National Institute of Corrections

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

Increasing Collaboration between Corrections and Mental Health Organizations: Orange County Case Study

I. Introduction

On June 2, 2001 corrections staff at the Orange County, Florida Jail were summoned to the cell of Karen Johnson and found her in the midst of a violent seizure. She was rushed to the Orlando Regional Medical Center, where she slipped into a coma after unsuccessful resuscitation efforts. Johnson died five days later from complications due to methadone withdrawal. It was the second death related to mental illness and substance abuse problems at the jail in four years, and the press and public responded with loud calls for reform.

Within months of the incident, Orange County Chairman Richard Crotty established a Jail Oversight Commission (JOC) to review all aspects of jail operations. Such commissions are myriad in government, as are the stories of their recommendations being ignored, watered down, or simply neglected, either for lack of resources or political will. Indeed, the introduction to the JOC report acknowledges as much, pointing out that "no less than five different studies of the Orange County Corrections Department sit on the shelves of the County Administration Building gathering dust."[1] But the JOC report did not similarly languish.

Prior to the establishment of the JOC, a group of officials and advocates in Orange County had been developing strategies to better respond to the many people who were landing at the intersection of the criminal justice, mental health, and substance abuse systems. Over the next four years, these officials launched an array of initiatives, including an effort focusing on police (the establishment of Crisis Intervention Team), a pretrial services initiative, and a pretrial services program for individuals with co-occurring mental illness and substance use disorders that links participants to an assertive community treatment team designed to serve people involved with the criminal justice system.

That such a broad array of stakeholders has worked together so closely and deliberately over several years to develop joint strategies, and that this collaboration has led to a range of new programs, distinguishes Orange County from many counties across the United States.

But officials in Orange County recognize that their work is far from finished. Jail crowding persists, the percentage of the jail population with

1 Orange County Jail Oversight Commission, *Report of Findings*, May 2002.

mental illness and co-occurring disorders remains high, and various challenges limit the impact of programs launched in the past four years. This case study reviews Orange County's efforts with the hope that it will provide useful lessons for other communities working to convene coalitions of criminal justice, mental health, and substance abuse stakeholders to address similar issues.

The case study is part of a technical assistance project launched by the Council of State Governments (CSG) and the National Institute of Corrections (NIC) to improve collaboration between corrections and mental health agencies.[2] In July 2003, CSG and NIC invited state and local corrections and mental health agencies to jointly apply for technical assistance related to any shared undertaking. Of more than 60 applications received, NIC and CSG provided initial technical assistance to 13 jurisdictions and, from those 13, selected four sites to receive long-term, intensive assistance and serve as "learning sites" for the rest of the country. Orange County, Florida, is one of those four sites.

II. Summary of Initiatives

The efforts in Orange County at the intersection of the criminal justice, mental health, and substance abuse systems comprise a variety of discrete initiatives. Some were spurred directly by the JOC report and subsequent task forces. Others' origins can be traced prior to the JOC, but have been incorporated into a systemic response strategy. This case study will describe how these strategies have come about and their current status, but to aid the reader, the most prominent among them are summarized below.

- *Specialized Response Team in the Police Department*—More than 800 officers and deputies from all 12 law enforcement agencies in Orange County, as well as from the corrections department, have gone through eight hours of training on the basics of mental illness, community services, and de-escalation techniques. In-service, specialized training continues after this initial eight-hour course to selected officers who become part of their departments' Crisis Intervention Teams

CORRECTIONS, MENTAL HEALTH, AND SUBSTANCE ABUSE TREATMENT SERVICES IN ORANGE COUNTY

The Orange County Corrections Department (OCCD) operates the 22nd largest jail in the country; Orange County is one of only 124 jails nationwide accredited by the American Correctional Association. On an average day the jail holds approximately 3,800 to 4,000 inmates, of which more than 85 percent are men. Unlike many jails, the majority of the population—more than 2,900—have been charged with felonies. About 40 percent of the jail population is sentenced, while the other 60 percent is awaiting trial. The OCCD also supervises more than 8,000 individuals in the community who are on probation, pretrial release, home confinement, work release, or other forms of community supervision.[3]

Mental health and substance abuse services in Florida are overseen by the state Department of Children and Families, which contracts with local organizations to provide community-based services. In Orange County, Lakeside Alternatives provides the lion's share of mental health treatment, including case management, day treatment, and outpatient and residential services. Substance abuse treatment in the county is provided by a wider array of agencies, principal among them the Center for Drug-Free Living.

