DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Guidance for Applicants (GFA) No. SM 02-010
Part I - Programmatic Guidance

Targeted Capacity Expansion (TCE) Grants for Jail Diversion Programs

Short Title: Jail Diversion Programs

APPENDIXES

Application Due Dates:
June 19, 2002 and September 10, 2002

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Date of Issuance: April 2002

Catalog of Federal Domestic Assistance (CFDA) No. 93.243
Authority: Public Health Service Act Section 520G

Table of Contents
Appendixes

APPENDIX A
ASSURANCES THAT MUST BE MET BY CAPACITY EXPANSION SITE APPLICANTS

In accordance with the Public Health Service Act 520G, all Capacity Expansion Site applications must contain the following assurances.

Please check the appropriate boxes below and attach as Appendix 4 to your application. Only applicants that are able to provide the following assurances will be eligible for this grant. This form must be signed by the chief executive of the State, political subdivision of the State, Indian tribe, or tribal organization.

___Yes ___No In your jail diversion program, will community-based mental health services be available for individuals who are diverted from the criminal justice system?

___Yes ___No Will the services offered to jail diversion clients be based on current research findings and include case management, assertive community treatment, medication management and access, integrated mental health and co-occurring substance abuse treatment, and psychiatric rehabilitation?

___Yes ___No Will the services offered to jail diversion clients be coordinated with social services, including life skills training, housing placement, vocational training, education job placement, and health care?

___Yes ___No Will there be relevant interagency collaboration between the appropriate criminal justice, mental health, and substance abuse systems?

___Yes ___No Will the federal support provided by this grant be used to supplement, and not supplant, State, local, Indian tribe, or tribal organization sources of funding that would otherwise be available?

___Yes ___No Is the jail diversion program going to be integrated with a pre-existing system of care for those with mental illness?

Signature of the chief executive of the State, political subdivision of the State, Indian tribe, or tribal organization

Date

Form Approved
OMB No. 0930-0208
Expiration Date 10/31/2002

Appendix B
CMHS GPRA Client Outcome Measures for Discretionary Programs

The Government Performance and Results Act of 1993 (Public Law 103-62) requires all federal departments and agencies to develop strategic plans that specify what they will accomplish over a 3- to 5-year period, to annually set performance targets related to their strategic plan, and to annually report the degree to which the targets set in the previous year were met. In addition, agencies are expected to regularly conduct evaluations of their programs and to use the results of those evaluations to "explain" their successes and failures based on the performance monitoring data.

Therefore, SAMHSA is now accountable for demonstrating the effectiveness of all its programs through performance data. In order to support current and future funding, we need your full cooperation in collecting and reporting performance data. Our ability to support these awards in future years depends on the data that you can provide. This performance element will carefully be considered in assessing awardee performance, and may have implications for future awards.

Public reporting burden for this collection of information is estimated to average 20 minutes per response if all items are asked of a client; to the extent that providers already obtain much of this information as part of their ongoing client intake or followup, less time will be required. Send comments regarding this burden estimate or any other aspect of this collection of information to SAMHSA Reports Clearance Officer, Room 16-105, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The control number for this project is 0930-0208.

A. RECORD MANAGEMENT

Client ID |____|____|____|____|____|____|____|____|____|____|____|____|

Contract/Grant ID |____|____|____|____|____|____|____|____|____|____|____|____|

Grant Year |____|____|
Year

Interview Date |____|____| / |____|____| / |____|____|

Interview Type 1. INTAKE 2. 6-month follow-up 3. 12-month follow-up

B. DRUG AND ALCOHOL USE

1. During the past 30 days how many days have you used the following: **Number of Days**

a. Any alcohol |____|____|

b. Alcohol to intoxication (5+ drinks in one sitting) |____|____|

c. Illegal drugs |____|____|

C. FAMILY AND LIVING CONDITIONS

1. In the past 30 days, where have you been living most of the time?

- " Shelter (safe havens, TLC, low-demand facilities, reception centers, other temporary day or evening facility)
- " Street/Outdoors (sidewalk, doorway, park, public or abandoned building)
- " Institution (hospital, nursing home, jail/prison)
- " Housed (own or someone else's apartment, room, house, halfway house, residential treatment)

2. During the past week, to what extent have you been experiencing difficulty in the area of:

Managing day-to-day life (e.g., getting to places on time, handling money, making every day decisions)?

- " No difficulty
- " A little difficulty
- " Moderate difficulty
- " Quite a bit of difficulty
- " Extreme difficulty
- " Don't know

" Not applicable
" Refused

3. **During the past week, to what extent have you been experiencing difficulty in the area of:**

Household responsibilities (e.g., shopping, cooking, laundry, keeping your room clean, other chores)?

" No difficulty
" A little difficulty
" Moderate difficulty
" Quite a bit of difficulty
" Extreme difficulty
" Don't know
" Not applicable
" Refused

4. **During the past week, to what extent have you been experiencing difficulty in the area of:**

Work (e.g., completing tasks, performance level, finding or keeping a job)

" No difficulty
" A little difficulty
" Moderate difficulty
" Quite a bit of difficulty
" Extreme difficulty
" Don't know
" Not applicable
" Refused

5. **During the past week, to what extent have you been experiencing difficulty in the area of:**

School (e.g., academic performance, completing assignments, attendance)?

" No difficulty
" A little difficulty
" Moderate difficulty
" Quite a bit of difficulty
" Extreme difficulty
" Don't know
" Not applicable
" Refused

6. **During the past week, to what extent have you been experiencing difficulty in the area of:**

Leisure time or recreational activities?

" No difficulty

- " A little difficulty
- " Moderate difficulty
- " Quite a bit of difficulty
- " Extreme difficulty
- " Don't know
- " Not applicable
- " Refused

7. **During the past week, to what extent have you been experiencing difficulty in the area of:**

Developing independence or autonomy

- " No difficulty
- " A little difficulty
- " Moderate difficulty
- " Quite a bit of difficulty
- " Extreme difficulty
- " Don't know
- " Not applicable
- " Refused

8. **During the past week, to what extent have you been experiencing difficulty in the area of:**

Apathy or lack of interest in things?

- " No difficulty
- " A little difficulty
- " Moderate difficulty
- " Quite a bit of difficulty
- " Extreme difficulty
- " Don't know
- " Not applicable
- " Refused

9. **During the past week, to what extent have you been experiencing difficulty in the area of:**

Confusion, concentration, or memory?

- " No difficulty
- " A little difficulty
- " Moderate difficulty
- " Quite a bit of difficulty
- " Extreme difficulty
- " Don't know
- " Not applicable
- " Refused

10. **During the past week, to what extent have you been experiencing difficulty in the area of:**

Feeling satisfaction with your life?

- " No difficulty
- " A little difficulty
- " Moderate difficulty
- " Quite a bit of difficulty
- " Extreme difficulty
- " Don't know
- " Not applicable
- " Refused

D. EDUCATION, EMPLOYMENT, AND INCOME

1. Are you currently enrolled in school or a job training program? [IF ENROLLED: is it full time or part time?]

- " Not enrolled
- " Enrolled, full time
- " Enrolled, part time
- " Other (specify)_____

2. What is the highest level of education you have finished, whether or not you received a degree? [01=1st grade, 12=12th grade, 13=college freshman, 16=college completion]

|____|____| level in years

2a. If less than 12 years of education, do you have a GED (Graduate Equivalent Diploma)?

" Yes No

3. Are you currently employed? [Clarify by focusing on status during most of the previous week, determining whether client worked at all or had a regular job but was off work.]

