spectrum are united in recognizing the need for reform.

Alternatives

Cost studies suggest that taxpayers can save money by placing people with serious mental illnesses who come into contact with the criminal justice system into mental health and substance abuse treatment programs rather than jails and prisons. Proven models for diversion programs operate in many parts of the country.

The Eighth Amendment of the U.S. Constitution protects the right to treatment for acute medical problems, including psychiatric problems, for inmates and detainees in America's prisons and jails. Several models have been developed providing guidelines for Correctional Mental Health Care and some States have implemented them.

Costs appear to be lower for providing services within the mental health system rather than in the criminal justice system.

The Subcommittee on Criminal Justice envisions the availability of a range of effective interventions for offenders with mental illnesses. Its vision rests on years of research evaluating innovative programs in communities across the nation. Effective interventions come in a variety of forms. They include:

- Diversion programs to keep minor offenders with serious mental illnesses out of the criminal justice system where they do not belong,
- Services in correctional facilities for those with serious mental illnesses whose crimes

are serious enough to warrant incarceration, and

- Discharge planning, i.e., linking people with serious mental illnesses to community-based services upon discharge from correctional institutions.

This range of interventions creates effective alternatives for the courts, correctional institutions, and people with mental illnesses.

This Subcommittee finds that providing a range of effective mental health interventions for offenders with mental illnesses serves the public interest in two ways: improved public safety and better, more efficient public health.

With respect to public safety, streets are safer and correctional facilities are more secure. With respect to public health, the costs appear to be lower for providing services within the mental health system rather than in the criminal justice system. In addition, the most dispossessed Americans have better clinical outcomes and better chances for recovery. Their lives are no longer derailed by inadequate care and by the stigma of a criminal record. What has worked in a few U.S. communities can work in many more.

The Issues and Their Context

Mental Illnesses among Persons in the Criminal Justice System

Mental illnesses are common among persons in the criminal justice system. The rates of serious mental illnesses among incarcerated persons are about three to four times those of the general U.S. population. The most carefully developed 2-week rates of schizophrenia, bipolar disorder, and depression in incarcerated populations are about 6.4% for males and 12.2% for females in any 2-week period (Teplin, 1990). Overall, this means about 7% of all incarcerated people have current serious mental illnesses.

Applied to the prison, jail, and correctional supervision population figures above, this would mean about 910,000 people with serious mental illnesses are admitted each year to jails. On a given day, there are approximately 93,000 people with serious mental illnesses in U.S. prisons, 44,000 in U.S. jails, and 320,000 under corrections supervision in the community (APA, 2000).

As a comparison, there are only about 40,000 patients on a given day in State mental hospitals throughout the country (National Association of State Mental Health Program Directors [NASMHPD], 2001). The number of offenders with mental illnesses is growing due to the overall growth in the jail and prison populations (Bureau of Justice Statistics, 2001).

Using a broader definition of serious mental illness than did Teplin, the Federal Bureau of Justice Statistics found a 16% prevalence rate of mental illnesses among correctional detainees (Bureau of Justice Statistics, 1999). Their survey counted the number of surveyed inmates who answered "yes" to either of two questions, "Do you have a mental or emotional condition?" or "Because of emotional or mental condition, have you ever been admitted to a mental hospital, unit, or treatment program where you stayed overnight?" Both the clinical conditions and the timeframes ("ever") are much broader and less scientific than Teplin's estimates, but they are still useful.

If the Federal Bureau of Justice Statistics' 16% prevalence rate of mental illnesses among correctional detainees were used as the actual rate for program planning, there would be approximately 2,080,000 individuals with serious mental illnesses admitted to U.S. jails each year. On a given day, there would be 212,500 inmates with serious mental illnesses in U.S. prisons, 111,000 jail detainees with serious mental illnesses, and another 730,400 people with serious mental illnesses under the auspices of community corrections departments.

The People with Serious Mental Illnesses in Criminal Justice Settings

It is critical to understand who are the people with serious mental illnesses who come in contact with the criminal justice system because the composition of this population guides policies for individual programs and for the broader issues of program design and organization. These individuals tend to be poor, uninsured, homeless, and tend to have co-occurring substance abuse disorders. They tend to continually cycle through the mental health, substance abuse, and criminal justice systems (APA, 2000).

People with money and private health insurance who have serious mental illnesses rarely end up in the criminal justice system. This paper focuses on those who are poor and depend on public sector services and public insurance programs such as Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and charity for their health care.

Overrepresentation of Persons of Color in Correctional Settings

When examining issues involving the criminal justice system, it should be noted that persons of color are greatly overrepresented in the correctional population as compared to the U.S. population. African-Americans represent 41% of all jail detainees and 46% of prison inmates, and Hispanics represent 15% of jail detainees and 16% of prison inmates (Beck and Harrison, 2001; Beck and Karberg, 2000). However, each group (individually) represents only 12% of the U.S. population (U.S. Census, 2000).

The issue of overrepresentation of persons of color in the criminal justice system is especially important with respect to mental disorders and co-occurring substance abuse disorders. Persons of color with these disorders historically have been misdiagnosed, overrepresented in inpatient psychiatric care, and underrepresented in community mental health services (Osher, 2002).

The recent Surgeon General's report, *Mental Health: Culture, Race and Ethnicity* (2001), documents the disparities in access to behavioral health care for persons of color. Because some community mental health agencies are reluctant and often feel ill prepared to provide services to people with histories of arrest and incarceration, persons of color are more likely to experience barriers in accessing care (Osher, 2002). This points to the critical need for "cultural competence" to improve systems of care (Osher, 2002).

Women in Correctional Settings

Another group that warrants special consideration is women. Women are a dramatically growing presence in all parts of the criminal justice system. Between 1990 and 1998, the number of women on probation increased 40%, while the number of women in local jails jumped 60% and the number of women in State and Federal prison increased 88%. The number of women under parole supervision increased by 80% during this same time period (Chesney-Lind, 2000). Current statistics reveal that women comprise 11% of the total jail population (Beck & Karberg, 2001), 6% of prison inmates (Beck & Harrison, 2001), 22% of adult probationers, and 12% of parolees (BJS, 2001).

Gender-specific services and gender-responsive programming are increasingly needed but rarely present in correctional facilities designed primarily for men.

Women in correctional institutions have a rate of serious mental illnesses almost twice that of male detainees (Teplin, Abram, & McClelland, 1996). Many women entering jails have themselves been victims of violent crime and often have multiple problems in addition to mental health and substance abuse disorders, including childrearing and parenting difficulties, health problems, and histories of being victims of violence, sexual abuse, and trauma (Teplin et al., 1996).

Gender-specific services and gender-responsive programming are increasingly needed but rarely present in correctional facilities designed primarily for men. For women entering jails, early needs assessment and screening for mental health and substance abuse disorders, and other needs relating to self and family are critical to both the classification and treatment-planning phase.

Co-occurring Substance Abuse Disorders

The best estimates indicate that 75% of all people with serious mental illnesses in the criminal justice system have a co-occurring substance abuse disorder (Teplin, Abram and McClelland, 1996).

