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Program Focus

Coordinating Community Services for Mentally Ill Offenders:

Maryland's Community Criminal Justice Treatment Program

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by Catherine Conly

Looking around his apartment, 45-year-old Ray Carver can hardly believe his good fortune.[1] Not long ago, he was living in abandoned buildings and drinking cheap whiskey. He had survived like that since he was a teenager, traveling up and down the East Coast, periodically being arrested for shoplifting or vagrancy and spending months at a time in jail. In his early twenties, Ray was diagnosed with schizophrenia by a psychiatrist in a District of Columbia jail. Since then, he had taken medication sporadically and had been institutionalized twice for his mental illness. Most of the time, however, he lived on the streets and drank heavily.

Highlights

The number of mentally ill individuals in the criminal justice system has grown dramatically during the past 30 years. Often homeless and suffering from other health-related concerns (e.g., substance abuse, HIV infection), these individuals may cycle continuously between the community, where they commit mostly minor offenses, and jail.

Recognizing this pattern and seeking to intervene productively, local policymakers have worked with officials in Maryland's Department of Health and Mental Hygiene and with other State officials to establish the Maryland Community Criminal Justice Treatment Program (MCCJTP), a multiagency collaborative that provides shelter and treatment services to mentally ill offenders in their communities. Created to serve the jailed mentally ill, the program now also targets individuals on probation and parole.

MCCJTP operates in 18 of the State's 24 local jurisdictions and features:

- Local advisory boards composed of local and State decisionmakers who provide ongoing leadership.
- Case management services that include crisis intervention, screening, counseling, discharge planning, and community followup.
- Services for mentally ill offenders who are homeless or have co-occurring substance use disorders.
- Routine training for criminal justice and treatment professionals.
- Postbooking diversion for qualifying mentally ill defendants.

The MCCJTP model features strong collaboration between State and local providers, a commitment to offering transitional case management services, the provision of long-term housing support to mentally ill offenders, and a focus on co-occurring substance use disorders. Criminal justice and treatment professionals credit MCCJTP with improving the identification and treatment of jailed mentally ill individuals, increasing communication between mental health and corrections professionals, improving coordination of in-jail and community-based services for mentally ill offenders and defendants, and reducing disruption in local jails. Case managers and clients report that MCCJTP's comprehensive services have improved the quality of many clients' lives.

Independent evaluation of MCCJTP service delivery mechanisms and client outcomes is now under way. The investigation will help in determining whether providing coordinated, community-based services to mentally ill offenders can significantly reduce recidivism, increase residential stability, reduce psychiatric hospitalization, and increase voluntary participation in substance abuse treatment.

When Ray was arrested for shoplifting in Salisbury, Maryland, he reported to the Wicomico County Detention Center's classification officer that he had been taking medication for schizophrenia. The officer referred Ray to the mental health case manager assigned to the jail by the county health department through the Maryland Community Criminal Justice Treatment Program. With that referral, Ray Carver embarked on a journey that would significantly change his life.

Thousands of mentally ill individuals pass through local correctional facilities each year. In 1996, one-quarter of jail inmates reported that they had been treated at some time for a mental or emotional problem.[2] Nearly 89,000 said that they had taken a prescription medication for those types of problems, and more than 51,000 reported that they had been admitted to an overnight mental health program.[3]

The dramatic growth of the population of jailed mentally ill persons has coincided with the policy of deinstitutionalization that resulted in the release of thousands of mentally ill people from psychiatric facilities to the community.[4] Additional factors, including cuts in public assistance, more stringent civil commitment laws, declines in the availability of low-income housing, and limited availability of mental health care in the community, are thought to have exacerbated conditions for the mentally ill and contributed to their increased involvement in the criminal justice system.[5] Many mentally ill offenders are charged with relatively minor offenses (e.g., prostitution, shoplifting, vagrancy),[6] but are not diagnosed or treated while in jail and are released back to their communities with no plan for treatment or aftercare.

Finding humane, constitutional, and effective ways to address the needs of mentally ill individuals is a challenge for local correctional facilities nationwide. Crowded, outdated, and designed to ensure secure confinement, most jails are not optimal treatment settings for the mentally ill.[7] Nonetheless, the nature of jail populations increasingly demands—and numerous court decisions require—that jails respond to the needs of the mentally ill.[8]

Researchers consistently recommend correctional strategies that result in early identification and referral of the jailed mentally ill to the most appropriate treatment setting, preferably in the community.[9] However, only a few jails have achieved this goal.[10] Even in jails where psychiatric services are models for others nationwide, a significant proportion of the mentally ill can go undetected and/or untreated.[11] In addition, many mentally ill individuals are released with no plan for community-based care.[12]

Mentally ill offenders are poorly equipped to serve as advocates for their own welfare. They often face multiple challenges, including homelessness, unemployment, estrangement from family and friends, substance abuse, and other serious health conditions such as HIV/AIDS, tuberculosis, and hepatitis.[13] In turn, community-based providers often find mentally ill offenders challenging to serve because of their "coexisting conditions, noncompliance, criminal records, unkempt appearance, and clinically difficult and challenging presentation."[14] Consequently, mentally ill individuals may cycle repeatedly through the health, mental health, social service, and criminal justice systems, each with its unilateral focus, and never become stabilized because of a lack of coordinated care and treatment. This "system cycling" is discouraging to the mentally ill offender and costly to the network of community-based providers.

Overview of MCCJTP

After years of study and discussion, local corrections officials in Maryland worked with others in local government, with State officials, and with representatives from the private sector to create MCCJTP. In various stages of implementation in 18 of the State's 24 local jurisdictions,[15] MCCJTP brings treatment and criminal justice professionals together to screen mentally ill individuals while they are confined in local jails, prepare treatment and aftercare plans for them, and provide community followup after their release. The program also offers services to mentally ill probationers and parolees and provides enhanced services to mentally ill offenders who are homeless and/or have co-occurring substance use disorders (see "MCCJTP: At the Forefront of Efforts to Aid Mentally Ill Offenders," page 4).

MCCJTP targets individuals 18 or older who have a serious mental illness (i.e., schizophrenia, major affective disorder, organic mental disorder, or other psychotic disorders), with or without a co-occurring substance use disorder. It is founded on two key principles:

- **The target population requires a continuum of care provided by a variety of service professionals in jail and in the community that is coordinated at both the State and local levels.** In this regard, agency participants include local mental health and substance abuse treatment providers and advocates, local hospital professionals, housing providers,

members of local law enforcement, and representatives of key State criminal justice, mental health, and substance abuse agencies.

- **Local communities are in the best position to plan and implement responses to meet the needs of the mentally ill offenders in their jurisdictions.** To that end, each participating jurisdiction has developed a local advisory board to oversee the conduct of needs assessments, coordinate program implementation, monitor service delivery, and expand program options.

MCCJTP's goals are to improve the identification and treatment of mentally ill offenders and increase their chances of successful independent living, thereby preventing their swift return to jail, mental hospitals, homelessness, or hospital emergency rooms. In some locations, MCCJTP also aims to reduce the period of incarceration (through postbooking diversion) and even reduce the likelihood of incarceration altogether (through prebooking diversion).

According to data maintained by the Maryland Department of Health and Mental Hygiene, almost 1,700 mentally ill individuals received services through MCCJTP in 1996 (see "The Mentally Ill in Maryland Jails," page 5). Funding for the 18 programs totals approximately $4 million annually and comes from local, State, and Federal sources. In addition, many agencies contribute administrative time and support services (see "MCCJTP Funding," page 5).[16] The funding supports the provision of case management services in each jurisdiction and other specialized services such as housing to meet the needs of mentally ill offenders.

This Program Focus reviews the history of MCCJTP, describes key program features, and discusses the benefits of and challenges to program operation.