2 CSG is the coordinator of the Criminal Justice / Mental Health Consensus Project, a nationwide effort to improve the response to people with mental illness involved with the criminal justice system. NIC is the training and technical assistance arm of the Federal Bureau of Prisons, and has a longstanding commitment to helping corrections agencies respond to offenders with mental illness.

3 Orange County Corrections Department Daily Population Statistics, May 31, 2006.

(CIT). CIT members respond to calls in situations involving individuals with mental illness. Thirteen CIT teams currently operate in Orange County. Portions of the CIT training are conducted by Lakeside Alternatives (the largest provider of mental health services in Orange County), the Center for Drug-Free Living (a substance abuse treatment provider in Orange County), and other local agencies.

- *Receiving Center for People in Crisis*—The Central Receiving Center (CRC) is an acute crisis assessment location for individuals with mental illness and/or substance abuse disorders who would otherwise be taken to the jail or local emergency rooms. The CRC opened in April 2003 and is primarily operated by staff from Lakeside Alternatives and the Center for Drug-Free Living.
- *Pretrial Services*—The Mental Health Pretrial Release program (MHPTR) was established in 1999. Its purpose is to identify detainees with mental illness in the Orange County Jail who could be safely supervised in the community, develop a treatment plan for these individuals, and connect them to services while they await disposition of their cases. The Orange County Jail contracts with Lakeside Alternatives to provide treatment to MHPTR participants.
- *Post-booking treatment diversion program*—The Program of Assertive Community Treatment (PACT) is funded by a federal grant and targets jail inmates with non-violent charges who have co-occurring mental health and substance abuse disorders. The program links these individuals to treatment that follows the Assertive Community Treatment (ACT) model. The program is administered by the Orange County Forensic PACT team, and individuals are screened and diverted by Treatment Diversion Courts, as well as jail and traditional court staff.
- *Expedited case processing*—The chief judge of the ninth circuit, whose jurisdiction includes Orange County, is developing a mechanism to conduct expedited case processing meetings for misdemeanor offenders with mental illness or co-occurring disorders in the jail.

OVERVIEW OF THE JAIL MENTAL HEALTH POPULATION

Though determining the prevalence of mental illness among a jail population is never an exact science, the Orange County Corrections Department (OCCD) employs two mechanisms that attempt to do so. The first (and more general) is a "W" designation in the jail database that some inmates receive, which indicates that a staff member believes that the individual may have a mental health problem. Because this designation is not always based on clinical assessments, and because once applied, it is not altered in the database, the "W" method likely overestimates the prevalence of mental illness in the jail. Approximately 20 percent of the OCCD population has a "W" designation.

In 2003, a new system was introduced that rated each inmate identified as having a mental health problem at booking in terms of mental health acuity and chronicity. The most acute receive an A, moderately acute B, and the least acute a C. Chronicity is rated on a scale of 1 to 3, with 1 being the most chronic.

The jail inmates with a "W" designation are more likely to be repeat offenders (5.4 bookings as opposed to 3.4 for the general population), stay in jail 67 percent longer than other inmates, and are more likely to return within three years of being released (63 percent compared with 57 percent for the general population).[4]

4 Joblonksi, P. "Orange County Department of Corrections: A Statistical Analysis of OCCD Mental Health Inmates." January 30, 2004.