Recent research has shown persuasively that people with serious mental illnesses and co-occurring substance abuse disorders require integrated treatment services (Drake, Mercer-McFadden, Mueser, et al., 1998). Integrated treatment means that both types of disorders are treated as primary, that both disorders are treated

simultaneously rather than sequentially, and that the treatment team is fully integrated in its clinical approaches.

Because integrated treatment has been uncommon in U.S. communities, especially in the public sector, people with co-occurring disorders often enter the criminal justice system after having been bounced in and out of mental health and substance abuse programs where they were deemed "treatment resistant." In fact, it is now recognized that their constant cycling results much more from "client-resistant" services (i.e., services that are not oriented to the needs of individuals with co-occurring disorders) than from "treatment-resistant clients."

Seventy-five percent of all people with serious mental illnesses in the criminal justice system have a co-occurring substance abuse disorder.

Need for Community-Based Services

Quite clearly, using either estimate of mental illnesses among incarcerated people, there is a huge need to provide community-based services for those who do not need to be in the criminal justice system

In fact, most people with mental illnesses who are arrested are charged with crimes of public nuisance, petty larceny, drug possession, and/or assault without battery (e.g., pushing and shoving a police officer during apprehension) (Naples & Steadman, 2003).

Contrary to conventional wisdom, people with mental illnesses usually are *not* violent. While they may have higher rates of violence than other people in their neighborhoods, this is explained by their high rates of co-occurring substance abuse disorders (Steadman, Stainbrook, Griffin, et al., 2001). The overall rates of violence among people with mental illnesses are much lower than popular stereotypes would suggest (Link & Stueve, 1995). From the limited research, it is hard to put an exact number on what proportion of people with serious mental illnesses who come in contact with the justice system do so because of recent violence. However, the figure is probably between 15% and 20%, based on the fact that 16% of the subjects in the Substance Abuse and Mental Health Services Administration (SAMHSA) Jail Diversion Knowledge Dissemination Application (KDA) had some type of low-level violent charges (Naples & Steadman, 2003).

Need for Services in Correctional Institutions

There is also a huge need to provide services for those who *do* belong in correctional institutions. The provision of effective services fulfills the needs of detainees and inmates with serious mental illnesses, families of these people, law enforcement personnel dealing with them on the street, administrators and staff managing correctional facilities, court personnel (including judges, prosecutors and public defenders), and members of the community.

Costs of the Criminal Justice Setting

There are very little data with which to accurately measure the costs of processing and detaining people for whom community-based treatment would be preferable to the criminal justice system. Only two studies have carefully assessed costs for people with mental disorders in contact with the justice system. Each approached the problem from a different perspective, but both demonstrated that the costs of addressing mental illnesses in the criminal justice system are far greater than in the mental health system.

In a 3-year followup of 203 people enrolled in a program for co-occurring mental and substance

abuse disorders in New Hampshire, Clark and colleagues (1999) found that 169 participants had legal contacts, with 90 arrested at least once. The average cost associated with non-arrest encounters was $385, while for arrest encounters it was $2,295.

The second cost study compared the costs over a 90-day period to the criminal justice and mental health systems in Connecticut for people diverted from jails and for those with similar characteristics who were not diverted. For those diverted, the inpatient and incarceration costs averaged $1,322 and for those processed in the usual way in the criminal justice system, the costs averaged $3,819, a difference of $2,497 (Solnit, 2000).

While the data are very limited, they do suggest that, looking only at dollar costs, there are serious disadvantages to using the criminal justice system to respond to the needs of people with serious mental illnesses who most often have co-occurring substance abuse disorder.

Translating Commitment into Policy and Program Action

One way in which this paper attempts to inform policy planning is by describing successful programs that many U.S. communities have created, often with only a modicum of new resources. While the problems seem overwhelming, significant achievements have been made to improve the lives of people with serious mental illnesses as a result of new partnerships and innovative programs at the community level.

First and foremost, innovations occurred because of political will. The existence of the President's New Freedom Commission on Mental Health demonstrates that commitment at the Federal level. This paper addresses how this commitment can be translated into necessary policy and programmatic action. The President's Commission can build on the already large and growing levels of momentum on these issues.

Prioritizing Solutions

Federal programs and State mental health authorities must capitalize on the many opportunities that already exist for financing core services for people with mental illnesses in contact with the criminal justice system.

In this paper, the Subcommittee on Criminal Justice discusses the key issues for persons with mental illnesses in criminal justice settings and highlights exemplary programs that address these issues. Finally, the Subcommittee proposes nine policy options to ensure a range of effective interventions for people with mental illnesses who come into contact with the criminal justice system.

If these are the people who need to be served and if these are the realities of our criminal justice system, what must communities do to solve this problem? Based on the direct experience with 140 communities on these issues by the National GAINS[1] Center and the recent National Criminal Justice/Mental Health Consensus Report by the Council on State Governments, the basic steps are evident.

Needed Responses

Three major responses are needed:

1. **Diversion programs** to keep people with serious mental illnesses who do not need to be in the criminal justice system out of it**.**
2. **Institutional services** to provide constitutionally adequate services in correctional facilities for people with serious mental illnesses who do need to be the criminal justice system because of the severity of the crime**.**
3. **Reentry transition programs** to link people with serious mental illnesses to community-based services when they are discharged**.**

[1] GAINS is the acronym for gathering information, assessing what works, interpreting the facts, networking with key stakeholders, and stimulating change.

The remainder of this paper will:

- Elaborate on the essential components in each of these three response areas,
- Identify programs that have successfully implemented these components, and
- Offer policy options, particularly at the Federal level, that are suggested by these successful implementations.

Creating Effective Diversion Programs

Diversion programs for people with serious mental illnesses can be of two basic types: *prebooking*, i.e., before any criminal charges are filed; and *postbooking*, i.e., after charges are filed. Postbooking programs, in turn, can also be of two types, court-based and jail-based, with the location referring to where the people to be diverted are identified and their alternatives to incarceration are planned and negotiated.

Effective Diversion Programs

The data from the recently completed SAMHSA Jail Diversion KDA nine-site study indicated all three types of diversion (prebooking, jail-based postbooking, and court-based postbooking) may work equally well depending on other community characteristics. If there are appropriate services to which people are diverted, police, court, or jail diversion programs can successfully reduce recidivism and extend the community tenure to those diverted.

Diversion programs accomplish three things:

1. **Find** the people in the target group who are to be diverted;
2. **Arrange** an appropriate multisystem service plan; and
3. **Negotiate** an arrangement between prosecutor, defense council, and the judge for these services in lieu of incarceration.

To successfully accomplish these tasks requires dedicated staff members who are, above all, boundary spanners, i.e., people who are adept at operating across, and who have credibility with, multiple systems (i.e., mental health, substance abuse, criminal justice, social services, housing, and health; Steadman, 1992).

According to Steadman (1992), mounting a successful diversion program requires the following key components:

- **Coordinating a comprehensive set of services** at the community level, including integrated mental health care and substance abuse treatment, physical health, and social services (such as housing and entitlements), with a high level of cooperation among all involved agencies.
- **Liaisons** to bridge the barriers between the mental health and criminal justice systems and to manage the interactions between corrections, mental health, and judicial staff. These individuals need to have the trust and recognition of key players from each of the systems to be able to effectively coordinate the diversion effort.
- **A strong leader** with good communication skills and an understanding of the systems involved and the informal networks needed to put the necessary pieces in place.
- **Early identification** of detainees with mental health treatment needs who meet the diversion program's criteria. This is done through the initial screening and evaluation that takes place in a crisis triage center, an arraignment court, or at the jail.
- **Case managers** who have experience in both the mental health and criminal justice systems and who are culturally and racially similar to the clients they serve. An effective case management program is one of the most important components of successful diversion.