- " Employed full time (35+ hours per week, or would have been)
- " Employed part time
- " Unemployed, looking for work
- " Unemployed, disabled
- " Unemployed, volunteer work
- " Unemployed, retired
- " Other, specify_____

4. Approximately how much money did YOU receive (pre-tax individual income) in the past 30 days from…

		INCOME								
a. Wages	$				,				.00
b. Public assistance	$				,				.00
c. Retirement	$				,				.00
d. Disability	$				,				.00

e. Non-legal income $ | | | | , | | | | .00

f. Other_____ (specify) $ | | | | , | | | | .00

E. CRIME AND CRIMINAL JUSTICE STATUS

1. **In the past 30 days, how many times have you been arrested?** |____|____| times

2. **In the past 30 days, how many times have you been arrested for drug-related offenses?** |____|____| times

3. **In the past 30 days, how many nights have you spent in jail/prison?** |____|____| nights

F. MENTAL AND PHYSICAL HEALTH PROBLEMS AND TREATMENT

1. **How would you rate your overall health right now?**

- ▪ Excellent
- ▪ Very good
- ▪ Good
- ▪ Fair
- ▪ Poor

2. **During the past 30 days, did you receive**

a. Inpatient treatment for:	No	Yes ±	**If yes, altogether for how many nights** (DK=98)
i. Physical complaint	▪	▪	_____
ii. Mental or emotional difficulties	▪	▪	_____
iii. Alcohol or substance abuse	▪	▪	_____

b. Outpatient treatment for:	No	Yes ±	**If yes, altogether how many times** (DK=98)
i. Physical complaint	▪	▪	_____
ii. Mental or emotional difficulties	▪	▪	_____
iii. Alcohol or substance abuse	▪	▪	_____

c. Emergency room treatment for:	No	Yes ±	**If yes, altogether for how many times**

			(DK=98)
i. Physical complaint	"	"	_____
ii. Mental or emotional difficulties	"	"	_____
iii. Alcohol or substance abuse	"	"	_____

G. DEMOGRAPHICS (ASKED ONLY AT BASELINE)

1. Gender

" Male
" Female
" Other (please specify) _____

2. Are you Hispanic or Latino?

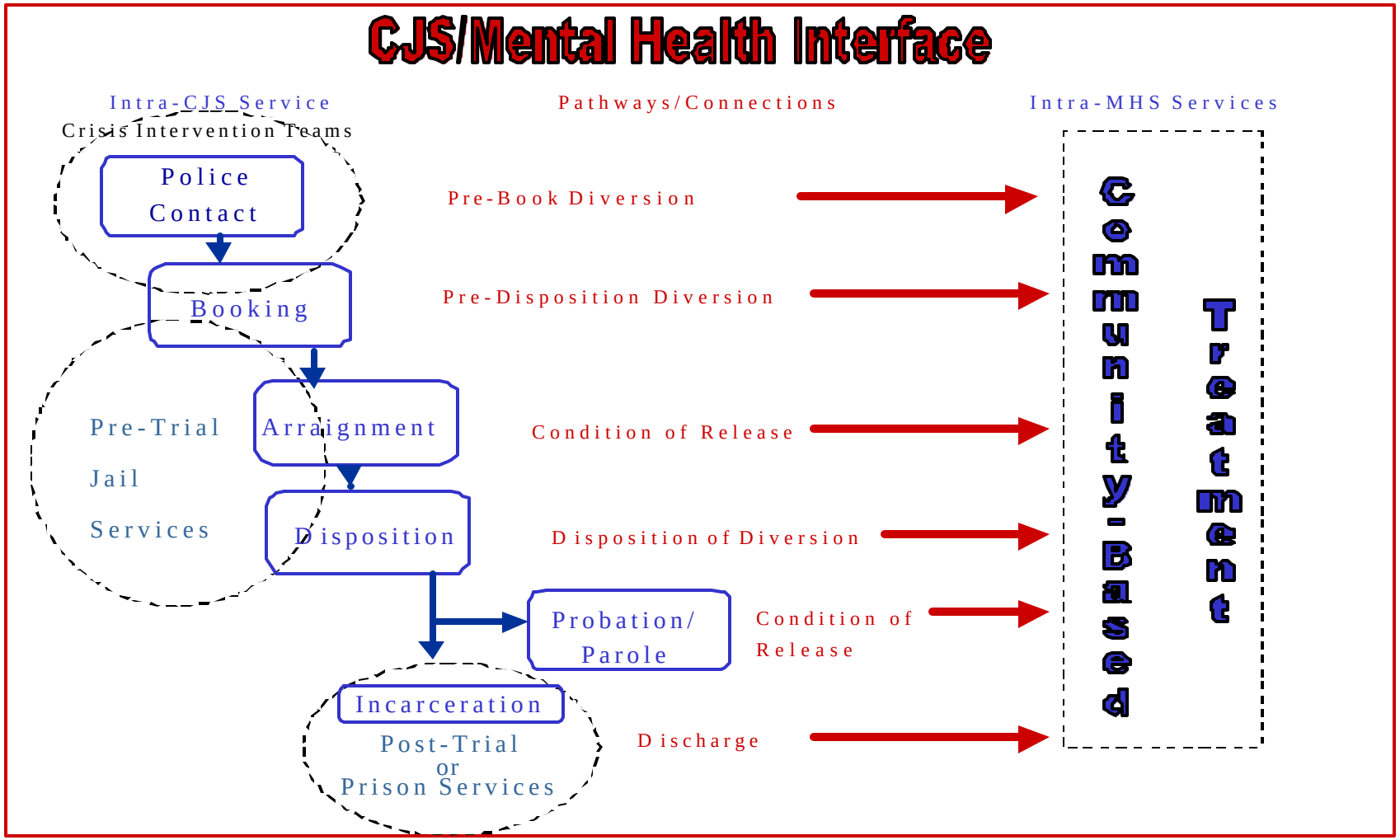
" Yes " No

3. What is your race? (Select one or more)

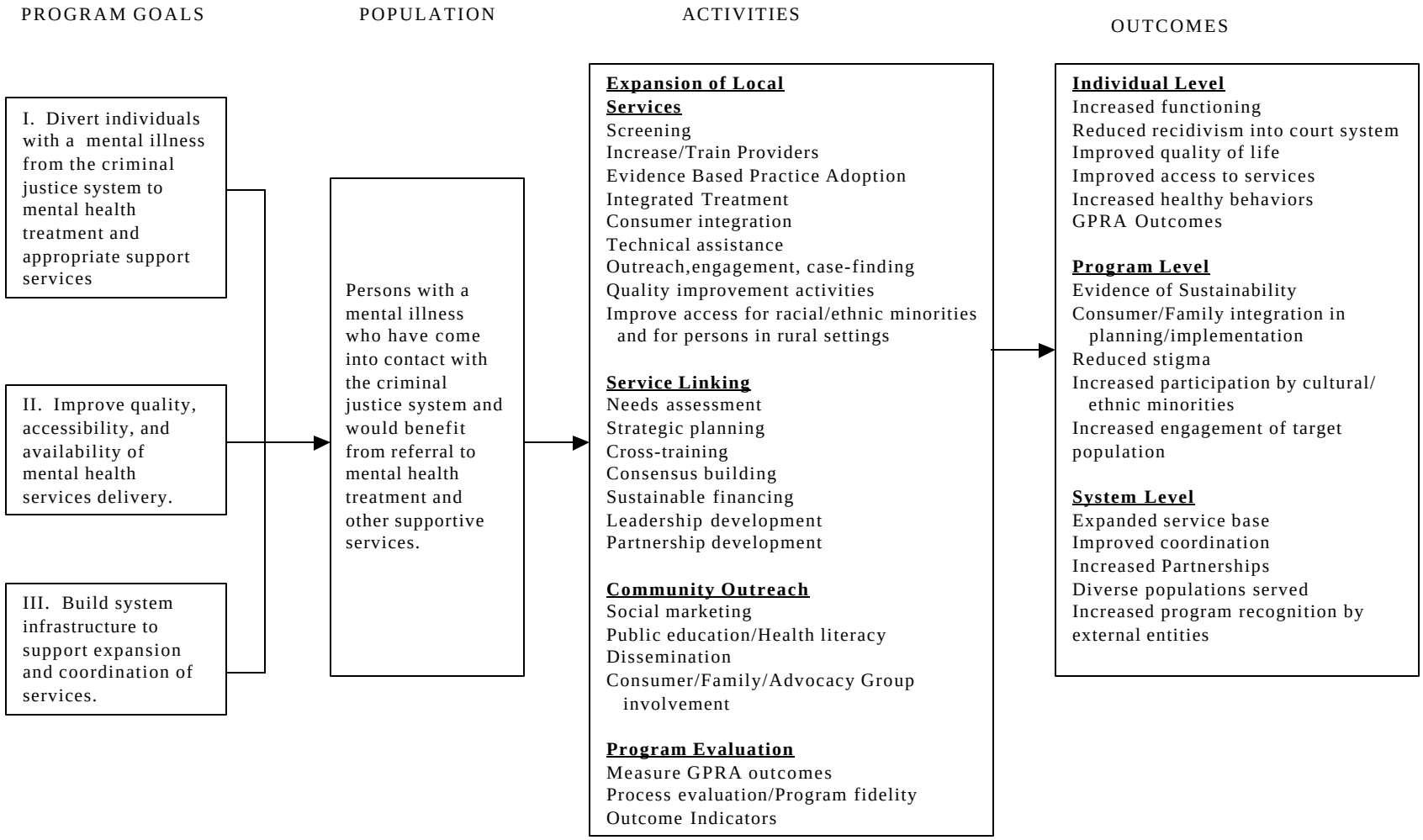
" Black or African American
" Asian
" American Indian
" Native Hawaiian or other Pacific Islander
" Alaska Native
" White
" Other (Specify)_____