MCCJTP: At the Forefront of Efforts to Aid Mentally Ill Offenders

Efforts to comprehensively address the needs of the jailed mentally ill are still relatively rare. According to a nationwide survey of jails conducted by researchers at the National GAINS[a] Center for People With Co-Occurring Disorders in the Justice System (see "Sources for More Information" at the end of this report), "most jails have no policies or procedures for managing and supervising mentally disordered detainees."[b]

Henry Steadman, one of the study's authors and a renowned expert on responses to mentally ill offenders nationwide, believes the features that set MCCJTP apart from most other efforts include:

- ***Strong collaboration between State and local providers.*** "Typically, States don't coordinate anything in these efforts," Steadman observed. "In addition, it is very rare for the State to do something that the county is receptive to without usurping county authority. It is usually left to the county to address the needs of the jailed mentally ill. The integration of funding streams at the different levels of government and the ongoing commitment by State officials involved in MCCJTP make the program unique."
- ***Transitional case management services that link detainees with community-based services.*** Based on their survey of jails nationwide, Steadman and his coauthor, Bonita Veysey, concluded that "case management services that link detainees, on release, to community services are seldom provided in jails of any size."[c] MCCJTP is a clear exception to this trend.
- ***Long-term housing support for homeless mentally ill offenders.*** According to Steadman, "Rarely do you see housing as a part of a jail/criminal justice program for mentally ill or substance abusing individuals. You may see some use of short-term housing vouchers but not the full-scale commitment Maryland has made."
- ***Focus on co-occurring disorders.*** "Officials in Maryland," Steadman noted, "have recognized that co-occurring disorders are the norm and not the exception." In his opinion, that awareness and the State's related programmatic response set MCCJTP apart from many of its counterparts across the Nation.

Notes

a. GAINS = G–Gathering information, A–Assessing what works, I–Interpreting the facts, N–Networking with key stakeholders, S–Stimulating change.

b. Steadman, H., and Veysey, B., *Providing Services for Jail Inmates With Mental Disorders,* Research in Brief, Washington, DC: U.S. Department of Justice, National Institute of Justice, April 1997, NCJ 162207, page 1.

c. Ibid, 2.

The Roots of the Program

In the early 1990s, an estimated 600 to 700 mentally ill offenders were confined in local correctional facilities throughout Maryland.[17] Because they lacked sufficient numbers of appropriately trained staff to screen and treat the mentally ill, jails were neither sensitive, nor especially safe, places for most mentally ill individuals. In those days, according to several local corrections officials, the special needs of mentally ill offenders were generally ignored unless such individuals were suicidal or disruptive. The disruptive ones were usually "locked down," but not until staff had spent considerable time in crisis management, trying to subdue them or negotiate with mental health agencies for emergency commitments. Lacking mental health training, correctional officers were frustrated and sometimes insensitive in their handling of mentally ill offenders, which exacerbated an already difficult situation. Adding to the concerns of corrections officials was the high rate of recidivism among mentally ill offenders (see "Assessing Service Needs," page 6). One frustrated former warden of a detention facility in southern

Maryland, who has since become a strong advocate of MCCJTP, admits having asked publicly about the mentally ill offenders in his jail, "Can't we shoot them up with something and just keep them asleep while they're here?"

In 1991, at the request of the Maryland Correctional Administrators Association, the Governor's Office of Justice Administration (GOJA) formed an interagency State and local task force to help define a strategy for responding to mentally ill offenders in the State. After careful review of available national research and reports on the topic by previous State task forces (see "Building on Research," page 7), the GOJA task force concluded that offenders with serious mental illnesses require a coordinated treatment approach that combines the expertise of criminal justice and treatment professionals.

The Jail Mental Health Program pilot

The State's Mental Hygiene Administration (MHA), part of the Maryland Department of Health and Mental Hygiene, assumed primary responsibility for the design and implementation of a pilot program to aid local detention centers in creating a multidisciplinary response to the jailed mentally ill. In 1993 and 1994, with $50,000 in seed money from MHA, four pilot Jail Mental Health Programs (predecessors to MCCJTP) were launched in Cecil, Charles, Frederick, and Wicomico counties. The pilots resulted in the creation of a system for providing case management services to mentally ill inmates.

The Mentally Ill in Maryland Jails

According to data maintained by the Maryland Mental Hygiene Administration, 1,682 jailed mentally ill individuals received MCCJTP services during 1996. The average daily jail population in the MCCJTP sites ranged from a low of 52 to a high of 1,362, with a median population of 237. The proportion of jailed individuals who were mentally ill varied considerably across the 18 jurisdictions. For instance, in the five jurisdictions visited by the author, prevalence estimates ranged from 8 to 21 percent.[a]

Diagnosis	Diagnosed Jail Detainees	
	Number*	Percentage
Depressed or Bipolar Disorder	51	72
Schizophrenic Disorder	5	7
Psychotic Disorder	3	4
Other**	17	23

*Some individuals have multiple diagnoses.

** These include: antisocial personality disorder, attention deficit hyperactivity disorder, conduct disorders, dissociative disorders, eating disorders, intermittent explosive disorder, learning disorders, obsessive-compulsive disorder, and personality disorders.

The following data from Frederick County, taken during a 1-day census in June 1997, indicate the prevalence of mental illness among the jailed population there. Of 341 inmates in the Frederick County Adult Correctional Center that day, 71 (21 percent) were diagnosed with 1 or more mental illnesses. Of those, 36 (50 percent) had a co-occurring substance use disorder.

Note

a. National estimates of the percentage of jailed populations with serious mental illness (e.g., schizophrenia, bipolar disorder, severe recurrent depression) range from 6 to 15 percent, depending on the study and institution. See Torrey, E.F., Editorial: "Jails and Prisons—America's New Mental Hospitals," *American Journal of Public Health* 85 (12) (December 1995): 1612.

MCCJTP Funding

MCCJTP combines Federal, State, and local funds to offer a mix of services within local detention centers and in the community. Current program funding includes:

- **$900,000** in annual Mental Hygiene Administration (MHA) funds to hire MCCJTP case managers.
- **$300,000** in annual Projects for Assistance in Transition From Homelessness (PATH)[a] funds for outreach, case management, mental health, and substance abuse services for homeless individuals with serious mental illness and/or co-occurring substance use disorders, and for parolees and probationers on intensive supervision caseloads.
- **$340,922** in Edward Byrne Memorial State and Local Law Enforcement Assistance Program funds to provide substance abuse treatment services in conjunction with mental health services in seven county detention centers and in the community.
- **$5.5 million** from the U.S. Department of Housing and Urban Development (HUD) to provide Shelter Plus Care housing over a 5-year period (1996–2001).
- **$6,557,719** in matching funds and services from jurisdictions participating in MCCJTP, $5.5 million of which supports the Shelter Plus Care housing program.
- **Administrative and support services** from participating agencies for which cost estimates are not available.

Note

a. PATH is part of the Mental Health Services Block Grant to the States that is overseen by Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Mental Health Services. PATH provides a variety of treatment formula grant awards to the States for homeless people with mental illnesses and co-occurring substance abuse problems, including treatment, support services in residential settings, and coordination of services and housing. See "Sources for More Information" at the end of this report for contact information.

Within a short amount of time, those involved in the Jail Mental Health Program began reporting improved identification of the jailed mentally ill, enhanced communication between mental health and corrections staff, and reduced disruptions associated with mentally ill inmates (see "Screening Mentally Ill Offenders in Charles County," page 8).

Fourteen additional counties have since developed similar programs to respond to mentally ill offenders. Over time, the focus of the Jail Mental Health Program has expanded to include greater use of community-based services and diversion. In addition, mentally ill probationers and parolees have been added to the client base. The program's title was changed to the Maryland Community Criminal Justice Treatment Program in 1994 to reflect its broader scope.

Case managers, MCCJTP clients, and other consumers at Go-Getters, Inc., a psychiatric day treatment program in Wicomico County, MD, share free time between classes.