Examples of Diversion Programs

What follows are descriptions of different types of diversion programs that embrace the key components described above.

Memphis, Tennessee, Pre-Booking Diversion

A cooperative effort of law enforcement, health care, and advocacy organizations, the Police Crisis Intervention Team (CIT) model originated in Memphis, Tennessee in 1988. The patrol division of the Memphis Police Department and the University of Tennessee Psychiatric Emergency Service at the Regional Medical Center (the MED) operate the program. The goal is to divert individuals with mental illnesses in crisis at the point of first interaction with the police.

The CIT program provides intensive training for about 20% of patrol division officers, those who volunteer to be part of the team. A coalition of community-based providers, consumers, and family members take the lead in providing the training. Police officers have the option of referring individuals in crisis to the MED in lieu of filing any criminal charges. The emergency service provides a 15-minute turnaround time for officers and accepts all individuals regardless of clinical condition or social services needs. Once admitted to the MED, unit staff members assess the need to transfer the individual to the State hospital or provide referrals to community mental health programs and other resources.

Evaluations of the Memphis CIT program have shown that it has had a positive impact on officers' perceptions related to crisis interventions and increased officer confidence in their own skill level (Steadman, Deane, Borum, & Morrissey, 2000; Borum, Deane, Steadman & Morrissey, 1998; Steadman, Stainbrook, Griffin, et al., 2000). Only 2% of CIT officer encounters resulted in arrests, compared to 16% for typical police encounters.

Preliminary results of the SAMHSA study on jail diversion indicate reduced rates of rearrest, decreased incidence of substance abuse and psychiatric symptomatology, and increased quality of life ratings among diverted persons (Dupont, 2001).

Connecticut, Court-based Post-Booking Diversion

In 2000, the Connecticut Department of Mental Health and Addiction Services (DMHAS) established diversion programs to serve all 22 of the lower level courts in the State. Diversion team members, who are employees of the local mental health center, work at the courts and screen the arraignment lists for known clients. Court staff also send the diversion team additional referrals.

Diversion clinicians conduct brief screenings and assessments as needed and develop treatment plans collaboratively with the client. This plan is presented to the court and negotiated with the bail commissioner, the public defender, the State's attorney, and the judge. The clinician refers the client to a community service or hospital and monitors the client's progress.

Possible outcomes include deferred prosecution with the condition of treatment resulting in the decision not to prosecute, probation with special condition of treatment, or dismissal of charges. The teams also provide services to those who cannot be diverted and are incarcerated.

Researchers found that diverted subjects had followup arrest rates comparable to those of a control group, but spent less time in jail or in a hospital. More specifically, 30% of the diverted subjects had an arrest in the followup period, compared with 32% in a comparison group drawn from courts with no diversion projects.

The diverted group, however, spent an average of 14.3 days in jail and .46 days in a hospital following enrollment compared to the nondiverted subjects' average of 29.8 days in jail and 2.4 days in a hospital (Frisman, Sturges, Baranoski, & Levinson, 2001). These figures translate into major cost savings for diversion programs.

Broward County, Florida Mental Health Court

Founded in June 1997, the Broward Mental Health Court is designed to divert misdemeanor defendants with mental illnesses arrested for nonviolent offenses from jail to appropriate treatment facilities. It is a voluntary, part-time court that convenes daily to address the specialized needs of these individuals.

Family members, lawyers, jail staff, or county criminal court judges usually refer potential clients to the court within 24 hours of arrest. The defendant is screened by a psychiatrist who works for the private firm that provides health services to the county jail, or by doctoral students assigned to the Public Defender's office. This screening determines whether the defendant is eligible to participate in the mental health court, is legally competent, or needs to be admitted involuntarily to a hospital. If eligible to participate, the defendant, the family, court personnel, and clinicians determine what treatment services are appropriate. Most often, the defendant is referred to a community mental health center, while homeless defendants are sent to a residential facility.

Treatment providers supply progress reports to court monitors who can, if necessary, go to the court to make adjustments in the treatment plan. Defendants with minor charges and no criminal history may have their charges dismissed with the prosecutor's consent. In most cases, adjudication is withheld, meaning that a record is made of the arrest and court disposition, but no judgment is entered.

A core principle in the Broward County Mental Health Court, which is common to all existing U.S. specialty courts, is a strong commitment by the presiding judge *to therapeutic jurisprudence* (Hora, Schma, & Rosenthal, 1999), which views the court as a therapeutic intervention for people with mental illnesses. It is closely allied to the idea of procedural justice, which views the court process from the defendant's standpoint and recognizes that when defendants with mental illnesses feel that they are given a "voice" in the court process, they feel less coerced, regardless of how much involuntary supervision and treatment may be ordered by the court. The Broward County Mental Health Court implements the concept of therapeutic jurisprudence through relatively informal proceedings that allow ample time for disposition and provide a direct link between mental health court defendants and appropriate community services (Poythress et al, 2002).

Arizona, Jail-Based Postbooking Diversion

Jail-based, postbooking jail diversion programs are operated by the Regional Behavioral Health Authorities (RHBA) in Maricopa (Phoenix) and Pima (Tucson) counties. The jail diversion programs consist of three diversion tiers, including release on conditions, deferred prosecution, and summary probation.

Jail liaisons employed by the RHBA identify and screen incarcerated persons receiving mental health services from RHBA networks and make recommendations to the court for diversion, in consultation with mental health case managers, jail mental health staff, public defenders, prosecutors, and judges.

Persons released on conditions are expected to report to their mental health case manager and comply with conditions of treatment. Charges may be dropped or clients may be offered deferred prosecution, where charges are suspended and ultimately dropped upon successful completion of the diversion treatment program.

Persons given summary probation are convicted and given special conditions to comply with mental health treatment in lieu of jail time.

The Nathaniel Project, Alternative to Incarceration

The Nathaniel Project is a 2-year alternative-to-incarceration program operated by the Center for Alternative Sentencing and Employment Services (CASES) for people with serious mental illnesses who are charged with felony offenses in New York City. The project's clients are usually facing prison sentences of 3 to 6

years. The program will consider any defendant regardless of offense, including violent offenses.

Project staff interview clients at the courthouse or in jail. Once accepted, Nathaniel Project staff advocate for the client's release to the project. After an agreement is reached with the court, staff coordinate the components of the treatment plan prior to the client's release, including housing, residential treatment, and other services, including case managers who are available 24 hours a day, 7 days a week. Clients are typically released after pleading guilty, with sentencing adjourned pending successful completion, which results in reduced or dismissed charges. Clients who fail receive lengthy sentences in State prison.

Data show that the number of arrests for Nathaniel Project clients dropped dramatically, from 101 arrests in the year prior to arrest project intake to seven in the year after intake. Also, while only 10% of clients had permanent housing at intake, 79% had permanent housing one year later (National GAINS Center, 2002).