4. What is your date of birth? |____|____| / |____|____| / |____|____|
Month / Day / Year

Appendix C - Schematic outline of the Criminal Justice Processing Spectrum



APPENDIX D: LOGIC MODEL FOR TARGETED CAPACITY EXPANSION JAIL DIVERSION PROGRAMS



APPENDIX E
GENDER-SPECIFIC SERVICES FOR WOMEN IN THE CRIMINAL JUSTICE SYSTEM*

***(This material was prepared under a SAMHSA collaborative grant that provides funding for "The National GAINS Center for People with Co-occuring Disorders in the Justice System.")**

BACKGROUND

Throughout U.S. history, female offenders have been largely invisible in a system designed to control and rehabilitate men (1). However, over the past 15 years, the presence of women in all aspects of the criminal justice system has increased dramatically. In 1998 there were 3.2 million arrests of women, accounting for 22% of all arrests that year, according to the Bureau of Justice Statistics. In that same year, 950,000 women were under correctional supervision, about 1% of the total U.S. female population. Between 1990 and 1998, the number of women on probation increased 40%, the number of women in jail increased 60%, the number of women in prison increased 88%, and the number of women under parole supervision increased by 80% (1). Although this increase has been attributed to a number of factors, including increased vigilance in the war on the drugs, the facts are compelling: women are a rapidly increasing presence in a male-oriented criminal justice system. Current statistics reveal that women make up 11% of the total jail population (2), 6% of prison inmates (3), 22% of adult probationers, and 12% of parolees (4).

SERVICE NEEDS

Although women represent only 11% of all jail inmates, 12% of them, almost twice the rate of male jail detainees, are likely to be diagnosed with a serious mental illness (5). Furthermore, 72% enter with a co-occurring mental health and substance disorder. Many women entering jails have themselves been victims and present multiple problems in addition to mental health and substance abuse disorders, including child–rearing and parenting difficulties, health problems, and histories of violence, sexual abuse, and resultant trauma. As many as 33% of women entering jails have been diagnosed with post traumatic stress disorder (PTSD) at some point in their lives (6). In a jail survey, 48% of women reported that they had been physically or sexually abused and 27% reported that they had been raped (7). These findings are considered by many to be conservative. As history of abuse is viewed as a direct correlate to circumstances leading to contact with the justice system, knowledge of this history is critical in treatment decisionmaking (8).

ACCESS TO SERVICES AND CONTINUITY OF CARE

Though many correctional facilities recognize that women bring different health and relationship issues to their period of incarceration, operationally most jails do not consider women to have substantially different issues from men. In a 1998 survey, 97% of jails used the same intake classification instrument for women as men; less than 30% screened women for histories of abuse or needs relating to their children, and gender-specific information obtained was rarely used to match women to services (9).

Jail settings also differ in provision of services because of their short-term nature, where the length of stay may range from overnight to a sentence of up to 1 year. Although specific programming, including child visitation, has become a more familiar feature of prison environments, there has been little movement in jails to redesign programming and services to meet the needs of women, despite the significant increase of women in contact with the justice system (10). Jails have a constitutional obligation to provide adequate services to detainees, whether male or female. However, jails typically do not know when someone will be released, whether it is pretrial or upon sentencing, except when inmates serve specific sentences. Early identification of needs and preparation for discharge planning is therefore part of the critical provision of services to jail detainees, and in the case of female detainees, includes linkage to a host of services for families (11).

Owing to significant differences in jail size throughout the United States, not all facilities are large enough to provide a full array of mental health services and housing options on-site. However, all jails are required to provide access to necessary services. Smaller jails typically access psychiatric care by contracting with community providers (12). This process actively encourages community in-reach and strengthens the linkage to community-based treatment services for the jail detainees upon release. Studies have shown that women respond best to long term care. This continuity of care is critical in the development of bonds, treatment adherence upon release, increased compliance with terms of probation, and as a successful intervention in breaking the cycle of recidivism. Despite their increased involvement in criminal justice programs, women remain significantly underrepresented in both community and institution-based treatment programs (13), while beds in community programs are often "earmarked" for men coming out of prison or jail.

For women with multiple co-occurring disorders, and often, complicated medical problems, engagement in treatment is key. If retained in treatment, women benefit most from "long-term continuous care" (14). Services provided in jail settings have not been conceptualized either as long-term or continuous in most communities. There is a growing consensus that to be successful, programming for women with co-occurring disorders necessitates the incorporation of gender-specific factors related to relationships, victimization, sexuality, depression, empowerment, culture, and ethnicity into evolving treatment models (15). Jail diversion is a special, targeted program to short-circuit the usual criminal court processing to the benefit of the detainee, the correctional staff, and the community. A pending publication outlines principles that can be used to create a family success paradigm in a jail setting for women entering jails with nonviolent or drug-related offenses. One principle states:

> Where appropriate the diagnosed mentally ill female offender with a history of physical or sexual abuse would be referred to community based alternatives in cases where less restrictive settings posed no obvious harm to the community. Jail staff would link more directly with human service and community based service workers and have them available on-site in jails for jail treatment and to prepare

detainees for release. (16).

THE NEED FOR GENDER-SPECIFIC SERVICES

Understanding that women in contact with the justice system possess myriad service needs is the touchstone for the development of gender-specific services. Women entering jails are more likely to have greater needs than men, in terms of range and types of services, and yet are less likely to have these needs met (17). Although not trained as clinicians, jail staff are the frontline for early identification of possible mental illness and early referral for psychiatric evaluation. As such, there is a significant risk that women with mental illnesses may not be identified and therefore not receive treatment during their confinement in jail. More importantly, some psychiatric disorders such as PTSD and anxiety disorders, if not addressed, are likely to increase the risk that women will became management problems for security staff, or inappropriately use expensive medical and psychiatric services they would otherwise not require.

In addition to serious mental heath disorders, female detainees have substantial emotional difficulties relating to survivorship of abuse, separation from their children, and low self-esteem. Unaddressed, these issues may result in "acting out" behavior or in the exacerbation of psychiatric symptoms. To achieve parity for male and female detainees, jail programming must:

1. Include services to women that are comparable with services available to the male population, and
2. Provide gender-specific services where gender differences exist or when providing interventions that are unique to the female population (18).

GENDER-SPECIFIC SERVICE PROGRAM PLANNING AND DEVELOPMENT

For women entering jails, early needs assessment and screening for mental health and substance abuse disorders, and other needs relating to self and family, is critical to both the classification and treatment-planning phase.

Recognizing that institutional treatment for women has largely been based on models developed with and for men, revised APA guidelines on psychiatric services in jails and prisons recommend that staff:

- Must be able to accurately diagnose PTSD.
- Assess the psychological consequences of childhood and adult physical and sexual abuse.
- Provide comprehensive mental health evaluations to postpartum women.
- Recognize what constitutes sexual harassment and abuse of inmates.
- Review procedures related to seclusion and restrains.
- Work to employ verbal de-escalation for symptoms and behaviors that are sequelae of abuse experiences.
- Offer mental health staffing at per capita rates that are "significantly higher than those offered

to male populations (19).