Key Features of Maryland's Coordinated Approach

Immediately after Ray Carver was referred for a mental health screening, the MCCJTP case manager reviewed his history of mental illness and referred him for medication. She counseled Ray throughout his stay at the detention center, and together they developed a treatment and aftercare plan for him that included taking his medication, participating in treatment for alcoholism, reinstating his Supplemental Security Income benefits, locating housing, and participating in the day program

Assessing Service Needs

From 1984 through the early 1990s, local task forces and MHA staff studied the capacity of existing service delivery mechanisms to meet the needs of mentally ill offenders and discovered the following:

- **Most detention centers had extremely limited access to mental health professionals.** Jail medical staff were generally not trained to address both the medical and psychiatric needs of inmates. If available, psychiatric services were limited to a few hours per week or month, when only the most severe cases could be evaluated. Jail officials also experienced considerable difficulty with the mental health system when trying to relocate individuals whose mental illness appeared to warrant admission to a State mental institution. Both in-jail and community-based services were being compromised by the lack of proper staff to screen mentally ill offenders, provide other supportive services within jail, prepare discharge plans, and offer community-based followup.
- **Mentally ill individuals had a high rate of recidivism.** Mentally ill offenders appeared to return quickly to correctional settings at least in part because of the lack of appropriate aftercare planning and services in the community. In addition, many mentally ill offenders were homeless and/or had co-occurring substance use disorders that increased the likelihood of their return to jail.
- **Mentally ill offenders tended to cycle through a variety of criminal justice and psychosocial service settings, in part because of the lack of coordination among service providers.** A survey by MHA staff of 536 individuals housed in detention centers, State psychiatric hospitals, homeless shelters, and substance abuse clinics showed that during the previous 12 months, 54 percent had been in jail, 36 percent had received inpatient hospitalization, 35 percent had used an emergency shelter, and 33 percent had seen a substance abuse counselor.[a] Investigators concluded that better service coordination was warranted to reduce duplication in services, stabilize mentally ill offenders in the community, and prevent their return to jail.

These findings strongly suggested the need to design a program that would increase services for mentally ill offenders, coordinate services already in existence, and support mentally ill offenders in the community.

Note

a. Gillece, J., "An Analysis of Health, Criminal Justice, and Social Service Utilization by Individuals Hospitalized, Incarcerated, or Homeless," unpublished doctoral dissertation, College Park: University of Maryland, 1996: 52.

at Go-Getters, Inc., a local psychiatric rehabilitation center and partner agency of MCCJTP.

The case manager discussed Ray's criminal charges with his public defender, the assistant State's attorney, and the district court judge. Ray pled guilty and was sentenced to a year's probation. Several components of the treatment plan, which he signed in the presence of the judge, were included as conditions of Ray's probation.

Because he was homeless before his incarceration and willing to quit drinking and participate in daytime activities at Go-Getters, Inc., Ray qualified for housing assistance through the Shelter Plus Care grant awarded to Maryland's Department of Health and Mental Hygiene by the Federal Department of Housing and Urban Development. Prior to Ray's release, the MCCJTP case manager helped Ray complete an application for Shelter Plus Care housing, and a representative from Hudson Health Services, another partner agency of MCCJTP, located an apartment for Ray in a relatively low-crime area of town, just a few blocks from Go-Getters. The furnishings for Ray's apartment—a sofa, bed, table, and chair—were donated by local church and community organizations and moved to the apartment by two of the detention center's work release inmates.

On the day he was released from jail, Ray's MCCJTP case manager spent the day helping him get settled in his new apartment. Together, they stocked Ray's refrigerator, met with the psychiatrist at the County Health Center, and visited Go-Getters, where Ray was assigned a case manager.

Building on Research

During the past decade, a number of researchers have recommended strategies for responding to the needs of the jailed mentally ill, all of which have been carefully integrated into MCCJTP.

Specifically, MCCJTP's grounding principle—that communities must provide a continuum of care for mentally ill offenders—is consistent with 1990 research that concludes that the mental health needs of inmates must be viewed as a community problem requiring the involvement of an array of service providers in addition to detention center staff.[a]

Although sites around the Nation differ in their approach to such service coordination,[b] a 1992 review of research and practice recommended that the following key elements, which are central features of MCCJTP, be part of any multidisciplinary response to the jailed mentally ill:

- Interagency agreements.
- Consensus on defined goals.
- Delineation of responsibilities.
- Interagency communication.
- Cross-training.
- Ongoing program review.[c]

In a 1995 discussion of strategies for diverting the mentally ill out of criminal justice settings, researchers called for:

- Integrated services.
- Regular meetings of key agency representatives.
- "Boundary spanners" (individuals who can facilitate communication across agencies and professions) to coordinate policies and services.
- Strong leadership.
- Early identification of the mentally ill in correctional settings.
- Distinctive case management services.[d]

More recently, a 1997 study suggested that traditional jail-based mental health strategies should include court liaison mechanisms, pre- and postbooking diversion, and the use of community mental health services (e.g., university resources), especially in small jails.[e]

Some research suggests that services for the jailed mentally ill should also include:

- Screening, classification, and referral.
- Crisis intervention.
- In-jail counseling.
- Discharge planning and community followup.
- Specialized services for subgroups of mentally ill offenders, such as those who are homeless and/or have co-occurring substance use disorders).[f]

Notes

a. Steadman, H.J. *Effectively Addressing the Mental Health Needs of Jail Detainees,* Washington, DC: U.S. Department of Justice, National Institute of Justice, 1990: 3.

b. Ibid., 3.

c. Landsberg, G. "Developing Comprehensive Mental Health Services in Local Jails and Police Lockups," in *Innovations in Community Mental Health,* ed. S. Cooper and T.H. Lentner, Sarasota, FL: Professional Resource Press, 1992: 97–123.

d. Steadman, H.J., S.M. Morris, D.L. Dennis, "The Diversion of Mentally Ill Persons From Jails to Community-Based Services: A Profile of Programs," *American Journal of Public Health* (December 1995): 1631.

e. Steadman, H.J., and B. Veysey, *Providing Services for Jail Inmates With Mental Disorders,* Research in Brief, Washington, DC: U.S. Department of Justice, National Institute of Justice, April 1997.

f. Steadman, H.J., D.W. McCarty, and J.P. Morrissey, *The Mentally Ill in Jail: Planning for Essential Services,* New York: Guilford Press, 1989; Dvoskin, J., "Jail-Based Mental Health Services," in Steadman, *Effectively Addressing the Mental Health Needs of Jail Detainees,* 64–90; Landsberg, G., "Developing Comprehensive Mental Health Services in Local Jails and Police Lockups"; Center for Mental Health Services, *Double Jeopardy: Persons With Mental Illnesses in the Criminal Justice System,* Report to Congress, Washington, D.C.: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, February 1995; Abram, K., and L. Teplin, "Co-Occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* (October 1991): 1042–1044.

For the first month after Ray's release, the MCCJTP case manager checked in on Ray several times a week. As Ray became more involved in community-based services, the MCCJTP case manager's involvement tapered off. She monitors Ray's progress with his case manager at Go-Getters and other service providers and is on-call in the event of a crisis.

As Ray's experience suggests, MCCJTP incorporates key features listed below and described more fully in the sections that follow:

- Local partnerships to aid mentally ill offenders.
- Support from State government agencies.
- A broad range of case management services for mentally ill offenders who are incarcerated or living in the community.
- Enhanced services for mentally ill offenders who are homeless and/or have co-occurring substance use disorders.
- Diversion strategies.
- Training for criminal justice and treatment professionals involved in the program.
- A commitment to program evaluation.

Local partnerships

Each MCCJTP program is guided by a local advisory board that assesses service needs, monitors program implementation, and investigates ways to expand program services. Although board membership varies across the counties, it generally includes representatives from the local detention center, as well as health and mental health professionals, alcohol and drug abuse treatment providers, public defenders, assistant State's attorneys, judges, parole and probation officers, law enforcement personnel, social service professionals, local hospital staff, housing specialists, mental health advocates, and consumers. Additional members are recruited as particular service needs (e.g., for diversion) are identified.

In most counties the advisory boards divide their time between reviewing specific cases and setting or refining policy. In most jurisdictions local health departments or related agencies coordinate MCCJTP and supervise the mental health staff assigned to the program. Other government agencies and private organizations have signed memorandums of understanding (MOUs) delineating their participation in local advisory boards and their willingness to provide services as appropriate.