- *Temporary housing*—The Preferred Living System, proposed by the Orlando Area Trust for the Homeless (OATH), would use federal and local funding to develop a 20- to 35-bed facility to provide temporary housing and referral services for individuals with mental health and substance abuse problems who also experience homelessness.

III. First Steps: 1999–2004

The establishment of the Jail Oversight Commission in 2001, which was formed in part in response to incidents relating to inmates with mental health and substance abuse problems, brought together representatives of the treatment communities mentioned in Section II along with agency directors from across the criminal justice system. This commission facilitated collaboration among the top officials of these systems, but in fact the groundwork for cross-system collaboration had already been established through the joint development of various innovative initiatives: the mental health pre-trial release program, CIT training, and the Central Receiving Center.

Mental Health Pretrial Release Program

One of the first initiatives that brought the criminal justice and treatment systems together was the development of the Mental Health Pretrial Release Program (MHPTR).

The MHPTR program was created to identify jail detainees with mental illness who could be safely supervised in the community while awaiting disposition of their cases. These individuals are identified at booking or shortly after receiving a mental health screen as having a major mental illness, a score of at least a B1 or B2 on the mental health grading scale, and a misdemeanor charge. Jail mental health staff and community mental health service providers propose a treatment plan to the court at defendants' first appearance. If the judge, prosecutor, and defense attorney agree on the plan, defendants are released to the custody of the service provider, typically Lakeside Alternatives, which provides case management, medication, treatment, and sometimes housing. Lakeside also keeps the court apprised of individuals' progress until their cases are disposed.

Crisis Intervention Team Training

In 1999, Lakeside Alternatives lost funding for its mobile crisis team, a unit that responded to individuals in crisis across the community. Lakeside staff were concerned that, in the absence of the mobile crisis team, many of their clients would end up coming into contact with law enforcement officers who would be less prepared to respond to clients' needs.

At the same time, the CIT program first launched in Memphis, Tennessee, was drawing national attention. Under the Memphis model, CIT officers receive 40 hours of specialized training on the basics of mental illness, mental health services, and de-escalation techniques in order to improve their response to people with mental illness in crisis. Recognizing that this kind of training could fill the void left by the mobile crisis team, Lakeside staff convened a group of law enforcement officials, treatment providers, and local advocates to examine the possibility of bringing CIT training to Orange County. After much deliberation, including two site visits to Memphis, the working group launched the first CIT training in Orange County in January 2001.

From Recommendations to Action: Central Receiving Center

The release of the JOC report pushed the county's criminal justice and mental health systems into an unprecedented joint venture. The preface to the report's recommendations on mental health, substance abuse, and medical issues, which comprise nearly half of the commission's 200 recommendations, exemplifies the elimination of system barriers that the report envisions: "Health services at the Jail cannot be divorced from the community. The services at the Jail impact the community—the services

in the community impact the Jail."[5] In other words, the existing initiatives in the county were essentially efforts to identify and refer people in contact with law enforcement to mental health services and were dependent entirely on the accessibility and quality of services in the community.

Recognizing this situation, the report authors' recommendations focused largely on the establishment of a centralized triage facility as an alternative facility to which police could bring people with acute mental health or substance abuse needs. At the time of the JOC report, police and sheriffs' officers in Orange County who came into contact with people in a mental health or substance abuse crisis had limited options (as is the case in most jurisdictions across the United States). One option was to take them to an emergency room, where an officer could wait with a person in crisis for hours before a doctor decided to admit him or her to the hospital based on acuity of need, commit him or her to involuntary treatment based on dangerousness statutes,[6] or simply return him or her to the street. The second option was for the officer to do nothing—hardly an option as it would be irresponsible and create issues of liability. Accordingly, officers often resorted to the third option, booking the person into jail, where individuals must be received and provided with mental health services.

Community leaders seized on the recommendation for a new receiving facility. Indeed, before the JOC report was even made official, an *ad hoc* committee had been formed to explore the feasibility of an alternative drop-off location. By the report's release in April 2002, planning was well underway for what would become the Central Receiving Center (CRC). Recognizing the need to involve high-level decision makers in the process, the *ad hoc* committee soon convened a board of directors to oversee the planning and operation of the CRC.