CRITICAL ELEMENTS FOR THE DEVELOPMENT OF GENDER-SPECIFIC PROGRAMS

In developing gender-specific programming for women diagnosed with mental illnesses in jail settings, comprehensive and integrated strategies are necessary. Veysey's 1998 report identifies eight key areas for program development:

- Parity of mental health services: Basic services must be available to all women before specialized services can be developed through the targeted allocation of resources.
- Targeted screening/evaluation procedures and gender-specific instruments: Women-specific tools must be developed that support appropriate classification of women and that can identify issues that complicate treatment and supervision, including histories of abuse, medical problems, and child care issues.
- Special crisis intervention procedures: Because of the overwhelming prevalence of physical or sexual abuse histories among female jail detainees, with or without mental illness, protocols for crisis intervention should be developed for all women in crisis. Jails should consider the use of noninvasive, nonthreatening de-escalation techniques for general use and to avoid retraumatizing procedures.
- Peer support and counseling programs: Because of the coercive nature of some psychiatric interventions, especially in jail settings (e.g. restraint, involuntary medications, locked rooms, paternalistic treatment), they may be rejected or resisted. Peer-counseling programs, in coordination with existing mental health services, show promise in helping women to address mental health problems and violent events in their lives. Peer-support programs offer an opportunity to connect the woman with her community prior to release.
- Parenting programs: Given the well-researched cycle of intergenerational abuse, and to the extent that women in jail settings may be both victims and perpetrators of violence, they are at increased risk of abusing their own children. Targeted parenting programs directed at education, empowerment, and practical skills are a promising practice in severing cycles of violence in families.
- Integrated services: Integrated services, in jail settings and in transition to the community, hold the most promise in assisting women to remain in the community and prevent recidivistic contact with the justice system.
- Training programs for security, mental health, and substance professionals: To maximize gender-specific programming, all correctional and treatment staff need to be trained to understand the specific issues and needs of female detainees, potential triggers, and purpose of program procedures.
- Outcome measures: Attention must be given to the development of appropriate outcome measures for treatment interventions designed to affect women diagnosed with mental illness in jails. Attention must be given to outcomes that acknowledge the wide variation in women's life experiences, adaptive styles, and modes of recovery. Measures should be developed through a

joint effort by mental health professionals, researchers, and the women using services (C/S/R's).

Despite the increase in promising programs over the last decade, program developers do not have a ready array of treatment protocols, manuals, or training curricula available to help them create innovative programs for women with co-occurring disorders in jail settings. Through an increased focus on early intervention and integrated treatment planning, services in jails can be tailored to meet the specific needs of women and help to break the cycles of recidivism and abuse.

MODEL PROGRAMS

Promising programs specifically designed to meet the needs of women, and in some cases their children, have been mostly initiated in prison settings, with a few more developed in jails. However, most of these programs feature common components:

- Early identification of the specific needs of the women served.
- Avoidance of re-traumatization in correctional settings.
- Provision of a range of integrated treatment.
- Linkage to services.

1. TAMAR Project, Baltimore, MD

TAMAR is a State, county, university, and foundation partnership that implements and evaluates a trauma treatment and education program for adult women with alcohol, drug abuse, and mental health disorders and histories of trauma who are currently incarcerated for misdemeanors or nonviolent felony offenses. The TAMAR Project's focus is the development and delivery of training on the long-term effects of traumatic abuse to the staff of all the agencies working with female jail detainees. This includes introductory trauma framework and crisis intervention training for frontline staff in the departments of corrections, parole and probation, substance abuse, mental health, domestic violence, and social services in each of the counties. Intensive trauma training is also provided for mental health treatment staff specialists in the jails and in the community.

The TAMAR Project has identified several important barriers and challenges that women survivors of trauma with substance abuse and mental health diagnoses face. These include:

- Incarceration separates women and their children.
- Incarceration itself is traumatizing.
- Jail policies and procedures, designed for men, can be re-traumatizing.
- Each county has its own culture, services, and gaps and barriers to services.
- Because women are a small percentage of the jail population, few resources are available to them.

Central tenets of the project include a belief that lives can change with appropriate support and that

jail is a viable point of intervention.

TAMAR provides the support to address the issue of trauma based on the following beliefs:

- Post-trauma responses include long lasting psychological, medical, behavior, and social effects.
- Recovery is a process that can begin while incarcerated but must be supported after release.
- Interventions must integrate treatment for substance abuse, psychiatric disorders, and trauma in a gender- and culturally sensitive manner.
- Emphasis must be on competency-building and empowerment.
- An integrated system of care should strive to preserve the mother/child relationship.

Women are assessed for substance abuse, psychiatric disorders, and trauma histories as they enter the jail system. They participate in psycho-educational groups, peer support groups, and individual case management sessions with an in-jail trauma specialist. After release, women can continue treatment under the guidance of the trauma specialist, participate in the ongoing peer support groups developed by On Our Own, and work with the trauma specialist to access housing entitlements, mental health services, and substance abuse counseling.

2. Cook County Jail, IL

The Department of Women's Justice Services of the Cook County Sheriff's Office was formed in 1999 to administer gender and culturally appropriate services to female drug offenders in Cook County, Illinois. The three phases program consists of pre-treatment, treatment education, and relapse prevention components, each of which lasts between 20 and 30 days. An array of services includes health, education, life skills, training, and community reintegration components.

Trauma services are provided by Trauma Incident Reduction, a foundation composed of community members, researchers, and practitioners to provide effective trauma treatment within the program. Life skills and mentoring services are administered by the Women in Community Service in order to promote self-reliance and the formation of a support network during the transition from jail to the community. Physical and mental health services are provided by Cermak Health Services, an affiliate of the Cook County Bureau of Health Services. A 24-hour mental health crisis team and regular treatment programs are operated through Cermak Health Services. Domestic violence, education, and legal aid programs are also provided by the Children's Advocacy Center and Chicago Legal Aid to Incarcerated Mothers.

The first two phases of the program focus on self-help, direct services, and health treatment programs within the jail setting. As the phases progress, it is expected that the participants will have made meaningful progress towards their substance abuse, health, trauma, and life-skills goals and that they will be prepared to work on a discharge plan in the third phase. Towards the end of the third phase, the women will be prepared for reintegration into the community, with an established

support network and available services.

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

Located within the Women's Unit of the Hampden County Correctional Center in Massachusetts, the *Women's* V.O.I.C.E.S. program is a series of classes and groups focused on addiction, trauma, and parenting needs. The title of the program stands for validation, opportunity, inspiration, choice, empowerment, and safety. It is a jail-based treatment and educational program for women inmates, and is available to both pretrial and sentenced inmates.

The gender-specific curriculum employs five principles that take note of the documented gender differences between male and female offenders: validation, safety, personal application, relational/support building, confidentiality, and boundaries. Its method of intervention involves 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.* are specifically trained with a focus on trauma, mental health, addictions and violence histories. They focus on matching the women in the program to community resources and clinically appropriate group activities, building problem solving skills, and increasing the choices available to them in their lives.

All inmates in the women's unit are eligible to take part in the introductory elements of the *Women's V.O.I.C.E.S.* program. However, to progress further through the phases of the program, it is essential to take into account an inmate's length of stay, classification, level of functioning, and self-assessment of their own strengths and problems.

Women's V.O.I.C.E.S is a four phase program of education, peer health, life skills, and addiction treatment classes. The program components include both 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. Furthermore, release planning from the jail to the community is provided for inmates during the final phase of the program. Additional components include 12-step Alcoholics Anonymous and Narcotics Anonymous groups, religious services, and activities to promote greater physical health.

GENDER-SPECIFIC SERVICES FOR WOMEN IN THE CRIMINAL JUSTICE SYSTEM

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(6) Teplin, L.A., Abram, K.M., and McClelland, G.M. 1996. "Prevalence of Psychiatric Disorders Among Incarcerated Women: I. Pretrial Jail Detainees." *Archives of General Psychiatry* 53: 505 – 512.

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(10) National GAINS Center. 1999. *Addressing the Needs of Women in Mental Illness/Substance Use Disorder Jail Diversion Programs: The Wicomico County (Maryland) Phoenix Project*. Delmar, NY: National GAINS Center.

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(13) Alexander, M.J. 1996. "Women with Co-Occurring Addictive and Mental Disorders: An Emerging Profile of Vulnerability." *American Journal of Orthopsychiatry* 66(1): 61-70.