These formal agreements are thought to be essential to ensure the smooth execution of local policies. In addition, working together to handle specific cases has reportedly been extremely beneficial to solidifying relationships among

Screening Mentally Ill Offenders in Charles County

When corrections officials in the Charles County Detention Center met with MHA staff to begin the county's Jail Mental Health Program pilot, they were confident that only three mentally ill individuals were housed in the jail. But screening by trained mental health staff resulted in 17 inmates being diagnosed as seriously mentally ill. Among them was an individual who was also deaf. Frustrated by his bizarre behavior, but unaware of his deafness, correctional officers had been speaking loudly to him for days and were becoming increasingly annoyed by his unresponsiveness. MHA staff were able to diagnose the inmate and, working with corrections staff, assist in relocating the individual to a secure mental health facility.

Months later, when the man again arrived at the jail, staff were prepared. The protocol that had been developed through the Jail Mental Health Program ensured that the inmate was identified quickly, placed on medication, moved swiftly through the certification process, and transferred to a State mental hospital.

Local and State officials convene the monthly meeting of the Task Force on Community Criminal Justice Treatment, the advisory council for Wicomico County's MCCJTP.

An MCCJTP case manager assists jail personnel in booking an inmate with potential psychological problems.

participating agencies and organizations. As program participants have been able to solve the needs of specific mentally ill offenders, mutual trust has grown and formal organizational agreements have evolved. Shelley McVicker, assistant State's attorney in Frederick County, recalls, "At first we worked out relationships with others in the [MCCJTP] network on a case-by-case basis. Then we worked on organizational MOUs. The State's involvement has helped us cement the relationships."

In addition, the willingness of community treatment providers to provide honest feedback to the criminal justice system about offenders' compliance has resulted in support from criminal justice professionals for placing mentally ill offenders in the community. According to McVicker, "My office has a good relationship with Way Station [a local psychiatric rehabilitation facility participating in MCCJTP]. They share information honestly about those who stay in treatment and those who don't. When necessary, we are able to work together to define reasonable consequences."

Support from State government

A number of State agencies have made strong commitments to local MCCJTP programs. In 1994, in an effort to better serve mentally ill offenders, MHA expanded its priority population to include MCCJTP participants and gave those individuals the same access to MHA-funded services and housing as persons discharged from MHA inpatient facilities. Other State agencies, including the Division of Parole and Probation and the Alcohol and Drug Abuse Administration, made formal commitments to ensure the participation of their local representatives in MCCJTP.

MHA's Division of Specific Populations has primary responsibility for supporting MCCJTP, providing nearly $1 million in annual funding for the program. In addition, MHA staff have worked cooperatively with local decisionmakers to prepare grant proposals for other types of Federal, State, and local funding to enhance program services and create opportunities for local MCCJTP participants to receive technical assistance and training from the National Institute of Corrections Jails Division and from the National GAINS Center for People With Co-Occurring Disorders in the Justice System.[18]

MHA staff have also been quick to address issues that cannot be resolved easily at the local level (e.g., regarding inmates who require competency hearings or emergency commitment to State mental hospitals). In addition, MHA staff regularly participate in meetings of local MCCJTP advisory boards and the Maryland Correctional Administrators Association. Along with wardens and other local advisory board members, MHA staff have met on several occasions with county councils to discuss the merits of MCCJTP and seek local funding for program enhancements.

Case management services

Each MCCJTP jurisdiction employs at least one case manager who is responsible for screening mentally ill individuals while they are jailed, counseling them while they are detained, helping them develop discharge plans, assisting them in obtaining services in the community, advocating for them with criminal justice officials and community-based service providers, and monitoring their progress following release (even if their criminal charges are dismissed).

MCCJTP case managers also help link mentally ill offenders on intensive probation or parole with community-based services and monitor their progress following release. Although most mentally ill offenders in the program are contacted in detention centers, some are not. For example, parolees from the State prison system may be referred to an MCCJTP case manager by prison or parole officials via MHA, or they may refer themselves following release.

In most jurisdictions, county health departments or equivalent government agencies receive up to $50,000 per year from MHA to hire a full-time MCCJTP case manager who is an experienced mental health professional with an advanced

degree in counseling. In some jurisdictions, a portion of the $50,000 is used to increase psychiatric treatment time in jail. Administrative support and supervisory hours are usually contributed by the recipient agency.

According to MHA, the average MCCJTP caseload is 35 clients, but caseload size ranges from 10 to 56 depending on the jurisdiction and the number of clients supervised in the community. In some settings, following a period of close supervision by the MCCJTP case manager, community-based case managers from government or private-sector mental health organizations assume primary responsibility for monitoring released individuals, which reduces the supervisory responsibilities of the MCCJTP case manager.

Though adaptations are necessary to accommodate local needs and service capabilities, each participating jurisdiction adheres to the following general case management protocol:

Identification. Preliminary identification of candidates for program services is made following arrest, after self-referral by the defendant, or as a result of referrals by the arresting officer, the classification officer, jail medical staff, the substance abuse counselor, or other jail personnel.

The warden of the Wicomico County Detention Center meets with the MCCJTP case manager to discuss legal issues related to an inmate's care and treatment.

Screening and needs assessment. The MCCJTP case manager meets with the candidates to conduct an in-jail diagnostic interview and an individual needs assessment. If an individual qualifies for program services, he or she may be referred for medication.

Counseling and discharge planning. While in jail, the mentally ill defendant meets with the case manager for counseling and development of an aftercare plan. A typical plan will include mental health and substance abuse counseling, educational services, recreational activities, employment training, and housing placement. Before the individual is released, the MCCJTP case manager and, in some cases, a residential rehabilitation specialist work to identify suitable housing.

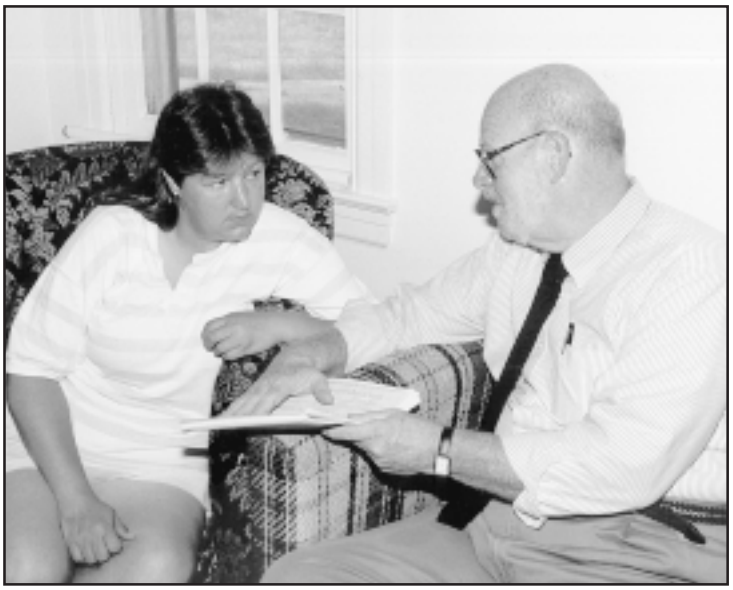
Criminal justice system liaison. The MCCJTP case manager also meets with assistant State's attorneys and defense counsel to advocate for the swift resolution of criminal charges (e.g., through diversion or plea negotiation) and for the return of the MCCJTP client to the community whenever possible. These negotiations usually succeed when criminal charges are relatively minor because the MCCJTP case manager is able to ensure close supervision of the mentally ill offender in the community and the quick, honest reporting of any problems.

Referral and monitoring in the community. For those who agree or are required to participate in community followup,[19] MCCJTP case managers help link clients to specified services, such as psychiatric

day treatment, substance abuse treatment, vocational rehabilitation, and educational services. In addition, MCCJTP case managers meet regularly with community-based providers to monitor client progress.

MCCJTP's community-based partners are essential to the implementation of aftercare plans. In some jurisdictions, released individuals are able to participate in day-treatment programs offered by local psychiatric rehabilitation centers. These programs offer an array of work opportunities, skills development classes, substance abuse counseling, and housing assistance. They may also assign a case manager to work with the mentally ill offender in the community. In other locations, a mix of providers offer these services.

An MCCJTP case manager helps a jailed inmate develop an aftercare plan.