The CRC opened its doors just one year after the JOC issued its report. Converted from an old hospital building, the secure facility is operated by Lakeside Alternatives with staff support from the Center for Drug-Free Living and Human Services Associates (HSA). It was designed as the receiving point for law enforcement officers encountering people with mental illness who would otherwise be taken to jail *or* an emergency room. CRC staff receive and assess these individuals, provide any necessary crisis stabilization, and refer them to appropriate services in the community. As of April 2006, of the 5,111 individuals screened at the CRC, 83 percent would have been involuntary committed under the Baker Act (3,995) or the Marchman Act (261) because authorities felt they were a danger to themselves or others. In addition, the majority of individuals received, assessed, and referred through the CRC were individuals with mental illness and substance abuse problems who otherwise would have gone to the emergency room because they needed crisis intervention or who would have potentially been involuntarily committed under the Baker and/or Marchman Acts: 55 percent of all saved bed days (hospital and jail bed days) were due to individuals being sent to the CRC instead of the emergency room.[7] Only 371 individuals would have otherwise been arrested by law enforcement had they not been taken to the CRC. Yet, these 371 individuals save 1,484 jail bed days.

The creation and operation of such a facility is not inexpensive—the yearly budget tops $1.75 million. For the first three years of its operation, the funding came from a variety of sources: The Chairman and Board of County Commissioners allocated $1.2 million, two local hospitals each contributed $250,000, and the state Department of Children and Families (DCF) also contributed resources. From the County Commissioner's point of view, the CRC

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5 JOC Final Report, p. 77.

6 In Florida, individuals whose mental health or substance abuse issues are so severe that they pose a danger to themselves or others can be involuntarily committed to receive mental health or substance abuse treatment by law enforcement, authorized treatment providers and judges. Individuals who are involuntarily committed for mental health treatment are committed under Florida's Baker Act. Individuals who are involuntarily committed for substance abuse treatment are committed under Florida's Marchman Act.

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would alleviate jail overcrowding and provide appropriate treatment to low-level offenders with mental illness. In addition, the CRC would provide a place for law enforcement officers to quickly and humanely connect these individuals to services and return to their duties. The CRC also represented a chance to curb the rising number of people being received by hospital emergency rooms. And as the mental health authority, DCF saw the center as a crucial additional component in the local treatment system.

Literature about "pre-booking" diversion for people with mental illness and co-occurring disorders emphasizes the importance of a central drop-off point for law enforcement. With the advent of the CRC, Orange County became one of only a handful of communities across the country to establish and staff such a location. In the wake of Karen Johnson's death and the JOC report, community leaders could proudly point to the CRC as a concrete, significant, and relevant response.

IV. Beyond the Central Receiving Center: 2004–2006

In April 2003, just as the CRC was opening, the JOC issued an interim report on the status of its recommendations. As the opening of the center illustrates, considerable progress was made in one year. In fact, the JOC interim report indicates that more than half of the recommendations had been implemented in full, and a large portion were being actively considered. The implemented recommendations include:

- A new methadone treatment protocol for jail detainees
- CIT training for law enforcement and corrections officers
- A new jail unit for inmates with infectious diseases
- A medical unit at the jail's new Female Detention Center

But the County Chairman felt that more could be done, and he made implementation of the remaining recommendations a continued priority. The ongoing oversight of the report's recommendations was transferred in full to the Criminal Justice Coordinating Council (CJCC), a body mandated by statute to oversee all aspects of criminal justice policy and planning in the county. The council in turn formed a forensic task force to examine the remaining recommendations and determine strategies for their implementation.