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APPENDIX F
TRAUMA-SPECIFIC SERVICES FOR WOMEN IN THE CRIMINAL JUSTICE SYSTEM*

***(This material was prepared under a SAMHSA collaborative grant that provides funding for "The National GAINS Center for People with Co-occuring Disorders in the Justice System.")**

BACKGROUND

Throughout U.S. history, women offenders have been largely invisible in a system designed to control and rehabilitate men (1). However, over the past 15 years, women's presence in all aspects of the criminal justice system has increased dramatically. According to the BJS, in 1998 there were 3.2 million arrests of women accounting for 22% of all arrests that year. In that same year, 950,000 women, were under correctional supervision, about 1% of the total U.S. female population. Between 1990 and 1998, the number of women on probation increased 40%, the number of women in jail increased 60%, the number of women in prison increased 88%, and the number of women under parole supervision increased by 80% (1). Although this increase has been attributed to a number of factors, including increased vigilance in the war on the drugs, the facts are compelling: women are a rapidly increasing presence in a male-oriented criminal justice system. Current statistics reveal that women make up 11% of the total jail population (2), 6% of prison inmates (3), 22% of adult probationers, and 12% of parolees (4).

WHAT IS TRAUMA-INFORMED TREATMENT?

Trauma-informed treatment refers to incorporating an awareness of trauma and abuse into all aspects of treatment and the treatment environment. This awareness can also be used to modify procedures for working with women in jails. Just as drug treatment best occurs in a drug-free environment, trauma treatment is best accomplished in as trauma-free an environment as possible. Some abuse survivors, especially those with histories of severe or prolonged abuse, may experience angry outbursts, self-destructive or self-mutilating behaviors or other apparently irrational behaviors, that can be considered disruptive in jail.

A trauma-informed approach suggests alternative procedures that are not only less likely to make symptoms worse, but are also more effective as behavioral management techniques. Programs such as the TAMAR project in Maryland have been designed to increase the awareness of trauma for those working with incarcerated women and to provide trauma-informed and trauma-specific services in criminal justice settings.

PREVALENCE OF MENTAL ILLNESS, TRAUMA AND CO-OCCURRING DISORDERS

Of women entering jails, 12.2% are diagnosed with serious mental illnesses, while 72% have a co-occurring mental health and substance abuse disorder (5). Many women entering jails have themselves been victims and present multiple problems in addition to mental health and substance abuse disorders, including child-rearing and parenting difficulties, health problems, and histories of

violence, sexual abuse, and resultant trauma. In fact, 33% of women entering jails have been diagnosed with post-traumatic stress disorder (PTSD) at some point in their lives (6). In a jail survey, 48% of women reported that they had been physically or sexually abused and 27% reported that they had been raped (7). The Michigan Women's Commission found that 50% of female Michigan jail detainees had been victims of physical or sexual abuse at some point in their lives. These findings are considered by many to be conservative. Childhood physical and sexual abuse has been estimated to range as high as 80% in some local facilities (8).

NEED FOR TRAUMA-SPECIFIC PROGRAMMING

In considering the research, studies show that women in jail have often been the victims of physical or sexual abuse in childhood and/or adulthood. Consistent findings demonstrate that most women with co-occurring disorders also have histories of abuse. Prevalence studies show that 72% of women entering jail have a co-occurring mental health and substance abuse disorder. As such, trauma histories of severe abuse or violence can be considered the norm for women with co-occurring disorders in jail.

As history of abuse is viewed as directly contributing to circumstances leading to contact with the justice system, knowledge of this history is critical in treatment decisionmaking (9).

TRAUMA AND RE-TRAUMATIZATION IN JAIL SETTINGS

Within the jail environment, routine procedures and involuntary mental health services are, by nature, often coercive situations that may be misperceived, by female detainees with histories of abuse, as dangerous and threatening. Responses to perceived threat may be withdrawal, fighting back or extreme outbursts, worsening of psychiatric symptoms, and physical health problems, thereby increasing safety problems for jail staff or necessitating more expensive or longer term treatment (10).

In a review of jail practices and female detainees with abuse histories, Veysey, De Cou, and Prescott point out that procedures have been developed for practical security and treatment purposes but have historically not accommodated gender differences. The jail environment and procedures themselves may unintentionally be re-traumatizing to women with abuse histories. For women in jail settings, those with abuse histories may have problems directly associated with male authority figures as perpetrators of abuse. Many standard jail procedures routinely used to process jail inmates, ensure security, and meet medical standards of care in jails, including strip searches, examinations, use of physical force in crisis or psychiatric response, isolation, locked rooms, and restraints, may be re-traumatizing triggers.

TRAUMA-SPECIFIC SERVICE PLANNING AND PROGRAM DEVELOPMENT

The impacts of abuse and violence can affect all aspects of a woman's and her children's lives and contributes both to the development of and recovery from mental health and substance abuse

disorders. Fortunately, in the past few years, survivors, clinicians, and other service providers have worked together to develop principles, procedures, and techniques to assist women in their recovery from trauma even with coexisting mental health, substance abuse, and criminal justice issues (11).

Trauma-responsive programming has evolved in the context of therapeutic community-based programs and shelters serving women in crisis, at risk, or presenting mental health and/or substance disorders. The SAMHSA Women, Co-Occurring Disorder and Violence KDA Study identified eight program components critical to the development of successful trauma-focused models (12).

These components are also applicable within the context of a jail setting:

- Outreach and engagement.
- Screening and assessment.
- Treatment.
- Trauma-specific services.
- Parenting skills.
- Peer-run services.
- Crisis interventions.
- Resource advocacy and coordination.

ADAPTATION OF TRAUMA-SPECIFIC SERVICES TO JAIL SETTINGS

Certain elements have been identified as critical to the combined development of a trauma-sensitive approach to treatment, services, and jail programming. Routine procedures have been successfully adapted in some jails to include these elements for trauma responsive programming. Veysey et al. (13) identified these elements in the jail context:

1. Booking

- Information disclosure about procedures, including strip searches and examinations, availability of services and how to access them.
- Early screening and assessment of a woman's history of abuse should be included in all routine mental health and substance abuse assessments. Sensitivity to cultural issues is also important, as revealing victimization outside the family, for example, may be inhibited by cultural norms (14).
- Even where no clinical services are available in the jail, information from trauma histories can still be helpful in creating a trauma-informed environment and for discharge planning.
- Crisis and de-escalation intervention screening to identify settings, people, and environments that increase stress or trigger violence for new detainees. Early identification of this information can be used in the development of behavior management, crisis, and treatment plans.
- Use of female staff to perform strip searches or medical examinations may reduce the risk of re-traumatization.

2. General Conditions of Confinement During Incarceration

- The jail environment can cause undue stress for female detainees with abuse histories. As most female offenders are not arrested for violent crimes, staff should be trained in managing women in a nonaggressive and nonthreatening manner with time for social interactions maximized for inmates.
- Psychological distress associated with administrative isolation should be weighed against its punitive sanction for women with abuse histories, while the greater need for privacy among women, as compared to men, should also be considered.

3. Treatment Services and Crisis Response

- Service providers sometimes express reluctance to ask about abuse and violence for fear of re-traumatizing clients, being unable to offer follow-up support, feeling it is intrusive, or even because of their own abuse issues. Experience with assessments, however, shows that most survivors appreciate being asked about their history, when asked in a respectful manner. Nevertheless, women should always be given the option of not answering these or any other personal questions. With few exceptions, the emotional responses elicited by such an assessment require the same basic counseling skills needed for any mental health or substance abuse assessment.
- Specialized staff are needed to engage and talk with detainees with trauma histories.
- Behavioral management techniques should be developed between the inmate and the treatment staff to identify boundaries of acceptable behavior and keep women informed about procedures while assuming responsibility for actions.
- Single-gender group treatment should be offered to women in jails who have histories of sexual or physical abuse. Care should be taken to discuss the purpose of the group as supportive, educational, and to learn new skills to handle the effects of trauma rather than relating the actual stories of trauma.
- Crisis response should utilize de-escalation techniques and include the use of least restrictive means or force.

4. Release Planning and Referral to Community Services

- As with gender-specific program planning, early development of linkages for release is critical despite the frequently unknown imminence of a release date.
- Discharge planning should focus on continuity of care, including continuation of services provided in jail and ensuring linkage to community supports for housing, mental health, and substance abuse services; and community counseling services, rape crisis, or domestic violence programs.
- Many women are released on probation, so probation officers should be involved in release planning for consistency and to avoid technical violations of probation.
- Getting permission to share trauma history and assessment with the follow-up provider in the community can be very beneficial. This alerts the community provider to issues they may not regularly assess and helps the woman not have to repeat the telling of her abuse history.
- As with in-jail intervention, the most important discharge planning consideration is making safety a top priority in any placement. The best trauma treatments in the world will be ineffective if the

woman returns to an abusive or violent situation. If safe placement is not possible, priority attention should be placed on giving women information on options and resources such as domestic violence shelters, so that if they do become able to leave the violent situation they will know where to turn.