A case manager and an MCCJTP client review the rules for Shelter Plus Care housing.

Enhanced services

State and local MCCJTP participants have become increasingly aware of the need to address certain subpopulations of mentally ill offenders, including homeless persons and those with co-occurring substance use disorders. State and Federal grant funds are being used to enhance the response to individuals in these groups.

Homeless mentally ill offenders. In 1995, MHA was awarded a $5.5-million Shelter Plus Care grant by HUD to provide rental assistance for up to 5 years to homeless mentally ill offenders served by MCCJTP.[20] In turn, local service providers participating in MCCJTP have pledged to provide services such as vocational training, substance abuse treatment, and life-skills training to ensure that Shelter Plus Care recipients have access to meaningful daytime activities.

Shelter Plus Care applicants are eligible to receive the equivalent of the fair market rate for rent and utilities in the jurisdiction where they live, provided their incomes do not exceed the predetermined ceiling for the county of residence, they agree to pay up to one-third of their incomes in rent, and they participate in fulfilling the components of their MCCJTP treatment plans. Shelter Plus Care recipients may live alone or with a roommate. In situations involving families, the spouse and/or children are also eligible for housing as long as the adult receiving the assistance will aid in the care and support of the children and the family's income does not exceed the ceiling for the county.

The MCCJTP case manager and/or other case managers available through community-based service providers are responsible for developing treatment plans, gathering documentation of homelessness, and filing paperwork with the appropriate county and State mental health offices. In some jurisdictions, case managers are also responsible for locating housing. In others, such as Calvert, Frederick, Prince Georges, and Wicomico counties, where MCCJTP partner agencies work with local realtors, community-based organizations assume substantial responsibility for locating housing. Rental agreements can be made with the tenants or sponsor based, which means that a credible third party vouches for the tenant and signs the lease.

Case managers are responsible for monitoring tenants to ensure their compliance with housing agreements and participation in the daily activities outlined in treatment plans. To assist in this process, each service provider submits monthly documentation of the services clients receive to the MCCJTP case manager.

Program implementation has been remarkably smooth. By all accounts, landlords have responded favorably to the program. They appreciate that it guarantees that rents will be paid and that tenants will be supervised closely. In addition, there has been no community opposition, probably because Shelter Plus Care clients are housed throughout the community in single- or double-occupancy dwellings, and because close supervision by case managers helps to ensure that client problems are addressed swiftly. Bureaucratic issues such as creating tracking forms, training staff, and developing protocols for timely rental payments by State and county government agencies have arisen, but are now mostly resolved.

Other issues have emerged as well. First, rental assistance does not cover the costs of such household necessities as furniture, linens, dishes, and utensils. Although these items are often donated by local charitable organizations, they must be moved to the housing locations. In Wicomico County, detention center inmates on work release help transport furnishings, which has proven a cost-effective way to reduce the burden on the MCCJTP case manager. Second, housing is not always located near public transportation. This is especially true in rural counties where transportation to daytime activities is generally limited. In some locations, community-based participants in MCCJTP provide transportation for program clients. Third, it is not always easy to guarantee that affordable housing will be located in relatively crime-free neighborhoods, though that is certainly the goal. Finally, in locations where sponsor-based lease agreements are required, some clients' reputations make it difficult to identify an organization willing to sign their lease agreements. Some counties, such as Frederick, have addressed this concern by involving multiple sponsors in the program.

According to MHA, 216 individuals and/or families were placed in Maryland's Shelter Plus Care Housing Program in the first 2 years of operation (April 1996 to April 1998). At the end of the period, nearly 90 percent remained in permanent housing. Eleven individuals had been evicted; 7 were rearrested; and 9 left the program.

Mentally ill offenders with co-occurring substance use disorders. In 1996 MHA received nearly $350,000 in Edward Byrne Memorial State and Local Law Enforcement Assistance Program funds from the U.S. Department of Justice's Bureau of Justice Assistance to hire substance abuse and mental health case managers to aid dually diagnosed offenders in seven MCCJTP jurisdictions.[21] These funds are being used in a variety of ways. For example, Frederick County has hired a case manager who provides treatment planning to mentally ill offenders with co-occurring substance use disorders while they are confined in the Frederick County Adult Detention Center and community followup after they are released. The case manager also coordinates mental health services at the detention center with medical, inmate classification, substance abuse program, and security staff. In Dorchester County, a full-time case manager is involved in treatment of dually diagnosed inmates; Kent County uses its funds for community followup of dually diagnosed clients.

Other counties that do not receive Byrne funding have taken steps to ensure that mental health services are coordinated with their jails' substance abuse treatment providers. Substance abuse treatment professionals in the jails report that, as a result of MCCJTP, mentally ill offenders, who often went undiagnosed or untreated in the past, can now benefit more fully from substance abuse services and are less disruptive in substance abuse treatment settings.

Diversion

In a number of jurisdictions, diversion is included among the MCCJTP's objectives. Hoping to reduce the length of confinement for mentally ill individuals who are arrested for nonviolent offenses, Wicomico County added postbooking diversion to its bank of program services soon after implementing MCCJTP. According to the county's guidelines, diversion candidates must demonstrate a willingness to participate in the program, and community-based services must be available to meet participants' needs. Individuals with a history of violence or arson are not eligible for the program.

In a typical situation, the MCCJTP case manager works with a diversion candidate to develop a treatment plan. The treatment plan is then discussed with the assistant State's attorney, the public defender, and the judge assigned to the case. When all parties agree that diversion is appropriate,

Participants in an art class at Go-Getters, Inc., a psychiatric day treatment program in Wicomico County, MD.

the judge places the case on the "stet" docket, which leaves it open for 1 year. The defendant is then released to the community to complete his or her treatment plan. Knowing that released individuals will be supervised closely by the MCCJTP case manager, judges have reportedly been active and enthusiastic participants in the diversion program.

More recently, Wicomico's MCCJTP advisory board has focused its attention on prearrest diversion. In 1996 the Wicomico County Detention Center, in collaboration with the county health department, received Edward Byrne Memorial State and Local Law Enforcement Assistance Program funds to establish a mobile crisis unit. With assistance from the GAINS Center, county planners visited mobile crisis programs in Birmingham, Alabama, and Albany, New York. "I came back really enthused," says M. Kirk Daugherty, Chief Deputy in the Wicomico County Sheriff's Office, about his visit to Albany. "It's always nice to hear from a guy who's done a program already. We started our unit in October of 1997 and it's been very beneficial."

Staffed by a deputy sheriff and two case managers (one on call 24 hours a day; one working 2–10 p.m.), Wicomico's mobile crisis unit is always available to help the sheriff's office identify the most appropriate placement for mentally ill individuals. If law enforcement officers responding to an incident involving a mentally ill person determine that criminal charges do not need to be filed, other options (e.g., for shelter or emergency room evaluation) are pursued. The case manager accompanies the mentally ill individual to the agreed-upon destination, thereby relieving law enforcement officers of time-consuming interactions with the health and mental health systems and ensuring that the mentally ill individual has a mental health advocate at his or her side.

Commenting on the kinds of situations that prompt calls to the mobile crisis unit, Daugherty says, "Down here, citizens call the police for everything—marriage counseling—the whole gamut. In situations involving the mentally ill, there may not be a crime, but an emergency petition [to the court to send someone to a State mental health facility] probably won't work either. For instance, one time we had a guy who wasn't taking his meds and was very depressed, but there was nothing we could do. The hospital wouldn't take him. So we called mobile crisis and they relieved our people and surely made the family feel a whole lot better. I like it [mobile crisis] as a safety net. It gives our people more confidence that the [mentally ill] person won't do anything crazy when we're gone. It's a very valuable tool."

Training

Providing training for both criminal justice and mental health professionals is a key objective of most local advisory boards and MHA. With assistance from the GAINS Center and the Virginia Addictions Technology Transfer Center, MHA offers regional cross-trainings for professionals involved in the criminal justice, mental health, and substance abuse treatment systems. The aim of these trainings is to have professionals from the three disciplines learn each other's terminology and understand each other's job duties, roles, and responsibilities. Individual counties have also participated in training and technical assistance offered by the GAINS Center and the National Institute of Corrections Jails Division. In addition, some counties have developed their own training modules.