Around the same time the CJCC's forensic task force was established, a board of directors was appointed to oversee the CRC. The JOC may have been the first time that agency directors from substance abuse, mental health, and criminal justice representatives came together to address the high rates of individuals with mental illness in the jail, but it was on the CRC Board of Directors where these partnerships began to solidify and a broader review of these systems emerged. The county's chief judge chairs the CRC's board and its members include the sheriff, public defender, hospital administrators, treatment officials, advocates, the police chief, elected officials, and prosecutors.

The diversity of the board enabled it to appreciate the CRC's role in the community-based health care system and the criminal justice system. Members recognized that the effectiveness of the facility's crisis response function depended on efficient linkage to community services, which was proving difficult. The CRC originally planned to keep no client for more than 24 hours. But a six-month review of the CRC found that almost half of those admitted stayed past the one-day mark, primarily because of the shortage of longer-term treatment beds in the community.[8] To review these and other

8 Review of the Orange County Central Receiving Center, December 2003, Center for Community Partnerships, University of Central Florida.

systemic issues, the CRC board established a mental health / substance abuse task force of middle-level administrators from across the county government. This task force undertook various analyses of mental health and substance abuse treatment system issues on behalf of the board. In addition, the board commissioned a report from the University of Central Florida mapping the local treatment system, comparing it to nationwide best practices, and identifying gaps.[9]

It soon became apparent that a handful of independent committees and task forces had been established in the county, comprising many of the same people, to analyze different aspects of the same problem. Two task forces, ("forensic" and "substance abuse / mental health") reported to two oversight boards, (the CJCC and the CRC Governing Board), both of which had similar memberships. While less than efficient, the numerous conversations among these leaders helped highlight significant shortcomings in Orange County's response to people with mental illness coming into contact with the criminal justice system.

Addressing Program Gaps

With the introduction of CIT training in 2001 and the opening of the CRC in 2003, Orange County had in place core elements of pre-booking diversion from the jail—training for law enforcement and the establishment of a central drop-off location. The MHPTR provided a mechanism to move some detainees with mental illness from the jail into the community while they awaited case disposition. But the staff at the jail had no vehicle to connect similarly situated individuals to treatment —a true diversion in the traditional legal sense. In April 2004, Orange County was awarded a grant by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to establish just such a program.[10]

The SAMHSA-funded grant program had two components. First, recognizing that the vast majority of people with mental illness in the criminal justice system also suffer from substance abuse problems, the new diversion program specifically targeted individuals with mental illness (individuals who scored at least B1 or B2 on the OCCD's mental health grading scale) and co-occurring substance abuse disorders and were charged with a misdemeanor who could be referred to treatment while awaiting their case disposition. Second, program participants were referred to a Program of Assertive Community Treatment (PACT) program specifically created for this target population. PACT is a service delivery model, typically reserved for individuals with the most severe mental illnesses, which uses a team approach to offer 24/7 services wherever the client is located. It is a practice with an extensive evidence base proving its effectiveness. Underlying this program design was the assumption that members of the target population were in jail precisely because they had not been effectively engaged by typical community-based treatment, and that a more comprehensive treatment approach—PACT—was called for.

Even with the MHPTR program in place and the advent of the PACT diversion program, the chief judge in Orange County felt that there were cases involving misdemeanants who were spending too much time in the jail. Most recently, he has been working with jail staff and treatment providers to develop a system of expedited case processing that would target those inmates who are not eligible for MHPTR or the PACT program. The plans for this strategy are still being developed and will be informed by the program analyses to date. At the time of this writing, launch was scheduled for the spring of 2006.

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9 Orange County Central Receiving Center (CRC) Phase 2: Review of Best Practices in Community Mental Health & Substance Abuse Services, Center for Community Partnerships, University of Central Florida.