Meeting Constitutional Standards in Correctional Facilities

Inmates and detainees in America's prisons and jails, unlike the general public, have constitutional rights to some degree of treatment. The protections are similar to those afforded to patients in State mental hospitals who, as a *quid pro quo* for deprivation of their liberty, have a right to treatment (c.f. Wyatt v. Stickney, 344 F. Supp. 373, 344 F. Supp. 387 (M.D.Ala. 1971)).

Constitutionality of a Correctional Mental Health System

Courts have interpreted the Eighth Amendment of the U.S. Constitution, which protects against cruel and unusual punishment, as requiring a modicum of treatment for acute medical problems—including psychiatric problems—for jail and prison inmates.

This is not to say that jail or prison is to be thought of as a preferred place for people with mental illnesses. Community-based treatment is the first choice via diversion or transition planning. However, for those people appropriately incarcerated who have mental illnesses, the deliberate failure to provide treatment has been interpreted by the courts to be cruel and unusual punishment.

Court cases have established a distinction between intentional versus negligent failure to provide care. *Intentional* failure to provide inmates with adequate medical care and to tend to their medical needs has been interpreted as violating the Eighth Amendment, thereby constituting cruel and unusual punishment.

However, the *negligent* failure to provide medical care does not violate the Eighth Amendment. The 1976 U.S. Supreme Court case, *Estelle v. Gamble*, set the precedent that for prison officials to be deliberately indifferent to the serious medical needs of those in their custody was unconstitutional, while *Bowring v. Godwin* (1977) expanded the scope to include psychiatric care.

The 1980 case, *Ruiz v. Estelle*, listed six criteria for constitutionally acceptable mental health services in jails and prisons, while *Madrid v. Gomez* (1995) identified an additional six factors to determine the constitutionality of a correctional mental health system. All 12 factors are listed below.

From *Ruiz v. Estelle:*

1. Systematic screening and evaluation;
2. Treatment that is more than mere seclusion or close supervision;
3. Participation by trained mental health professionals;
4. Accurate, complete, and confidential records;
5. Safeguards against psychotropic medications that are prescribed in dangerous amounts, without adequate supervision, or otherwise inappropriately administered; and
6. A suicide prevention program.

From *Madrid v. Gomez:*

7. A means for inmates to make their needs known to medical staff;
8. Staffing that is sufficient to allow individualized treatment of each inmate with a serious mental illness;
9. Speedy access to services for inmates;

10. A system of quality assurance;
11. Competent and well-trained staff; and
12. A system to respond to emergencies and to prevent suicides.

Guidelines for Correctional Mental Health Care

Several guidelines have been developed for correctional mental health care. An American Psychiatric Association Task Force developed comprehensive guidelines outlined in *Psychiatric Services in Jails and Prisons* (APA, 2000), while the National Commission on Correctional Health Care (NCCHC) published *Standards for Correctional Health Care for Jails* (1996) and *Prisons* (1997).

In a consistent approach these publications broadly divide jail and prison mental health services into three categories:

- **Identification**, including screening, referral, and evaluation;
- **Treatment**; and
- **Linkage**, including discharge planning from jail or prison.

IDENTIFICATION: SCREENING, REFERRAL, AND EVALUATION

1. Mental health screening and determination of safety issues or custodial requirements must occur upon arrival at jail or prison and include observation, symptoms identification, and treatment and medication records.
2. Screening must include standardized questions, written policies and procedures, and required actions with timeframes for positive mental health screening.
3. A brief mental health assessment must be conducted within 72 hours of a positive screening and referral—or immediately in the case of an emergency—and any further comprehensive diagnostic mental health exams must be conducted within 14 days of arrival and include access to psychological services.
4. Mental health emergency services must be accessible upon referral on a 24-hour basis and a psychiatrist must be on staff for diagnostic exams and medication prescription.
5. All health care and custodial staff must receive ongoing training in use of the referral process.
6. All inmates must receive an early explanation of the referral process.

TREATMENT

1. **Jail: Crisis Intervention**

   Because of the short-term nature of most jail stays, treatment emphasizes crisis intervention with medications and brief or supportive therapies and consumer education. Longer jail stays or pretrial confinement may require services similar to those offered in prison programs. Jail-based mental health services should include inpatient resources in the jail or external hospital settings, 24-hour mental health and nursing coverage (including a staff psychiatrist), written treatment plans, medications and medical personnel, special observation capabilities, out-of-cell programs, and custodial staff trained in the recognition of mental disorders. Even crisis intervention responses should be connected to plans for referral to treatment services following release to the community.

2. **Prison: Intermediate/Long-term Treatment**

   Due to the longer duration of most prison sentences, long-term treatment plans may be implemented. Mental health treatment still includes crisis intervention and suicide prevention. However, in the prison setting the emphasis is on continued monitoring and treatment throughout the incarceration and the development of discharge plans.

LINKAGE: DISCHARGE PLANNING FROM JAIL OR PRISON

All treatment services should be related to the transition back to the community. This process is discussed in detail in the next section.

For all of these institutional services, it is critical to adhere to Veysey's (1998) key areas for developing effective gender-specific programs.

- Parity of mental health services between men and women;
- Targeted screening and evaluation procedures and gender-specific instruments to identify histories of abuse, medical problems, and child care issues;
- Special crisis intervention procedures to avoid re-traumatizing consumers, including noninvasive, nonthreatening de-escalation techniques for general use;
- Peer support and counseling programs to help women to address mental health problems and violent events in their lives, and to connect with their communities prior to release;
- Targeted parenting programs directed at education, empowerment, and practical skills; this is a promising practice for ending cycles of violence in families, especially because women in jail settings, frequently both victims and perpetrators of violence, are at increased risk of abusing their own children;
- Training programs for security, mental health and substance professionals on gender-specific services, procedures, and issues; and
- Development of appropriate outcome measures for treatment interventions for women diagnosed with mental illnesses in jails; these measures should accommodate the wide variation in women's life experiences, adaptive styles, and modes of recovery.

Two Model Correctional Mental Health Programs

Below we describe two correction mental health programs in Ohio and Massachusetts that adhere to the guidelines above.

Ohio Department of Rehabilitation and Corrections: The Ohio Plan

The State of Ohio settled a 1991 class action lawsuit (*Dunn v. Voinovich)* by signing and implementing a consent decree that inspired a set of new initiatives in prison mental health care. The Ohio Department of Rehabilitation and Corrections (DOC) chose to develop a service system that is consistent with a community mental health model. The new system aims to coordinate appropriate and continuous care for inmates with mental illnesses, providing a continuum of care and treatment that spans from prison intake to community reentry and parole supervision. The Ohio Plan emphasizes the following components in its continuum of care:

- **Identification and treatment planning**

  All inmates received by DOC or transferred to other institutions within the system are screened by medical and mental health staff for mental illnesses. If screening identifies a history of mental illness or current distress, the inmate is referred for an evaluation by psychiatrists or licensed psychologists who make treatment recommendations. Treatment planning is conducted by a multidisciplinary team that includes the inmate.

- **Tracking**

  A computerized classification system identifies the current level of needed mental health care. Before being transferred to other facilities, the inmate's level of classification is verified to ensure care can be continued in the new facility.