Program evaluation

During the past 4 years, State and local planners have concentrated on program development; with funding from two Federal grants, they are now able to focus attention on evaluating service delivery and client outcomes.

Creating a client tracking system and research database. Eight pilot jurisdictions are working with MHA staff and researchers at the University of Maryland at Baltimore to develop a client-tracking system that will assess service provision and individual client outcomes.[22] After helping to create a uniform data-collection instrument, MCCJTP case managers at each pilot site began entering data in April 1998. The database will include intake, aftercare planning, and community follow-up information on each MCCJTP client.[23] It will provide data on the characteristics of clients who receive MCCJTP services; the types and amounts of services MCCJTP clients actually use, both in jail and in the community; the costs of services; and changes in client circumstances within the jail and in the community (e.g., regarding housing, employment, psychiatric hospitalization, arrest, or substance abuse treatment).

Studying the prebooking diversion of mentally ill women offenders. In July 1998 Wicomico County launched an experimental prearrest diversion program for women with co-occurring severe mental illness and substance use disorders who face arrest for a misdemeanor or nonviolent felony offense. The program is one of nine research programs funded nationally by SAMHSA's Center for Substance Abuse Treatment and Center for Mental Health Services. Called the Phoenix Project, Wicomico County's program builds on MCCJTP networks to offer 24-hour mobile crisis services, secure crisis housing for women and their children, an integrated outpatient treatment program, case management services with client-to-staff ratios of 20 to 1, and transitional housing for women and their children.

Participants in the study are being assigned randomly to the prebooking intervention or to the standard MCCJTP (postbooking) services available through the Wicomico County Detention Center. Women in the intervention group are being recruited into the program prior to arrest but after determination by law enforcement officers that a complaint is chargeable as a misdemeanor or nonviolent felony. Interview data on women in the intervention group will be compared with similar data collected from women involved in the county's postbooking MCCJTP program. Both process and outcome data will be analyzed to evaluate service provision and client-level outcomes (i.e., recidivism, use of treatment and support services, residential stability, time spent with children, psychiatric symptomology, and level of substance use). Additional analyses involving the pre- and postbooking samples will focus on individual recovery processes, costs, and child outcomes (i.e., social and behavioral functioning and self-concept).

Sustaining Funding: An Ongoing Challenge

With its substantial base of State and Federal funding and with matching funds and in-kind services from many local providers, MCCJTP has been able to serve a large number of mentally ill offenders in jail and in the community. But sustaining financial support is an ever-present challenge.

A key concern is whether local governments will, in the future, assume responsibility for funding services that are now provided with Federal grant monies. In this regard, some MCCJTP advisory board members believe that program evaluation will be essential in persuading local legislators to make a financial commitment to MCCJTP.

A second concern is that MCCJTP funds from MHA have remained capped at $50,000 per site since the Jail Mental Health Program pilots were launched in 1993. Yet with increased costs due to inflation, and with improved identification of mentally ill offenders, those funds cover less of the actual program expenses each year, resulting in increased administrative burdens for participating agencies. Thus far, those agencies have determined that the increases in efficiency and the improved care provided by MCCJTP offset any additional operating expenses it creates.

Finally, like many other States, Maryland has adopted a managed public mental health care system. Prior to its implementation in July 1997, some State and local MCCJTP participants expressed concern that indigent clients might be "lost" in the new fee-for-service system and that compensation might not be adequate to allow providers to respond to the diverse—and often extreme—needs of mentally ill offenders. Some feared that if services were substantially reduced, mentally ill offenders would be sent back into local detention centers and mental institutions.

So far, there is reason for optimism. Because MHA has continued to provide grant funds for MCCJTP, which offers support services that are not covered under managed care (i.e., screening and case management services for jailed mentally ill inmates and community followup for released offenders), mentally ill offenders do not experience interruptions in treatment. When mentally ill offenders are released from jail, they are linked immediately with community-based mental health care providers, ensuring a smooth transition to the managed care system. MCCJTP case managers and other providers involved in the program then continue to work together to provide mentally ill offenders with the full complement of community-based services they require.

Tallying the Accomplishments

Ray Carver smiles as he prepares a pot of spaghetti in his apartment. He is proud that he has food in his refrigerator and a safe place to live. Out of jail for 6 months, Ray now works in the kitchen at Go-Getters and participates in life- and social-skills classes there. He is also preparing for his general equivalency diploma. He attends Alcoholics Anonymous meetings nightly and has regular appointments with a psychiatrist at the county health center. He reports monthly to his probation officer. Ray appreciates the support that he has received from his MCCJTP case manager and other program participants, saying, "In 45 years, this is the only time that people have really cared—have helped me, believed in me, and really supported me. I was tired of the life I was living, but before this, I had no one to turn to for real help."

When the MCCJTP pilot programs were launched in 1993, program planners had several goals. By improving the treatment of mentally ill offenders in jails and in the community, they hoped to improve the quality of care those offenders received, decrease the disruption mentally ill offenders created in correctional and community settings, reduce "system cycling" by coordinating services, and help mentally ill offenders live productively in the community. Five years later, through the dedication of local advisory boards, the commitment of case managers and community-based service providers, and the support of MHA, jurisdictions throughout Maryland have constructed a framework for achieving these goals. The result, as summarized by Charlie Messmer, a substance abuse counselor in Washington County, is that "treatment of mentally ill offenders has become an 'our' problem rather than 'mine' or 'yours.' "

Perhaps the most dramatic changes have occurred in detention centers around the State. Local corrections professionals report that early identification and treatment have reduced inmates' disruptive behavior, training has improved the ability of correctional officers to identify and refer mentally ill inmates for screening, and correctional officers now feel supported by treatment professionals in the jail. According to Barry Stanton, Warden of the Frederick County Detention Center, "These changes have made me feel a whole lot more relaxed. Mentally ill offenders are no longer the primary issue on my desk."

Other criminal justice professionals have also benefited from MCCJTP. Judges and assistant State's attorneys have the assurance that treatment plans will be closely monitored in the community and can rely on case managers for careful assessments of community placements and individual performance. Defense counsels are reassured that clients who are confined in local detention centers receive better care and treatment than in the past and that MCCJTP case managers are able to provide information helpful to making decisions regarding diversion, pretrial release, and case disposition. Probation and parole officers receive support from MCCJTP case managers, who monitor and report on the progress of mentally ill clients in fulfilling their aftercare and treatment plans.

MCCJTP appears also to have dramatically changed the lives of individual clients. Although only careful evaluation of service delivery and case outcomes will demonstrate whether MCCJTP services significantly reduce recidivism, case managers around the State report that some MCCJTP clients have made substantial progress in improving the quality of their lives and contributing to the communities in which they live. As Maureen Plunkert, a case manager in Wicomico County, remarked, "Amazing personalities are revealed as these men and women start getting well."