10 See *http://gainscenter.samhsa.gov/html/* for more on the relevant grant program.

Expanding Community Treatment Capacity

From its first days of operation, the CRC experienced difficulties successfully linking clients to longer-term treatment beds. According to an early review of the CRC, this was due in large part to the lack of sufficient residential treatment space in the community. In the second year of its operation, the CRC partners took steps to address this issue. Florida Hospital purchased 12 community residential treatment units at Lakeside Alternatives, and the county purchased another four, which made an additional 16 residential opportunities at Lakeside dedicated to CRC clients. This additional program capacity helped reduce clients' length of stay in the CRC by 50 percent during its second year.[11]

Officials overseeing the CRC also began to recognize that many of the clients brought to the CRC were experiencing homelessness; they needed some sort of safe housing, which the CRC could not provide in any sustained way. Given this situation, the Orlando Area Trust for the Homeless (OATH) initiated a planning process in spring 2005 to develop what would eventually be called the Preferred Living System (PLS). The PLS was envisioned as both a physical facility with 20 to 35 temporary beds and a system for referring people who experienced homelessness to mental health and substance abuse treatment, housing, and other supports. The county recently received more than $1 million from the Department of Housing and Urban Development for the project, which will augment the $2 million that OATH will contribute. At the time of this writing, the PLS was scheduled to open in 2007.

V. Assessing the Impact of New Initiatives

The preceding sections reflect an extraordinary level of activity in a short period of time to improve the response to people with mental illness involved in the criminal justice system. But as officials in Orange County began working extensively with technical assistance providers from CSG and NIC in late 2004, it became evident that they could not state with any certainty whether these new programs and services had realized their original goals. The number of people with mental illness these programs were serving, their impact on the jail population generally, and their affect on recidivism and public safety all were unknown. Furthermore, administrators of the different programs could not clearly convey to policymakers in the county how their distinct efforts related to each other and the process through which people came into contact with police, were booked into the jail, and released.

Focusing an Evaluation

CSG and NIC consultants urged the county to hone in on one initiative as the first step in examining the impact of their collaborative work. Analyzing all of the new programs at once was too large an undertaking, especially considering the uniqueness of each initiative and the distinct data systems involved. Furthermore, the relationship among the initiatives was unclear: in some cases, their target population appeared to overlap, pointing out the need to understand the flow of people through each of these initiatives. (Figure 1 illustrates the basic flow of individuals through the Orange County criminal justice system.) County officials agreed and decided to focus on the MHPTR program because it had been operational the longest and because it had the most available data.

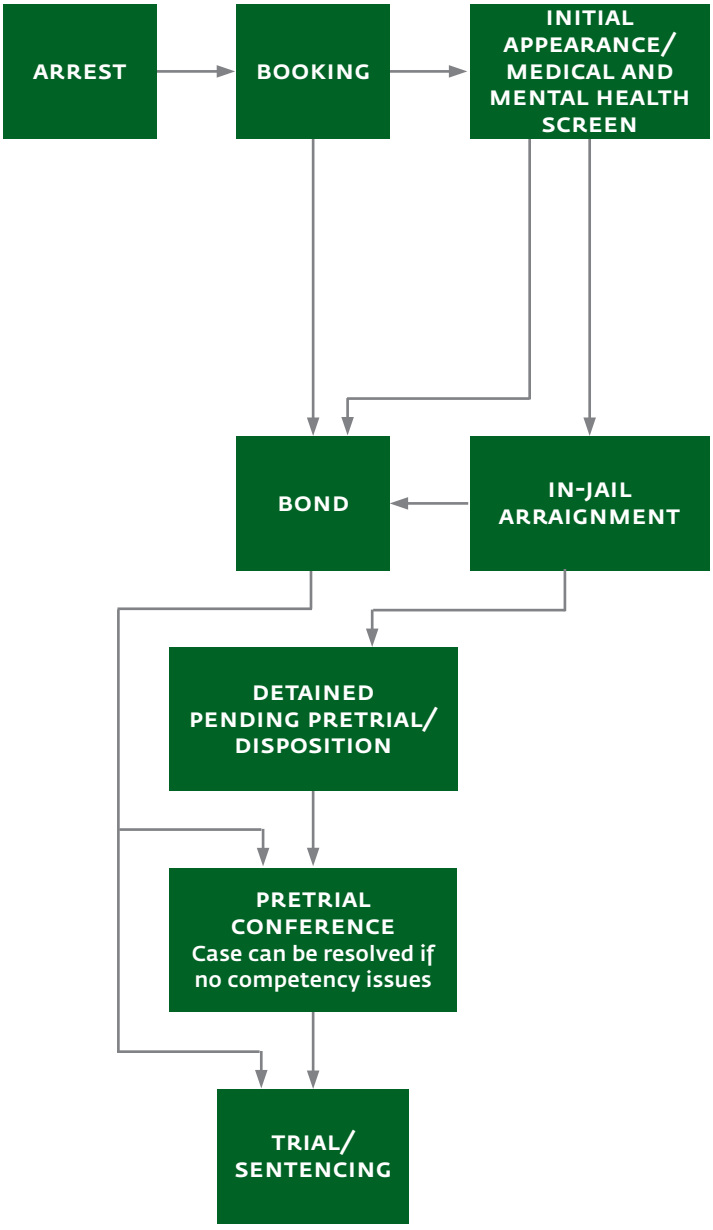
Understanding the Process of Program Screening, Referral, and Enrollment