5. Training for Corrections Officers and Other Staff

To be effective, adequate training must be provided to correctional and treatment line-staff to ensure their support, understanding of the critical issues relating to trauma and gender-specific programming, and appropriate responses to women with histories of abuse.

ELEMENTS OF TRAUMA-SPECIFIC TREATMENT APPROACHES

Full recovery from trauma and its related sequelae can be a lengthy process. Some effective interventions involve special training, time, and clinical expertise that is not usually available in a jail setting but may be provided through a community-based service provider or adapted for short-term jail stays. Many skills needed to recover from traumatic experiences and build healthy lives are similar to those taught in a variety of settings and may include:

- Skills in identifying thoughts, feelings, and behaviors, learning how these work together, and effective problem-solving techniques.
- Relaxation, grounding, and self-soothing behaviors to handle the internal agitation and psychic pain so often reported by survivors.
- Interpersonal effectiveness skills such as assertiveness, setting appropriate boundaries, giving and receiving social support, and evaluating violent/nonviolent relationships.
- Relapse prevention skills and alternatives to substance abuse.
- How to make short and long-term safety plans and protecting oneself in the community.

Most trauma-informed interventions cover three primary areas important to all trauma recovery work:

- Education on the nature and extent of violence and the relationship of existing problems and disorders (including co-occurring disorders) to the original violence and abuse.
- Creation of a safe and supportive "space" to discuss these issues.
- Learning specific skills to facilitate recovery.

MODEL TRAUMA PROGRAMS IN JAIL SETTINGS

TAMAR: Operated by the Maryland Department of Health and Mental Hygiene, Baltimore, MD, the TAMAR Project (Trauma, Addictions, Mental health, And Recovery) offers a full array of training and clinical services to women who have been traumatized by physical and/or sexual abuse and are inmates in detention center settings. To participate, the women must have a co-occurring substance abuse and psychiatric disorder in addition to a trauma history. Cross-generational issues

are addressed by providing coordinated case management across agencies to both mothers and their children. The TAMAR Program is a voluntary trauma treatment and education program for adults. It is designed to help individuals learn to cope with the aftermath of childhood traumatic experiences as well as dealing with trauma as an adult. The program includes trauma treatment groups and one-to-one counseling in the detention center as well as in some communities. Peer support groups also meet in several counties.

Women are assessed for substance abuse, psychiatric disorders, and trauma histories as they enter the jail system. They participate in psycho-educational groups, peer support groups, and individual case management sessions with an in-jail trauma specialist. After release, women can continue treatment under the guidance of the trauma specialist, participate in the ongoing peer support groups developed by On Our Own, and work with the trauma specialist to access housing entitlements, mental health services, and substance abuse counseling.

TIR – The Department of Women's Justice Services of the Cook County Sheriff's Office (Cook County, IL) was formed in 1999 to administer gender- and culturally appropriate services to female drug offenders in Cook County, IL. The three-phase program consists of pretreatment, treatment education, and relapse prevention components, each of which lasts between 20 and 30 days. The array of services includes mental health, education, life skills, training, and community reintegration components. The Cook County Sheriff's Office subcontracts with TIR Traumatic Incident Reduction, a nonprofit educational foundation composed of community partners, mental health practitioners, university faculty and researchers. TIR is committed to providing effective trauma treatment for those suffering from the effects of trauma. TIR is a brief, simple, profound, and systematically focused memory recovery technique for permanently reducing or eliminating the effects of traumatic events.

TRAUMA PROGRAMS IN NON-JAIL SETTINGS

Some psycho-educational interventions have been developed that hold potential for adaptation and effective use in a jail setting with an average stay of 30 days and only three to eight opportunities for treatment sessions. Some examples with potential for jail settings follow:

1. **TRIAD**: The Triad Women's Groups, funded through the SAMHSA Women, Co-Occurring Disorders and Violence Study, include 16 sessions but are designed to be beneficial in groups of four sessions each, and the treatment manual is set up for this flexibility. Triad Women's Groups are designed specifically to address issues of co-occurring disorders, trauma, and gender. A female jail detainee could potentially begin or complete one of the 4-week sessions and be engaged with the other 4-week TRIAD sessions upon release to the community.

2. **TREM**: Maxine Harris, at Community Connections, DC, has developed a curriculum for 21 to 30 weekly group sessions in a community-based setting for working on trauma issues with women

who also have mental health and substance abuse issues. However, the model requires at least 7 months, and a participant must take a minimum of 26 sessions to meet the criteria for completion. This model may only be applicable to women serving jail sentences between 6 months and 1 year unless services are provided through a community provider able to continue the program upon release of the detainee to the community.

TRAUMA-SPECIFIC SERVICES FOR WOMEN IN THE CRIMINAL JUSTICE SYSTEM

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(3) TRIAD:
Triad Women's Project Clinical Interventions Committee. 2000. *Triad Women's Project: Group Facilitator's Manual*. Avon Park, FL: Triad Women's Project Clinical Interventions Committee.

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APPENDIX G:
GUIDELINES FOR CONSUMER AND FAMILY PARTICIPATION

SAMHSA is committed to fostering consumer and family involvement in substance abuse and mental health policy and program development across the country. A key component of that commitment is involvement of consumers and family members in the design, development, and implementation of projects funded through SAMHSA's grants and cooperative agreements. The following guidelines are intended to promote consumer and family participation in SAMHSA grant and cooperative agreement programs.

In general, applicant organizations should have experience or a documented history of positive programmatic involvement of recipients of mental health services and their family members. This involvement should be meaningful and span all aspects of the organization's activities as described below:

• Program Mission - The organization's mission should reflect the value of involving consumers and family members in order to improve outcomes.

• Program Planning - Consumers and family members should be involved in substantial numbers in the conceptualization of initiatives, including identification of community needs, goals and objectives; identification of innovative approaches to address those needs; and development of budgets to be submitted with applications. Approaches should incorporate peer support methods.

• Training and Staffing – Organization staff should have substantive training in, and be familiar with, consumer and family-related issues. Attention should be placed on staffing the initiative with people who are themselves consumers or family members. Such staff should be paid commensurate with their work and in parity with other staff.

• Informed Consent - Recipients of project services should be fully informed of the benefits and risks of services and make a voluntary decision, without threats or coercion, to receive or reject services at any time. SAMHSA confidentiality and participant protection requirements are detailed in SAMHSA GFAs. These requirements must be addressed in SAMHSA funding applications and adhered to by SAMHSA awardees.

• Rights Protection - Consumers and family members must be fully informed of all of their rights, including those designated by the President's Advisory Commission's Healthcare Consumer Bill of Rights and Responsibilities: information disclosure, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and nondiscrimination, confidentiality of healthcare information, complaints and appeals, and consumer responsibilities.

• Program Administration, Governance, and Policy Determination – Efforts should be made to hire consumers and family members in key management roles to provide project oversight and guidance. Consumers and family members should sit on all Boards of Directors, Steering Committees, and

advisory bodies in meaningful numbers. Such members should be fully trained and compensated for their activities.

• Program Evaluation - Consumers and family members should be integrally involved in designing and carrying out all research and program evaluation activities. These activities include determining research questions, adapting/selecting data collection instruments and methodologies, conducting surveys, analyzing data, and writing/submitting journal articles.

APPENDIX H
Cultural Competence Resources

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APPENDIX I

RECENT DEVELOPMENTS IN JAIL DIVERSION PROGRAMS FOR ADULTS WITH CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE USE DISORDERS IN CONTACT WITH THE CRIMINAL JUSTICE SYSTEM

***(This material was prepared under a SAMHSA collaborative grant that provides funding for "The National GAINS Center for People with Co-occuring Disorders in the Justice System.")**

BACKGROUND

As correctional populations have burgeoned over the past decade and the number of persons with mental illness living at the fringe of their communities has risen, the absolute number of persons with mental illness who come into contact with the criminal justice system has also escalated. As community-based mental health services have dwindled, emergency care, law enforcement departments, and jails have increasingly become *de facto* providers to persons with acute psychiatric and frequently co-occurring substance abuse disorders.