- **Acute care**

  The Oakwood Correctional Facility provides short-term crisis treatment for those who

represent a risk of harm to themselves or others.

- **Clusters**

  The prison system is divided into clusters of one to five institutions. Each cluster, which is like a catchment area, has a mental health team that works collaboratively, using a multidisciplinary approach to developing a range of interventions, including outpatient and residential services. Each cluster has one residential treatment unit for those who require a therapeutic milieu and a full range of services.

- **Psychiatric outpatient services**

  Mental health care and support services are offered for prisoners with serious mental illnesses who can function in the general population.

- **Community linkages**

  The DOC and the Department of Mental Health work together to provide community linkages for inmates with mental illnesses who are leaving prison. To ensure continuity of care, community linkage social workers assist inmates prior to their release in setting up appointments with mental health agencies.

Women's V.O.I.C.E.S., Hampden County, Massachusetts

Located within the Women's Unit of the Hampden County Correctional Center in Massachusetts, the Women's V.O.I.C.E.S. (validation, opportunity, inspiration, choice, empowerment, and safety) program is a jail-based treatment and education program focused on assisting pre-trial and sentenced women inmates in dealing with addiction, trauma, and parenting.

Women's V.O.I.C.E.S is a four-phase program of education, peer health, life skills, and addiction treatment classes. Components include:

- High school and college level education classes,
- Anger management,
- HIV/AIDS education and treatment,
- Trauma treatment, and
- Vocational courses.

Addiction treatment is provided through a graduated program that coincides with the four phases. Additional components include 12-step Alcoholics Anonymous and Narcotics Anonymous groups, religious services, and activities to promote greater physical health.

The gender-specific curriculum employs principles that take note of the documented gender differences between male and female offenders:

- Validation,
- Safety,
- Personal application,
- Relational/support building,
- Confidentiality, and
- Boundaries.

The curriculum includes female-only groups, an emphasis on cognitive and behavioral change, a validation of self-expression, and phased progression through treatment and educational components.

The staff of Women's V.O.I.C.E.S. is specifically trained to focus on trauma, mental health, addictions, and histories of violence. Staff members match the women in the program to community resources and clinically appropriate group activities, build problem-solving skills, and focus on increasing the choices available to women inmates in their lives.

Release planning from the jail to the community is provided for inmates during the final phase of the program.

New Approaches for Reentry Programs

Hundreds of thousands of people return to our communities from jails and prison each year. Given that 7 to 16% have serious mental illnesses, many will need to be linked to community-based services or they risk return to correctional institutions, often after having caused serious distress to their families and members of the community Ventura, Cassel, Jacoby, & Huang, 1998). Despite this serious need, a survey of our nation's approximately 3,500 jails in the mid-1980s found only 26% reported that they had any type of discharge planning (Steadman & Veysey, 1997).

Transition Planning

Transition planning can and should be different for people with mental illnesses who are completing long-term prison stays than for those completing short-term jail stays (Griffin, 1990; Hartwell and Orr, 2000; Hammett, Roberts, & Kennedy, 2001).

Transitioning from Jails

Jails, unlike prisons, detain individuals who are awaiting appearance in court and those awaiting sentencing who are denied or unable to make bail. They also hold people serving short-term sentences, usually less than a year. The short-term nature of many incarcerations in jails (often less than 72 hours) requires rapid assessment and planning. The challenge may be offset by the fact that jail inmates are less likely than prisoners to have lost contact with treatment providers in the community.

Nonetheless, short stays and the frequently unpredictable nature of discharges can make transition planning from jails particularly challenging (Griffin, 1990). Inadequate transition planning puts people with mental illnesses who entered the jail in a state of crisis back out on the streets in the midst of that same crisis.

Good transition planning for jail inmates with mental illnesses and co-occurring substance abuse disorders requires coordination of responsibility among jails, jail-based mental health and substance abuse treatment providers, and community-based treatment providers. Jails should be charged with screening and identifying inmates with mental illnesses and co-occurring disorders, crisis intervention, and psychiatric stabilization.

Jails are required by the Constitution to perform such functions, and providing them often improves the management of these facilities. They also supply important information to discharge planners who have the responsibility for establishing linkages between inmates and community services.

Model Transition Programs

APIC Model

Recently, an innovative model for transition reentry planning for both jails and prisons—APIC (Assess, Plan, Identify and Coordinate)—was developed by Osher, Steadman, and Barr (2002). The APIC model is a set of critical elements that, if implemented in whole or in part, are likely to improve outcomes for persons with co-occurring disorders who are released from jail. The components of this model are described below:

1. **Assessment** involves:
   - Cataloging the inmate's psychosocial, medical, and behavioral needs and strengths;

- Gathering information from law enforcement, court, corrections, correctional health, and community providers necessary to create a fully informed transition plan;
- Incorporating a cultural formulation in the transition plan to ensure a culturally sensitive response; and
- Engaging the inmate in assessing his or her own needs and ensuring that the inmate has access to and the means to pay for treatment and services in the community.

The transition plan must consider special needs related to cultural identity, primary language, gender, and age to ensure that the inmate is linked with services that will accept the person and connect him or her with a compatible peer group.

The need for continuity in mental health treatment following arrest and upon release from jail is paramount. Medications that have been started by community providers must continue without interruption when a person with a mental illness is detained.

Obtaining a release to talk with community providers and calling them to ascertain current treatment is critical to the inmate receiving effective care and subsequently behaving within the jail setting and participating in his or her own defense. Families will often have important information to share regarding the effectiveness of treatment for the inmate. Jail personnel, even without a release, can listen to advice provided by family members and check the accuracy of this information with the inmate.

2. **Planning** involves responding to assessed needs by learning from the inmate what has and has not worked during past transitions, and by seeking family input when relevant. Arranging an integrated treatment approach through transition planning can work only if justice, mental health, and substance abuse systems have the capacity and commitment to work together, addressing the critical period immediately following release—the first hour, day, and week after leaving jail—as well as long-term needs, by ensuring that the inmate:
   - Is on an optimal medication regimen and has sufficient medication to last at least until followup appointment;
   - Has adequate clothing;
   - Has resources to obtain adequate nutrition;
   - Has transportation from jail to his or her place of residence and from this residence to appointments; and
   - Has childcare arrangements that will allow appointments to be kept.

   Addressing housing needs and initiating a benefits application or reinstatement of benefits for eligible inmates—for Medicaid, SSI/SSDI, Veterans, food stamps, and Temporary Assistance for Needy Families (TANF)—while they are incarcerated is another essential piece of the transition plan.

3. **Identifying** the specific community and correctional programs that will be responsible for post-release services is the next step. It involves naming in the transition plan specific community referrals that are appropriate to the client based on the underlying clinical diagnosis, cultural and demographic factors, financial arrangements, geographic location, and legal circumstances. This planning will provide the outside provider, prior to release, with a complete discharge summary, including diagnosis, medications and dosages, legal status, and transition plan.

   Community providers should employ evidence-based practices to ensure optimal outcomes. Family psychoeducation, illness self-management, and integrated treatment for co-occurring mental and addictive disorders may be essential components in reducing recidivism following reentry.

   An often poorly understood transition component is ensuring that every individual who is released has a photo ID, supporting conditions of release, and community corrections supervision that matches the severity of the individual's criminal behavior. The goal is to ensure that the

treatment and supportive services match the ex-inmate's level of disability, motivation for change, and the availability of community resources.