Sources for More Information

The Maryland Department of Health and Mental Hygiene's Division of Specific Populations fosters the development of innovative programs for recipients of mental health services with special needs, such as individuals with psychiatric disabilities who are homeless, are in jail but could be appropriately served in the community, have co-occurring substance abuse disorders, and/or are deaf. The Division of Specific Populations sponsors MCCJTP. For more information, contact:

Joan Gillece
Assistant Director
Division of Specific Populations, Mental Hygiene Administration
201 West Preston Street
Baltimore, MD 21201
Telephone: 410–767–6603
TTY: 410–767–6539
Fax: 410–333–5402

The National Institute of Justice (NIJ) is the principal research, evaluation, and development agency of the U.S. Department of Justice (DOJ). For information about NIJ's efforts in corrections and program development, contact:

Marilyn C. Moses
Program Analyst
National Institute of Justice
810 Seventh Street N.W., 7th Floor
Washington, DC 20531
Telephone: 202–514–6205
Fax: 202–307–6256
E-mail: moses@ojp.usdoj.gov

The National Criminal Justice Reference Service (NCJRS) was established by NIJ in 1972. It serves as the national and international clearinghouse for the exchange of criminal justice information. For more information about topical searches, bibliographies, custom searches, and other available services, contact:

NCJRS
P.O. Box 6000
Rockville, MD 20849–6000
Telephone: 800–851–3420 (8:30 a.m. to 7 p.m. Eastern time, Monday through Friday)
E-mail: askncjrs@ncjrs.org

The Bureau of Justice Assistance (BJA), a component of DOJ's Office of Justice Programs, supports innovative programs that strengthen the Nation's criminal justice system by assisting State and local governments in combating violent crime and drug abuse. BJA primarily makes funding available through the Edward Byrne Memorial State and Local Law Enforcement Assistance Program. Under this program, BJA is authorized to make formula grants to States and territories, which award subgrants to local units of government. States are required to contribute a 25-percent cash match toward overall funding. For more information, contact:

Mary Santonastasso
Director, State and Local Assistance Division
Bureau of Justice Assistance
810 Seventh Street N.W., 4th Floor
Washington, DC 20531
Telephone: 202–305–2088
Fax: 202–514–5956
E-mail: santonas@ojp.usdoj.gov

The American Jail Association (AJA) provides regional training seminars, onsite technical assistance, and training materials related to inmate programming, direct supervision, and other corrections topics for a modest fee. The Association also sponsors an Annual Training Conference & Jail Expo. Contact:

Stephen J. Ingley
Executive Director
American Jail Association
2053 Day Road, Suite 100
Hagerstown, MD 21740–9795
Telephone: 301–790–3930
Fax: 301–790–2941
E-mail: aja@corrections.com
World Wide Web site: http://www.corrections.com/aja

The National Institute of Corrections (NIC) Jails Division coordinates services to improve the management and operation of jail systems throughout the United States and its commonwealths and territories. Technical assistance, training, and information are provided in many areas, including medical and mental health services and suicide prevention. For more information on technical assistance and training activities, contact:

NIC Jails Division
1960 Industrial Circle, Suite A
Longmont, CO 80501
Telephone: 800–995–6429
Fax: 303–682–0469

HUD's Shelter Plus Care program provides rental assistance in connection with support services from other providers to homeless people with disabilities. The program allows for a variety of housing choices, such as group homes or individual units, coupled with a range of supportive services funded by other sources. Grantees must match the rental assistance with supportive services that are at least equal in value to the amount of HUD's rental assistance. States, local governments, and public housing agencies may apply. HUD awards Shelter Plus Care funds as annual competitive grants. For more information, contact:

Allison Manning
U.S. Department of Housing and Urban Development
Office of Community Planning and Development
Office of Special Needs Assistance Programs
451 Seventh Street S.W.
Washington, DC 20410
Telephone: 202–708–0614, ext. 4497

The Substance Abuse and Mental Health Services Administration (SAMHSA) is part of the U.S. Department of Health and Human Services. Its mission is to improve the quality and availability of prevention, treatment, and rehabilitation services to reduce the illness, death, disability, and cost to society that result from substance abuse and mental illness. SAMHSA comprises the Center for Mental Health Services (CMHS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). The **Phoenix Project,** which involves the pre-arrest diversion of mentally ill women offenders in Wicomico County, MD, is funded jointly by CMHS and CSAT under the Federal **Knowledge Development and Application Program.** For more information on that program, contact:

Susan Salasin
Director of Mental Health and Criminal Justice Programs
Center for Mental Health Services
5600 Fishers Lane, Room 11C–26
Rockville, MD 20857
Telephone: 301–443–6127
Fax: 301–443–0541
E-mail: ssalasin@samhsa.gov

CSAT Office of Communications and External Liaison
5600 Fishers Lane, 6th Floor
Rockville, MD 20857
Telephone: 301–443–5052
Fax: 301–443–7801

Established in 1995, the **National GAINS Center for People With Co-Occurring Disorders in the Justice System** serves as a national locus for the collection and

dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system. The GAINS Center is a Federal partnership between NIC and the Office of Justice Programs within the U.S. Department of Justice and CSAT and CMHS within the U.S. Department of Health and Human Services. The GAINS Center is operated by Policy Research, Inc., through a cooperative agreement with the Federal partners that is administered by NIC. For more information, contact:

The GAINS Center
Policy Research, Inc.
262 Delaware Avenue
Delmar, NY 12054
Telephone: 800–311–GAIN
Fax: 518–439–7612

Projects for Assistance in Transition from Homelessness (PATH) is part of the Mental Health Services Block Grant to the States that is overseen by SAMHSA's CMHS. PATH provides a variety of treatment formula grant awards to States for homeless people with mental illnesses and co-occurring substance use problems. Services covered include treatment, support services in residential settings, and coordination of services and housing. For more information, contact:

Center for Mental Health Services
Homeless Programs Branch
5600 Fishers Lane, Room 11C–05
Rockville, MD 20857
Telephone: 301–443–3706
Fax: 301–443–0256

Funded by SAMHSA, the **Virginia Addiction Technology Transfer Center** has developed a 1-week cross-training curriculum on offenders with co-occurring disorders. Offered to corrections officers, substance abuse counselors, and mental health treatment counselors, the training consists of 15 modules that may be used separately or in conjunction with each other as needed. For more information, contact:

Scott Reiner
Criminal Justice Coordinator
Virginia Addiction Technology
Transfer Center
Division of Substance Abuse Medicine
Medical College of Virginia
1112 East Clay Street
P.O. Box 980205
Richmond, VA 23298–0205
Telephone: 800–828–8323
Fax: 804–828–9906

NIJ Publications on Offender Health Care and Transitional Services

The National Institute of Justice has sponsored a number of publications related to the issue of offender health care and transitional services. To get a free copy of these publications, write the National Criminal Justice Reference Service, P.O. Box 6000, Rockville, MD 20849–6000; call them at 800–851–3420; or send e-mail to *askncjrs@ncjrs.org.*

Case Management in the Criminal Justice System, Research in Action, 1999 (NCJ 173409).

The Women's Prison Association: Supporting Women Offenders and Their Families, Program Focus, 1998 (NCJ 172858).

The Delaware Department of Correction Life Skills Program. Program Focus, 1998 (NCJ 169589).

Chicago's Safer Foundation: A Road Back for Ex-Offenders, Program Focus, 1998 (NCJ 167575).

Texas' Project RIO (Re-Integration of Offenders), Program Focus, 1998 (NCJ 168637).

Successful Job Placement for Ex-Offenders: The Center for Employment Opportunities, Program Focus, 1998 (NCJ 168102).

Providing Services for Jail Inmates With Mental Disorders, Research in Brief, 1997 (NCJ 162207).

The Orange County, Florida, Jail Educational and Vocational Programs, Program Focus, 1997 (NCJ 166820)

The Effectiveness of Treatment for Drug Abusers Under Criminal Justice Supervision, Research Report, 1995 (NCJ 157642).

Evaluation of Drug Treatment in Local Corrections, Research Report, 1997 (NCJ 159313).

The Americans With Disabilities Act and Criminal Justice: Mental Disabilities and Corrections, Research in Action, 1995 (NCJ 155061).

Managing Mentally Ill Offenders in the Community: Milwaukee's Community Support Program, Program Focus, 1994 (NCJ 145330).

Notes

1. Ray Carver's history is a composite of those reported to the author in interviews with 14 Maryland Community Criminal Justice Treatment Program participants.

2. Harlow, C.W., *Profile of Jail Inmates 1996,* Bureau of Justice Statistics Special Report, Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, April 1998, NCJ 164620. In 1996, there were 507,026 jail inmates. Men were less likely than women to have ever been treated for a mental or emotional problem. The author notes that 24 percent of male inmates and 36 percent of female inmates reported having received mental health services.

3. Ibid., 12.

4. Palermo, G.B., M.B. Smith, F.J. Liska, "Jails Versus Mental Hospitals: A Social Dilemma," *International Journal of Offender Therapy and Comparative Criminology* 35 (2) (Summer 1991): 97–106; Judiscak, Daniel L., "Why Are the Mentally Ill in Jail?" *American Jails* (November–December 1995): 11–15.