The MHPTR was designed to serve detainees with mental illness who previously were not making bond, but could be safely supervised in the community.

11 CRC Annual Report 2005.

FIGURE 1.

Flowchart of select events in the Orange County criminal justice system



As Figure 2 illustrates, the MHPTR targeted jail detainees identified during the course of their mental health screening and before their arraignment.

Evaluating the MHPTR

The analysis of the MHPTR program had two basic components: 1) a process evaluation and 2) an outcome evaluation. In other words, the jail and treatment providers wanted to understand how many people the program reached, when the program reached them during the course of their involvement in the criminal justice system (the process evaluation) and what impact the program had on them (the outcome evaluation). Both analyses relied on a two-year retrospective look at all of the individuals referred to and participating in the MHPTR program. A local Ph.D. candidate was willing to conduct a process and outcome evaluation of the 1,416 detainees referred to the MHPTR over the course of two years.[12]

Process Evaluation

The results of the process evaluation first enabled county officials to understand how people with mental illness flowed from their admission into the jail to the MHPTR program.

As Figure 3 illustrates, approximately 20 percent of the detainees who received a mental health screen were referred to the program and, of this universe, 315 people (or 22 percent), were released to and participated in the program. Detainees who were referred to and participated in the program were more likely than the general population to:

- Have previous arrests
- Be older and African-American

Perhaps the most revealing finding from the process evaluation was that approximately 77 percent (1,101) of the people referred to the program ultimately *did not* participate in the program. It turns out that 36 percent of the 1,101 detainees did not participate in the program because they had already been released from jail.[13] In other words, the MHPTR program was conducting assessments of literally hundreds of detainees who were going to be released from jail regardless of their participation in the program. The evaluation also revealed that 315 individuals who participated in the program spent just eight fewer days in jail for their precipitating arrest than those who did not participate in the program.

Outcome Evaluation

The outcome evaluation of the MHPTR program indicated that a majority of participants successfully completed the program: 170 of the 299 participants (almost 57 percent).[14] Participants who did not complete the program successfully were returned to jail because of an outstanding warrant, because of another arrest/charge, or because of a revocation due to noncompliance with the conditions of the MHPTR program.

People who completed the MHPTR program successfully had the same global functioning score at booking as those who did not complete the program successfully; however, the research conducted to date did not include analyses that might assist program administrators in determining which treatment protocols were associated with successful engagement in the program.