It is essential to clarify the issues of confidentiality and information sharing with the community treatment agency or managed care/case management entity in the community, addressing the community service provider's role (with regard to limits of confidentiality) vis-à-vis other social service agencies, parole and probation, and the court system. The transition plan should be documented in the charts of both the jail behavioral health service agency and the community provider.

4. **Coordinating** the transition plan to ensure implementation and avoid gaps in care involves supporting the case management entity in coordinating the timing and delivery of services and in helping the client span the jail/community boundary after release. First and foremost, it means confirming that the individual knows where, when, and with whom the first followup visit is scheduled and that the individual has adequate medications to last, at the very least, until that visit.

   Responsibility for care of the individual between the time of release and the first followup appointment must be explicitly communicated to the individual, the family, the releasing facility, and the community agency. The individual being released must know whom to call if it is necessary to change the followup appointment. A corollary is having a mechanism in place to track individuals who do not keep the first followup appointment.

Which of these APIC elements are most predictive of improved outcomes awaits empirical investigation. Two examples of programs with key pieces of the APIC Model follow.

THRESHOLDS: TRANSITION FROM JAIL TO THE COMMUNITY

Begun in Chicago in 1997, the Thresholds, State, County Collaborative Jail Linkage Project helps inmates with mental illnesses in the Cook County Jail transition from jail to the community. This program uses the Bridge Model of assertive community treatment, which provides long-term, comprehensive, and integrated services.

Thresholds counselors work with the Illinois Office of Mental Health and the Cook County Bureau of Health Services to identify referrals. These counselors visit potential clients (called "members") in jail and accompany them to court, sometimes securing early release into the program's custody.

Members are expected to comply with medication regimens, work with a psychiatrist, and nominate Thresholds as a payee. Thresholds secures housing arrangements for members, usually in a single-room occupancy hotel. A multidisciplinary team shares responsibility for members, and staff are available to members 24 hours a day, 7 days a week. The program works to link members with their local community mental health centers.

This program received a Gold Achievement Award in 2001 from Psychiatric Services. Researchers found that the number of jail days for Thresholds members decreased by over 80% from the previous year to the year of involvement with Thresholds. There was also a 52% reduction in the number of arrests during this same time period, while the number of days in psychiatric hospitals decreased by 85% (American Psychiatric Association, 2001).

NEW YORK STATE PAROLE-MENTAL HEALTH INITIATIVES: TRANSITION FROM PRISON TO PAROLE/COMMUNITY

A Memorandum of Understanding (MOU) between the New York State Office of Mental Health (OMH) and the New York State Division of Parole, composed in 1986 and revised in 1994, laid the groundwork for a series of parole-mental health initiatives designed to enhance interagency collaboration around issues pertaining to reentering inmates with mental illnesses.

Various programs around the State resulted from the MOU, including a prerelease coordination program in which prerelease coordinators located at each of New York's prison-based and satellite mental health units are responsible for reentry planning for inmates with serious mental illnesses. In 2000, prerelease discharge planning was provided for 1,200 inmates.

Inmates with serious mental illnesses are identified six months prior to release and assessed within three to five months of release. At three months, applications for Supplemental Security Income (SSI) are filed. Within two to three months, the inmate is transferred to the Central New York Psychiatric Center Discharge Ward. A month before release, referrals are made for housing and case management.

The referral packet is sent to the Parole Board and to the outpatient "Single Point of Referral," which investigates the inmates' home county to identify possible assisted outpatient treatment programs. Three weeks prior to discharge, applications for Medicaid, cash assistance, and food stamps are filed. A 2-week supply of medications and a Medication Grants Program card are issued to the inmate upon release.

Inmates from urban areas (Buffalo and New York City) may be assigned to dedicated parole caseloads. All parole officer recruits receive training on serious mental illnesses, the mental health service system, and appropriate coordination between parole and local mental health agencies.

Policy Options

The goal of this Subcommittee paper is to make the case—and offer strategies—for providing a range of effective interventions for people with mental illnesses who come into contact with the criminal justice system. Achieving this goal involves increasing alternatives for judges, prosecutors, jail administrators, the community, family members, and people with mental illnesses.

The Subcommittee's goal supports that of the Council on State Government's *Criminal Justice/Mental Health Consensus Report* (CSG, 2002), which is to ensure the continuation of successful program initiatives and to facilitate their expansion to other U.S. communities. To realize this goal, a number of actions at the Federal and State levels are clearly needed. Federal programs, State mental health authorities, and other stakeholders must capitalize on the many opportunities that already exist for financing core services for people with mental illnesses in contact with the criminal justice system.

People with mental illnesses continually cycle among the criminal justice, mental health, and substance abuse systems, often because they are poor, have no health insurance, and, therefore cannot pay for essential services. While there are many federally funded programs that support the essential services these people need, they are often excluded because they lack immediate financial resources, are challenging clinically, and are stereotyped as treatment-resistant and potentially violent.

The reality is that people with mental illnesses in contact with the justice system have conditions for which effective interventions do exist. They can live safely in the community and, with assistance, many can attain employment and become caring and nurturing parents.

A major barrier to obtaining needed services is the inability of individuals to pay for these services. As one looks at Federal Medicaid rules and guidelines for the Department of Housing and Urban Development's (HUD's) Shelter Plus Care, HUD's McKinney programs, the Bureau of Justice Assistance's Edward Byrne Memorial Program, the Department of Labor's technical assistance programs, and SAMHSA's Block Grant Programs, it is clear that there are huge opportunities in existing Federal programs to prioritize and clarify how essential services for people with mental illnesses who come in contact with the justice system can be financed.

To realize these opportunities, States and local communities must be educated to maximize the utility of these programs for persons for whom effective interventions are known, but who are unnecessarily shut out because of their lack of immediate financial resources.

In the section that follows, the Subcommittee details nine policy options for ensuring a range of effective interventions for people with mental illnesses who come into the criminal justice system.

POLICY OPTION 1	**The Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration (SSA) should work with representatives of State agencies to offer technical assistance on provisions of Federal Medicaid and Disability Program rules as they apply to inmates.**

The goal of these efforts should be to:

- Promulgate a clear statement of the limited requirements for disenrollment from Medicaid for jail detainees, and of how State rules often result in a narrower interpretation

than is required by the Department of Health and Human Services (DHHS);

- Facilitate the process of application for SSI or SSDI benefits while incarcerated. Incentives for disenrolling recipients should be matched with incentives for enrolling eligible inmates prior to release; and
- Ensure released inmates are returned immediately to Medicaid rolls if previously eligible.

Whether the goal is diversion or reentry, many community service providers are unwilling or unable to accept referrals from the criminal justice system if the funding for the needed services (e.g., SSI or Medicaid) does not follow these individuals.

However, when detainees with Medicaid or SSI enter jails, they usually leave without these entitlements. The major causes of this are State Medicaid rules that misinterpret Federal regulations about the necessity to disenroll detainees, when, in fact, they simply need to be temporarily suspended from claims (Bazelon Center, 2001). As a result of this misinterpretation of the rules, when the critical period of community reentry occurs, the detainees who are released often lose access to the types of medical services they got in jail, and they are unable to reconnect with the community-based case management that most had prior to their detention.