There are more Americans in jails than ever before. As of midyear 2000, there were 621,149 people in 3,365 U.S. jails (Beck and Karberg, 2001). The latest available statistics indicate that there were 11.4 million admissions to local jails in 1999 (Stephan, 2001). Although there are correspondingly more persons with mental illness in U.S. jails, there is a substantially higher percentage of both male and female jail detainees with severe mental disorders than in the general population (GAINS, 2002). Many communities increasingly rely on jails as alternatives for inadequate community-based mental health services (Teplin and Pruett, 1992; Torrey et al., 1992), but most jails are not equipped to handle the influx of detainees with mental health needs.

PREVALENCE

The most rigorous research estimating prevalence of mental illness and substance use disorders for individuals admitted to urban jails is data collected from male and female jail detainees admitted to the Cook County Department of Corrections (Chicago jail) (Teplin, 1990a, 1994: Teplin, Abram and McClelland, 1996.) Two-week prevalence data revealed that the rate of current severe mental disorder was 6.4% for male detainees entering jail (Teplin, 1990) and 12.2% for female detainees (GAINS, 2002).

Extrapolating to the United States, among the 11.4 million annual admissions to jail there are 802,000 with severe mental disorders. Moreover, among these 11.4 million admissions, alcohol and drug abuse co-morbidities are exceedingly high. Abram and Teplin (1991, Abram et al., 2001) found, among their sample of male detainees with severe mental disorders, 72% also met criteria for co-occurring disorders of alcohol or drug abuse.

The trends and needs are even more evident for women and for individuals of color. In 2-week prevalence data, 12.2% of women detainees—almost twice the rate for men—had a severe mental illness at jail entry (GAINS, 2002) and 53.3% of women had a substance use disorder compared

with 29.1% of men (Teplin, 1994; Abram et al., 2001). Minorities are disproportionately represented in the correctional population. Even though African Americans make up only 13% of the nation's population, they constitute 49% of the incarcerated population (Bureau of Justice Statistics, 1999b). The overrepresentation of minorities is further seen in the number of inmates per 100,000 of each group. Of the 621,149 persons detained in local jails at mid-year 2000, white non-Hispanics made up 260,500 (41.9%) of total detainees; black non-Hispanics, 256,300 (41.3%); Hispanics, 91,400 (15.1%); and American Indians, Alaska Natives, Asians, and Pacific Islanders together made up 10,200 (1.6%) of total detainees. Data also show that Hispanics are the fastest growing minority group in the criminal justice system.

WHAT IS JAIL DIVERSION?

Diversion programs are considered to be one of the primary responses needed to deal with persons with mental illness who are at risk for arrest and incarceration. It is commonly believed that law enforcement and jails, working together with other community mental health programs, substance abuse providers, the judiciary, and other community resources, can successfully divert offenders who have committed misdemeanors.

There is no definitive model for organizing a criminal justice diversion program for persons with co-occurring disorders. When a diversion program is developed, different strategies are needed because local criminal justice systems vary so much in size, structural characteristics, levels of perceived need, resources available within the communities' mental health and substance abuse services network, and local politics and economics. Diversion alternatives to the criminal justice system, whether prebook or postbook, target interventions for the individual at four important choice points: (1) first police contact; (2) at arraignment; (3) after booking, but prior to trial; and (4) at the time of sentencing.

The term 'jail diversion" refers to specific programs whose goal is to avoid or dramatically reduce the length of incarceration in local jails and lockups of persons with serious mental illness, usually with co-occurring substance use disorders, who come in contact with the justice system. Key program activities involve: (1) defining a target group for diversion, (2) identifying them as early as possible in their processing by the justice system, (3) negotiating community-based treatment alternatives to incarceration, and (4) implementing linkages to comprehensive systems of care and appropriate community supervision consistent with the disposition of the criminal justice contact. (Steadman et al., 1995; Steadman et al., 2001)

WHEN TO DIVERT?

There are two general categories of jail diversion programs defined by the point in criminal justice processing where diversion occurs (Steadman et al., 1995):

Prebooking: Individuals with co-occurring disorders may be identified for diversion from the criminal justice system at any point, such as prebooking interventions by police that occur before formal charges are brought. Prebooking diversion occurs at the points of contact with law

enforcement officers and relies heavily on effective interactions between police and community mental health services.

Postbooking: Postbooking is the most prevalent type of jail diversion program in the United States. These programs exist in arraignment courts, specialty mental health courts, and jails to screen individuals who are potentially eligible for diversion for the presence of mental illness. Once a person's eligibility for diversion is evaluated, diversion program staff negotiate with prosecutors, defense attorneys, community-based mental health and substance abuse providers and the courts to develop and implement a plan that will produce a disposition outside the jail in lieu of prosecution or as a conditional of a reduction of charges (whether or not a formal conviction occurs).

It is important to distinguish jail diversion from discharge planning. It is clear that only a minority of U.S. jails have any systematic discharge planning for persons with serious mental illness and co-occurring substance use disorders (Steadman et al., 1989). Those that do are not considered to be performing diversion under this program because discharge planning activities should be part of the usual criminal justice processing and occur only when the detainee would ordinarily be leaving the jail as his/her case is being handled by the criminal court. By contrast, jail diversion is a special, targeted program to short-circuit the usual criminal court processing to the benefit of the detainee, the correctional staff, and the community.

DIVERSION GOALS

The goals of various types of diversion are as follows: (1) police-based to accomplish diversion before the individual is actually booked into jail and involved in the criminal justice system; (2) court or postbooking diversion to reduce the time spent in jail. In the case of postbooking diversion, time in jail may be reduced through pretrial release or through sentencing alternatives. Court-based diversion uses sentencing alternatives and sanctions to structure the course of treatment within or outside of incarceration.

WHY DIVERT?

Persons with mental illnesses who come into contact with the criminal justice system are a particularly vulnerable group. Combined with the stress and stigma associated with their mental disabilities, the burden associated with their arrest and charges can exacerbate the isolation and distrust that are often associated with mental illness. Persons with alcohol or other drug dependence often come into contact with the criminal justice system specifically because of their disorders. In addition, decreasing community resources, particularly the lack of available or accessible emergency mental health services, have increased the likelihood that persons with mental illnesses will come into contact with police and be arrested (CMHS, 1995). However, although substance abuse services are typically more accessible and available to offenders than mental health services, the problems associated with integration of services, community supports, and follow-up services are similar.

Despite the huge needs and the many barriers to meeting them, it has been amply demonstrated in the CMHS report to the U.S. Congress, "Double Jeopardy: Persons With Mental Illnesses in the

Criminal Justice System," that comprehensive and integrated services for persons with mental illnesses and substance abuse disorders who come into contact with the criminal justice system can be developed to address their special problems. Many of the needed services require rethinking of how we have been addressing these problems and redirecting existing resources, rather than requiring new funding. Other reports have identified effective treatment programs specifically for individuals with co-occurring disorders in contact with the justice system. In particular, Peters and Hills work on "Intervention Strategies for Offenders with Co-Occurring Disorders: What Works?" (1997), and Hills's report on "Creating Effective Treatment Programs for Persons with Co-Occurring Disorders in the Justice System" (2000), provide principles, strategies and models of intervention for addressing co-occurring disorders for individuals involved in the justice system.

WHO BENEFITS?

Approximately 800,000 inmates with serious mental illnesses are admitted to U.S. jails each year. Some individuals with mental illnesses must be held in the jail because of the seriousness of the offense they commit, and should receive mental health treatment in the jail. However, individuals with mental illnesses, many who have been arrested for less serious or nonviolent crimes, can often be diverted from jail to community-based mental health programs, generally with better long-term prognoses and reduced recidivism.

Thirty-four percent of jails indicated they had some type of formal diversion program for mentally ill detainees (Steadman, 1994). However, in a follow-up survey only 18% (approximately 50 jails nationwide) had programs that would fit the definition of a jail diversion program.