5. National Coalition for Jail Reform, *Removing the Chronically Mentally Ill From Jail: Case Studies of Collaboration Between Local Criminal Justice and Mental Health Systems*, Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health, 1984; Janik, J., "Dealing With Mentally Ill Offenders," *Law Enforcement Bulletin* 61 (7) (July 1992): 22–26.

6. Haddad, J., "Managing the Special Needs of Mentally Ill Inmates," *American Jails* 7 (1) (March-April 1993): 62–65; National Coalition for Jail Reform, *Removing the Chronically Mentally Ill From Jail: Case Studies of Collaboration Between Local Criminal Justice and Mental Health Systems;* The Center on Crime, Communities and Culture, *Mental Illness in U.S. Jails: Diverting the Nonviolent, Low-Level Offender*, Research Brief, Occasional Paper Series, No.1, New York: The Center on Crime, Communities and Culture, November 1996.

7. Wilberg, J.K., K. Matyniak, and A. Cohen, "Milwaukee County Task Force on the Incarceration of Mentally Ill Persons," *American Jails* (Summer 1989): 20–26; Snow, W.H., and K.H. Briar, "The Convergence of the Mentally Disordered and the Jail Population," in *The Clinical Treatment of the Criminal Offender in Outpatient Mental Health Settings*, ed. N.J. Palone and S. Chaneles, New York: The Haworth Press, 1990: 147–162; Torrey, E.F., J. Stieber, J. Ezekiel, S.M. Wolfe, J. Sharfstein, J.H. Noble, and L.M. Flynn, *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals*, Washington, DC: Public Citizen's Health Research Group, 1992; Landsberg, G. "Developing Comprehensive Mental Health Services in Local Jails and Police Lockups," in *Innovations in Community Mental Health*, ed. S. Cooper and T.H. Lentner, Sarasota, FL: Professional Resource Press, 1992: 97–123.

8. See for example, *Estelle* v. *Gamble*, 429 U.S. 97 (1976); *Bell* v. *Wolfish*, 441 U.S. 535, n.16, 545 (1979); *Bowring* v. *Godwin*, 551 F.2d 44 (4th Cir 1977).

9. Snow, W.H., and K.H. Briar, "The Convergence of the Mentally Disordered and the Jail Population"; Steadman, H.J., S.M. Morris, D.L. Dennis, "The Diversion of Mentally Ill Persons From Jails to Community-Based Services: A Profile of Programs," *American Journal of Public Health* 85 (12) (December 1995): 1630–1635. For more information on existing models for screening and linking mentally ill jail detainees with community-based services, see Veysey, B.M., H.J. Steadman, J.P. Morrissey, and M. Johnson, "In Search of the Missing Linkages: Continuity of Care in U.S. Jails," *Behavioral Sciences and the Law* 15 (1997): 383–397, in which the authors discuss program strategies in seven city and county jails.

10. Steadman, H., and B. Veysey, *Providing Services for Jail Inmates With Mental Disorders*, Research in Brief, Washington, DC: U.S. Department of Justice, National Institute of Justice, April 1997, NCJ 162207; Muzekari, L.H., E.E. Morissey, and A. Young, "Community Mental Health Centers and County Jails: Divergent Perspectives?" *American Jails* XI (1) (March–April 1997): 50–52.

11. Teplin, L.A., K.M. Abram, and G.M. McClelland, "Mentally Disordered Women in Jail: Who Receives Services?" *American Journal of Public Health* 87 (4) (1997): 604–609.

12. Steadman and Vesey, *Providing Services for Jail Inmates With Mental Disorders*, 5.

13. Correctional Association of New York, *Insane and in Jail: The Need for Treatment Options for the Mentally Ill in New York's County Jails*, New York: Correctional Association of New York, October, 1989; Abram, K., and L. Teplin, "Co-Occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* 46 (10) (October 1991): 1036–1045; Peters, R.H., W.D. Kearns, M.R. Murrin, and A.S. Donente, "Psychopathology and Mental Health Needs Among Drug-Involved Inmates," *Journal of Prison and Jail Health* 11 (1) (Summer 1992): 3–25; Martell, D.A., R. Rosner, and R.B.I. Harmon, "Base-Rate Estimates of Criminal Behavior by Homeless Mentally Ill Persons in New York City," *Psychiatric Services* 46 (6) (June 1995): 596–601; Gillece, J., "An Analysis of Health, Criminal Justice, and Social Service Utilization by Individuals Hospitalized, Incarcerated, or Homeless," unpublished doctoral dissertation, College Park: University of Maryland, 1996: 2–42.

14. Gillece, J., "An Analysis of Health, Criminal Justice, and Social Service Utilization by Individuals Hospitalized, Incarcerated, or Homeless," 4.

15. The following counties participate in MCCJTP: Allegany, Anne Arundel, Baltimore, Calvert, Caroline, Carroll, Cecil, Charles, Dorchester, Frederick, Harford, Kent, Prince Georges, Queen Annes, St. Marys, Washington, Wicomico, and Worcester. Several of these commenced program planning in February 1997.

16. Precise administrative cost figures are not available. In each jurisdiction, a portion of supervisory, fiscal, and secretarial staff hours are contributed to support MCCJTP staff. These costs are thought to vary considerably across jurisdictions because of variation in pay scales and in the complexity of MCCJTP programs.

17. Governor's Office of Justice Administration, *Report of the State/Local Criminal Justice/ Mental Health Task Force*, Baltimore, MD: Governor's Office of Justice Administration, January 1995: 12.

18. The GAINS Center is run by Policy Research, Inc., a not-for-profit branch of Policy Research Associates in Delmar, NY, a research firm studying issues in mental

health, substance abuse, criminal justice, and homelessness.

19. As might be expected, not all mentally ill individuals who are counseled in detention centers agree to take part in community-based followup. Case managers report that some individuals participate only after they fail repeatedly to make it on their own.

20. To ensure sufficient numbers of participants, the target population was subsequently expanded to include parolees and probationers on intensive supervision caseloads and participants in PATH, a Federal formula grant program that funds outreach, case management, mental health, and substance abuse services for homeless individuals with serious mental illness and/or co-occurring substance use disorders.

21. These include Baltimore, Calvert, Caroline, Dorchester, Frederick, Kent, and Queen Annes counties. The counties provide a 25-percent cash match.

22. Seven of the counties—Baltimore, Calvert, Caroline, Kent, Queen Annes, Dorchester, and Frederick—receive Edward Byrne Memorial State and Local Law Enforcement Assistance Program funds to aid dually diagnosed offenders. That funding also supports the 3-year database development and research effort. In addition, Wicomico County has been included among the pilot sites. Data collection in that county will aid in the evaluation of the Phoenix Project.

23. The tracking database has three modules. The Intake Module includes information on each client's demographic characteristics, current living situation, family history, employment and finances, prior alcohol and drug use, alcohol and drug treatment history, prior psychiatric treatment, medical treatment, and legal circumstances. Two standardized instruments—the Multnomah County Community Abilities Scale, which assesses a client's level of social functioning across multiple life domains and the Lehman Quality of Life Interview (TL–30S), which includes objective and subjective measures of quality of life across eight life domains—are also included in the intake data module. The Service Encounter Module includes information on the type, amount, and duration of services provided to jail-based clients. This module will support analysis of level of services and service costs. The Aftercare Module includes data on the aftercare service plan, client contacts with referral agencies, and self-reported changes in client circumstances (e.g., in residence, employment, psychiatric hospitalization, arrests, and substance abuse treatment).

About this study

This Program Focus was written by Catherine Conly, Associate at Abt Associates Inc. In preparing the report, Ms. Conly met at length with Joan Gillece and other staff of Maryland's Mental Hygiene Administration. She also interviewed officials who participate in the MCCJTP programs in Allegany, Charles, Frederick, Washington, and Wicomico counties; observed local advisory board meetings; and interviewed MCCJTP clients both in jails and in the community. In addition, Ms. Conly participated in a 3-day, multisite cross-training for mental health, substance abuse, and corrections professionals involved in the MCCJTP.

Findings and conclusions of the research reported here are those of the author and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

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