The action proposed could facilitate changes at the State level that would allow the retention of eligibility via suspension while in jail rather than termination, thus improving access to community-based services for diverted and released people with mental disorders.

One example of this approach can be found in Lane County, Oregon, where the Interim Incarceration Disenrollment Policy (National GAINS Center, 2002) delays termination of Medicaid benefits for short-stay detainees, i.e., those staying 14 days or less.

POLICY OPTION 2	**The Department of Housing and Urban Development (HUD) should provide guidance in its Continuum of Care application and to HUD McKinney grantees that explicitly recognizes that people who meet the McKinney definition for homelessness upon entry to the criminal justice system are eligible for targeted homeless housing and service programs upon discharge.**

Large numbers of people with mental illnesses needlessly cycle among today's institutions—jails and prisons, hospitals, and homeless shelters. To break the cycle, people with mental illnesses who are homeless before entering this cycle must have access to the services that are intended for them. This "no-wrong-door" approach is key to integrating the systems for many people who continually enter and exit homelessness.

There is a great deal of confusion in the field about whether or not persons detained in jails and prisons are eligible for HUD McKinney housing programs. Specifically, people in jails or prisons are eligible for HUD Continuum of Care homeless housing and service programs if they meet the eligibility criteria for people in institutions—that is, that they have been incarcerated for fewer than 30 days and were homeless upon entry.

HUD's Discharge Coordination Policy (Sec. 402 of the McKinney Act) explicitly requires that any government entity serving as an applicant agrees to develop and implement, to the maximum extent practicable and where appropriate, policies and protocols for the discharge of persons from publicly funded institutions or systems of care (such as corrections programs and institutions) in order to prevent such discharge from immediately resulting in homelessness for such persons.

Individuals are eligible for McKinney Act programs if they are being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison (after residing there for more than 30 consecutive days), they have no subsequent residence, and they lack the resources and networks needed to obtain housing.

HUD offices rarely provide program guidance that explicitly makes reference to the eligibility of homeless people in jail or prisons. (An exception is the Supportive Housing Program Desk Guide on-line operating manual.) The result has been underutilization of a program by an entire subgroup of homeless people with serious mental illnesses—a subgroup with a great need for stable housing, since they have more restricted access to affordable housing than most.

By making it clearer to HUD McKinney grantees that people exiting correctional facilities are eligible for Shelter Plus Care, the Supportive Housing Program, and other programs targeted to people who are homeless, the chronically and episodically homeless population can be reduced.

POLICY OPTION 3	**HUD should provide explicit guidance to all its programs, including Public and Indian Housing, Section 8, and others, that people with mental illnesses exiting the criminal justice system are eligible applicants.**

There is also a great deal of confusion among housing and service providers about eligibility for HUD programs for people who have arrests or convictions. Recent HUD guidance has left most decisions regarding eligibility to the discretion of local public housing agencies. In many instances, local rules excluding people with arrests or convictions from HUD housing programs are applied across the board, without regard to extenuating circumstances, especially the need for reasonable accommodation for people with disabilities.

Moreover, HUD's "one-strike, you're-out" policy for drug-related offenses does not recognize that many people with past substance abuse problems (many of whom also have mental illnesses) are actively and successfully on the road to recovery. Stable housing is an essential component in this recovery process.

HUD's policy of allowing local discretion without guidance encouraging consideration of specific practices and standards has effectively shut the door to public housing programs for people with mental illnesses who are leaving the criminal justice system. Moreover, local public housing agency policy with regard to eligibility often becomes the community standard that private landlords adopt as a starting point, which then often leads to even more restrictive community practices.

By recommending a raising of the bar to increase access for people with mental illnesses who are exiting the criminal justice system, we are promoting increased access to safe, affordable housing and reduced homelessness everywhere.

POLICY OPTION 4	**The Bureau of Justice Assistance Edward Byrne Memorial State and Local Law Enforcement Assistance Program guidelines should clearly state that funds can be used for community-based mental health services for inmates released from correctional facilities.**

The Byrne Program was established in 1988 to provide Federal aid to State and local criminal justice agencies to control violent and drug-related crime, improve operations, and build coordination and cooperation among the components of the criminal justice system (Dunworth et al, 1997). The Bureau of Justice Assistance makes Byrne Program funds available through a discretionary grant program ($94 million awarded in 2002) and a formula grant program ($486 million awarded in 2002) (Bureau of Justice Assistance, 2002).

A few additions to the Byrne Program guidelines that address the mental health needs of inmates released from correctional facilities would encourage states to attend to this issue:

- Specify that the mental health needs of people transitioning from correctional facilities are a program priority for the *discretionary grant program*. In 2002, program priorities for the discretionary grant program focused on comprehensive approaches to crime, stimulating partnerships and addressing unmet needs in the delivery of criminal justice services (Bureau of Justice Assistance, 2002).
- Add a 30th purpose to the existing 29 legislatively authorized purposes of the Byrne Program, as follows: that the formula grant program include programs to identify and meet the treatment needs of adult and juvenile offenders with mental health problems. Such a purpose currently exists for adult and juvenile drug- and alcohol-dependent offenders (Purpose #13).
- Explicitly state in the guidelines for the formula grant program statewide strategy that the mental health treatment needs of offenders should be addressed.

These changes would expand the scope yet remain consistent with the overall intent of the Byrne Program to make communities safe and improve criminal justice systems.

POLICY OPTION 5	**The Department of Justice, when investigating institutions under the Civil Rights of Institutionalized Persons Act (CRIPA), should review the extent to which institutional services are consistent with evidence-based practices.**

Inmates have a constitutional right to treatment while incarcerated. Numerous lawsuits have identified the obligation of prisons and jails to afford inmates their right to access to care, to care that is ordered, and to professional medical judgment. Further, the provisions in *Ruiz v. Estelle* (1980) established six minimum criteria for adequate prison mental health services.

The criminal justice system currently houses 1.9 million individuals, many who have complex health and mental health needs and who come from disadvantaged backgrounds without access to medical or mental health services. Using Bureau of Justice Statistics data, 16% of all correctional detainees have mental illnesses, of which a large percent have co-occurring substance abuse disorders. Approximately 600,000 previously incarcerated individuals are released back into the community each year.

The need for adequate service provision during incarceration, specifically use of evidence-based practices, is critical. Among the variety of treatment approaches, a wealth of information supports the effectiveness of integrated treatment for people with co-occurring disorders (Drake, Mercer-McFadden, Mueser, et al., 1998) both in correctional settings and in preparation for discharge planning.

By making it clear that early identification and treatment of mental illnesses and substance abuse disorders among inmates enhance institutional, individual, and post-release community safety, facilities can meet the constitutional requirements of treatment and protection during incarceration and adequately prepare for offenders' reentry into the community.

The reentry APIC model (National GAINS Center, 2002) identifies four core areas for service provision in correctional settings and in discharge planning:

- Assess the inmate's clinical and social needs, and public safety risks;
- Plan for the treatment and services required to address the inmate's needs;
- Identify required correctional and community programs responsible for post-release services; and
- Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services.

The extent to which institutional practices meet this model—another validated model—should be part of all CRIPA reviews.