The benefits of jail diversion include:

- Reduction of incarceration for persons with mental illness, or co-occurring mental health and substance abuse disorders, charged with low-level offenses.
- Enhancement of public safety by "freeing up" jail beds for more violent offenders or those ineligible for diversion.
- Reduction of recidivism of persons with mental illness, or co-occurring mental health and substance abuse disorders, through access and linkage to appropriate treatment.
- Provision of humane and confidential care for persons with serious mental illnesses, or co-occurring mental health and substance abuse disorders, who are involved in the justice system.
- Provision of more sentencing options to judges handling cases of persons with mental illness, or co-occurring mental health and substance abuse disorders, including alternatives to incarceration.
- Increased cost-effectiveness of courts, corrections, mental health, and substance abuse agencies through linkage of diverted persons with mental illness, or co-occurring mental health and substance abuse disorders, to appropriate integrated services.

ONE CORE PRINCIPLE, SIX KEY ELEMENTS

The fundamental principle on which all jail diversion programs must be based is treatment in the least restrictive alternative. SAMHSA is committed to supporting programs that combine an expansion of choices for persons with serious mental illness with careful attention to the rights of every community member to safety. Accordingly, all programs that would be funded under these SAMHSA

authorities must emphasize community-based treatment services that maximize individual choice and minimize legal constraints (civil or criminal). This principle recognizes that as alternatives to incarceration, the least restrictive alternative may include varying intensities of community supervision under the auspices of court supervision, community corrections, or civil mental health statutes. Where such mechanisms are used, it is expected that clear, informed, voluntary options will be offered to persons deemed competent to make these choices before entering the diversion program.

For the development and operation of any successful diversion program, there are six key elements:

(1) Interagency collaboration: Service integration at the community level, including involvement of social services, housing, mental health, health, local corrections (institutional and community), justice, and substance abuse agencies.

(2) Active involvement: Regular meetings for service coordination and information sharing and the establishment of written Memoranda of Understanding (MOUs).

(3) "Boundary-spanner": Staff who bridge the mental health, criminal justice, and substance abuse systems and manage cross-system staff interactions.

(4) Leadership: A strong leader to network and coordinate.

(5) Early identification: Detainees should be screened, at the earliest point possible, for mental health treatment needs and to determine whether they meet the criteria for diversion.

(6) Cross-trained case managers: Case managers should have adequate knowledge and experience with mental health and criminal justice systems.

EXAMPLES OF PROMISING JAIL DIVERSION PROGRAMS

(1) Akron, Ohio Crisis Intervention Team – Police-Based Prebooking Diversion

In May 2000, the Akron Police Department, in collaboration with the Summit County Alcohol, Drug Addiction and Mental Health Services Board and the National Alliance for the Mentally Ill – Summit County, inaugurated the Crisis Intervention Team. A Crisis Intervention Team is a partnership between law enforcement and community mental health services to enable police officers to de-escalate mental health crises in the community and provide a link to community-based mental health services while avoiding the criminalization of the mentally ill. Akron's program is based on the innovative model developed by the Memphis, TN, Police Department. The Crisis Intervention Team program consists of specially trained police officers and emergency medical services personnel from Akron and surrounding communities. Officers in the Crisis Intervention Team are trained in the de-escalation of mental health crises in the community. The majority of these encounters result in referrals to a psychiatric emergency facility or hospitals, with only 6% of encounters resulting in

arrest. Assistance in the development of Crisis Intervention Teams is possible through the Coordinating Center for Excellence in Jail Diversion and the Akron Police Department Training Bureau. For more information, contact (330) 375-2276.

(2) Montgomery County, Pennsylvania - Pre and Postbooking Diversion

Montgomery County Emergency Services offers both prebooking diversion and postbooking diversion, with a variety of dispositions that range from charges being dropped to returning the client to court to responding to the charges filed. The diversion program is supported through police training, a 24-hour crisis response team, inpatient treatment, case managers, and an outreach team. County Administrators and a local Task Force are also involved in diversion activities, both of which work closely with the Emergency Services to maximize multidisciplinary involvement in the diversion program. Montgomery County also has specialized probation caseloads. For more information, contact: (215) 349-8750.

(3) Lane County, Oregon - Postbooking Diversion

All inmates booked into Lane County Jail are screened for mental health and substance abuse problems. Persons identified are further assessed by the jail-based mental health staff and, in collaboration with the District Attorney and Public Defender's office, a diversion agreement is presented to the Drug Court. Participants are given 1 year to complete an integrated treatment program that is generally delivered in an outpatient setting. Persons requiring further stabilization can be hospitalized at the Lane County Psychiatric Hospital adjacent to the jail. A strong collaboration exists among law enforcement, corrections, the courts, the public mental health clinic, the psychiatric hospital and many private nonprofit agencies in order to maximize wraparound services. For more information, contact (541) 682-2121.

(4) Arizona Department of Mental Health Jail Diversion Programs – Postbooking Diversion

Postbooking jail diversion programs are operated by the Regional Behavioral Health Authorities of Pima and Maricopa Counties, which include the cities of Tucson and Phoenix, respectively. These postbooking diversion programs consist of a three-tier structure of diversion through a conditional release, deferred prosecution, or summary probation. Program clients diverted through conditional release receive treatment through a mental health case manager administered through managed care, clients whose prosecution is deferred have their charges dropped pending successful completion of their treatment plans, and clients diverted through summary probation are convicted with probation and a treatment plan as opposed to incarceration in jail. For more information, contact (602) 381-8999.

(5) Tulsa County, Oklahoma Parkside Jail Diversion Program – Postbooking Diversion

The Parkside Jail Diversion Program is a postbooking program for nonviolent seriously mentally ill

offenders in the David L. Moss Criminal Justice Center. The program was inaugurated in January 2000 and served 300 clients in its first year of operation. Most clients spent 1 to 2 days in the jail prior to being diverted, and mental health treatment services began prior to a client's court date. Approximately half of the persons referred to the program had been arrested at least twice in the previous 12 months, and approximately two-thirds of clients in the program had been in contact with the mental health system at the time of arrest. For more information, contact (918) 588-8839.

(6) State of Maryland "Phoenix Project" - Postbooking Diversion for Women and Children

The "Phoenix Project" springs from a highly successful postbooking program that focuses on dually diagnosed women and their children. Female consumers are diverted, prearrest, by police and the Mobile Mental Health Crisis Team, giving the women the option to access secure crisis housing and transitional housing that can accommodate them and their children. This program includes a formal interagency agreement linking local service organizations, regular interagency meetings, formal training for police, a Mobile Crisis Unit with a 24-hour response capacity, an integrated intensive mental illness/substance abuse disorder outpatient treatment program, case management services with a 20:1 client to staff case load, and transitional housing. For more information, contact (410) 724-3238.

(7) Connecticut Department of Mental Health and Addiction Services' Criminal Justice Diversion Program – Postbooking Diversion

The Criminal Justice Diversion Program, which has been operating since 1995, employs a postbooking diversion model for nonviolent misdemeanor and lower-level felony offenders. The program also provides jail-based treatment for mentally ill offenders who are not eligible for diversion. Diversion teams operate out of six mental health centers in the State, covering nine courts, and consist of several clinicians who develop treatment plans for offenders eligible for diversion. These individualized treatment plans are then presented to the judge at arraignment, with possible outcomes being diversion to community-based services, diversion to hospitalization, or incarceration. Potential candidates for diversion are identified each day through the arraignment lists, which are cross-referenced with the state's mental health client information system, and through recommendations from court, law enforcement, or corrections staff. The diversion team provides the court with information on whether or not the diversion client is attending treatment, but remains separated from the court system because the program is operated through local mental health centers. For more information, contact (860) 418-6788.

(8) Project Link of Monroe County, New York – Postbooking Diversion

Project Link was developed by the Department of Psychiatry at the University of Rochester in 1995 to reduce the incarceration and hospitalization of severely mentally ill persons in Monroe County, NY. Project Link provides a postbooking diversion program for persons with a severe mental illness and a history of involvement with the criminal justice system. Case managers work with court,

jail, and community corrections staff in developing dispositions for clients into Project Link and in maintaining treatment compliance. Treatment services provided through the program include case managers available 24 hours a day, housing, a mobile treatment team for highly impaired clients, and a treatment residence. In an evaluation of the 46 clients admitted to the program over a 1-year period in 1997 and 1998, it was found that mean number of days spent in jail per month dropped from 9.1 to 2.1 per client and the average monthly jail costs for the sample dropped from $30,908 to $7,235. For more information, contact (716) 275-0300 ext. 2237.

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