POLICY OPTION 6	**The Department of Labor should use its national evaluation and technical assistance resources to assist program grantees in the implementation of supported employment practices for inmates with serious mental illnesses released from jail and prison.**

People with serious mental illnesses want and need to work. Work helps many recover from their disabilities, while the income generated from employment helps people regain and maintain residential stability. In addition, employment and adequate standards of living are associated with better clinical outcomes (Mueser, Becker, Torrey, et al., 1997; Bond, Resnick, Drake, et al., 2001).

Typical challenges to employment for people with serious mental illnesses include:

- illness symptoms,
- lack of housing,
- stigma and discrimination, and
- co-occurring substance abuse disorders.

Likewise, people with co-occurring substance abuse disorders often exhibit problem behaviors that interfere with job success.

Successful job training programs for people with serious mental illnesses include:

- comprehensive assessment,
- ongoing case management,
- housing,
- supportive services,
- job training and placement services, and
- followup.

Employment program models that are effective for people with serious mental illnesses include transitional employment, supported employment, and individual placement and support. These models use a "work-first approach," as opposed to extensive prevocational training. To be effective, these programs must also be flexible in how they define success. The adaptation of popular vocational rehabilitation models, such as supported employment, for people with mental illnesses (e.g., individual placement and support) have demonstrated improved outcomes, (Ridgeway, 1998).

The Department of Labor (DOL) currently provides reentry programming for offenders and employment programs for individuals with disabilities through its Employment and Training Administration (ETA) grantee awards. DOL is also a Federal partner in the Serious and Violent Offender Re-Entry Initiative, which services high-risk offenders who face multiple challenges—often substance abuse disorders and mental illnesses—to re-entering their communities and obtaining employment. Consequently, DOL is ideally positioned to assist its program grantees in the implementation of supported employment practices for inmates with serious mental illnesses released from jail and prison.

POLICY OPTION 7	**SAMHSA should provide technical assistance to Alcohol, Drug Abuse, and Mental Health Services Block Grantees to improve access to comprehensive and integrated treatment programs for persons with mental illnesses and co-occurring substance abuse disorders diverted or released from the criminal justice system.**

This policy option focuses on targeting State-level planners and program managers of the Substance Abuse Prevention and Treatment Block Grant and Community Mental Health Services Block Grant to increase two primary areas:

1. Their awareness of the importance of these services for this target group, and
2. Their understanding of how communities have expanded these services and of the transferable principles they could use to

finance, design, and implement such programs.

As discussed earlier, high rates of co-occurring substance abuse disorders place people with serious mental illnesses who are in contact with the justice system at increased risk of violence compared to the general population. What has been convincingly demonstrated by Drake and colleagues (1998) is that participants in integrated treatment programs use less drugs and alcohol than comparison subjects in sequential or parallel treatment programs. The reduced use of illicit drugs and alcohol is associated with reduced arrest rates.

Unfortunately, most communities in the United States do not recognize the need to make integrated treatment programs a high priority. Even when they do, there rarely are sufficient program slots to accommodate the demand for such programs.

The impact that Federal technical assistance programs can have in these areas was evidenced in Connecticut in the nine-site SAMHSA Jail Diversion KDA program described earlier. As a result of the SAMHSA funds, data were developed that provided the leverage to expand from three sites to a statewide coverage program that leads to the diversion of individuals from arraignment courts to integrated treatment programs when clinically indicated.

POLICY OPTION 8	**CMS should work with representatives of State Medicaid agencies to offer guidance and technical assistance on revising State Medicaid plans to cover services provided by Assertive Community Treatment (ACT) teams for persons in contact with the criminal justice system.**

The Assertive Community Treatment (ACT) model, which since 1972 has been implemented in 35 States as an evidence-based practice for persons with serious mental illnesses, is appropriate for high-risk clients, including persons in contact with the criminal justice system. ACT has been associated with an array of positive outcomes, including increased compliance with medications and other treatments, which reduces the likelihood of returning to the criminal justice system (Lamberti, Weisman, Schwarzkopf, et al., 2001) The ACT model features a multidisciplinary team that provides round the-clock treatment, rehabilitation, and support services.

A number of specialized ACT programs around the country focus on persons in contact with the criminal justice system. Often, these programs are referred to as Forensic Assertive Community Treatment programs, although this name may be a misnomer because the programs do not necessarily serve clients of State forensic hospitals. Instead, the programs serve those at the front-end (e.g., diversion) or back-end (e.g., reentry) of involvement with the criminal justice system.

Project Link in Rochester, New York, is an example of a front-end program, and the Thresholds ACT Demonstration Project in Chicago is an example of a back-end or post-release program. In addition, about 80% of the 30 demonstration projects funded by the California Mentally Ill Offenders Crime Reduction Grant program involve some adaptation of the ACT model. The initiative is collecting data on fidelity to the ACT model.

An impediment to the adoption of ACT models in general has been financing streams shaped by an emphasis on hospital and office-based care (Stein and Santos, 1998). The primary source of funding for ACT is typically reimbursement through Medicaid under the rehabilitative services or targeted case management categories (Phillips, 2001), although often only partial reimbursement is available. A few States (e.g., New Hampshire and Rhode Island) have led the way in addressing limitations of Medicaid by revising State plans to cover services provided by ACT. CMS should provide assistance to State Medicaid directors for developing financial constructs to cover ACT services, including specialized ACT teams for criminal justice system clients.

POLICY OPTION 9	**HHS and the Office of Justice Programs should make the training of judges by existing and prospective technical assistance centers within SAMHSA a priority.**

The burgeoning number of people with serious mental illnesses and co-occurring substance abuse disorders in regular court, the rise of specialty courts, and the concept of therapeutic jurisprudence, have raised issues surrounding the needs of people with serious mental illnesses. Judges often are not aware of the dramatic changes that have recently occurred in the treatment of serious mental illnesses and co-occurring substance abuse disorders, or the fundamental changes in the organization and financing of mental health services. In addition, judges who do not routinely deal with people with mental illnesses and co-occurring disorders may be unfamiliar with the relevant laws of their jurisdiction with respect to the rights of people with mental illnesses and/or with the requirements of the Federal *Americans with Disabilities Act.*

States should be encouraged to require judges to receive training about behavioral health, with emphasis on the newest psychosocial rehabilitation treatments and the potential for individuals to recover. In addition, judges should be required to receive training about the *Americans with Disabilities Act* and the laws of their jurisdiction that have an impact on people with mental illnesses and co-occurring disorders, including training on the following:

- Rights in the mental health system with respect to involuntary commitment, treatment rights on an inpatient or outpatient basis, confidentiality and access to treatment records, the right to treatment, and the right to refuse treatment;
- Social Services statutes such as the termination of parental rights based upon mental illnesses or substance use; and
- Rights with respect to discrimination in employment and housing.

The Subcommittee on Criminal Justice suggests the adoption of multidisciplinary legal education for judges and lawyers relating to offenders with mental illnesses and co-occurring substance abuse disorders. This training would ensure that judges and court personnel understand mental illnesses and are aware of inherent adherence difficulties faced by offenders engaged in alternative programs. Judges benefit by understanding the spectrum of dispositional options and of available treatment or diversion programs for offenders presenting with co-occurring disorders.

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