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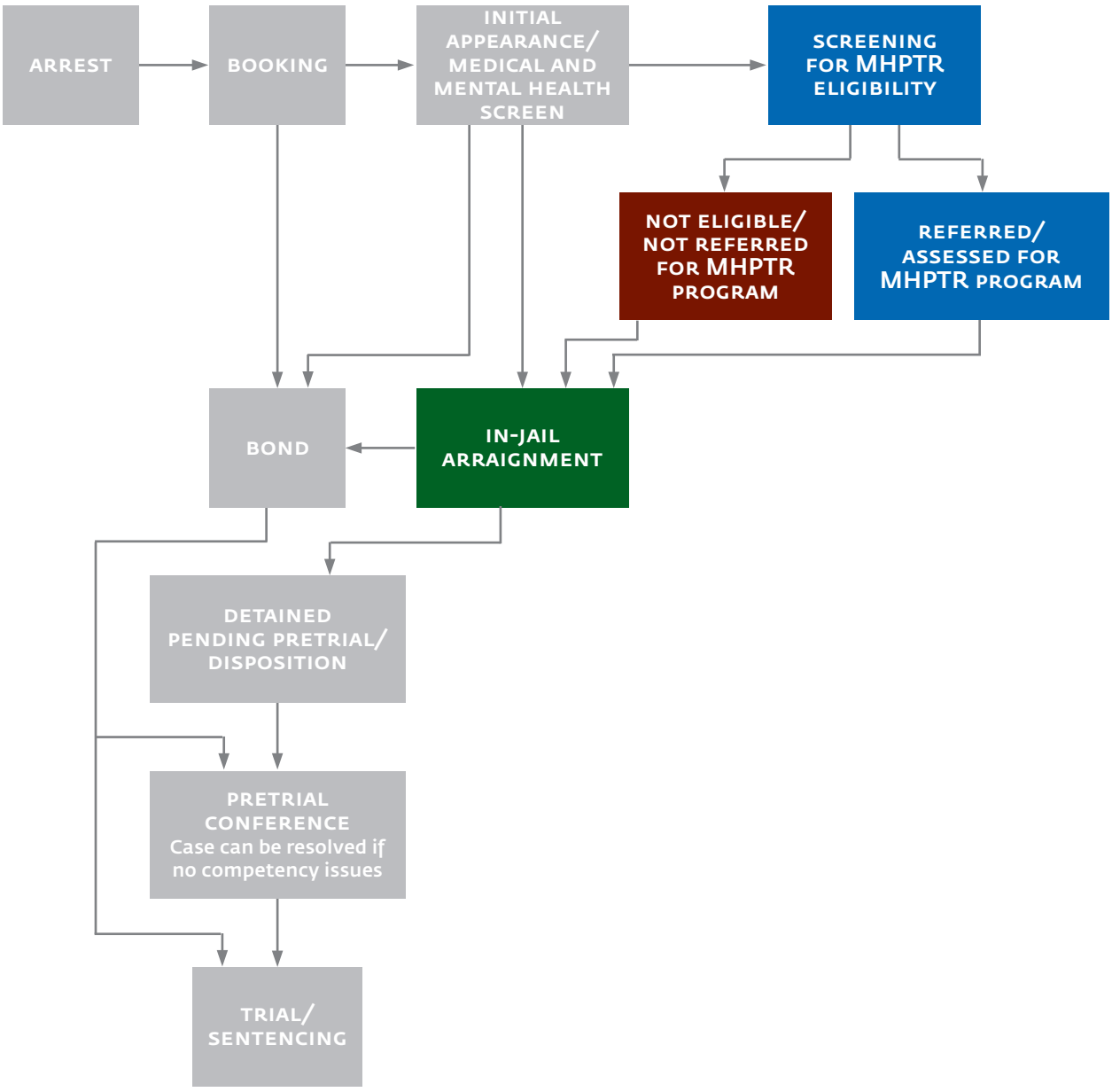
12 Michael Kofler, a Ph.D. student in Clinical Psychology within the Department of Psychology at the University of Central Florida.

13 Other reasons for not accepting individuals into the program were that they did not meet the clinical criteria, declined participation, had a history of violence, were not an Orange County resident, or had been referred to another program.

14 Data for 16 of the 315 individuals accepted to the MHPTR was missing.

FIGURE 2.

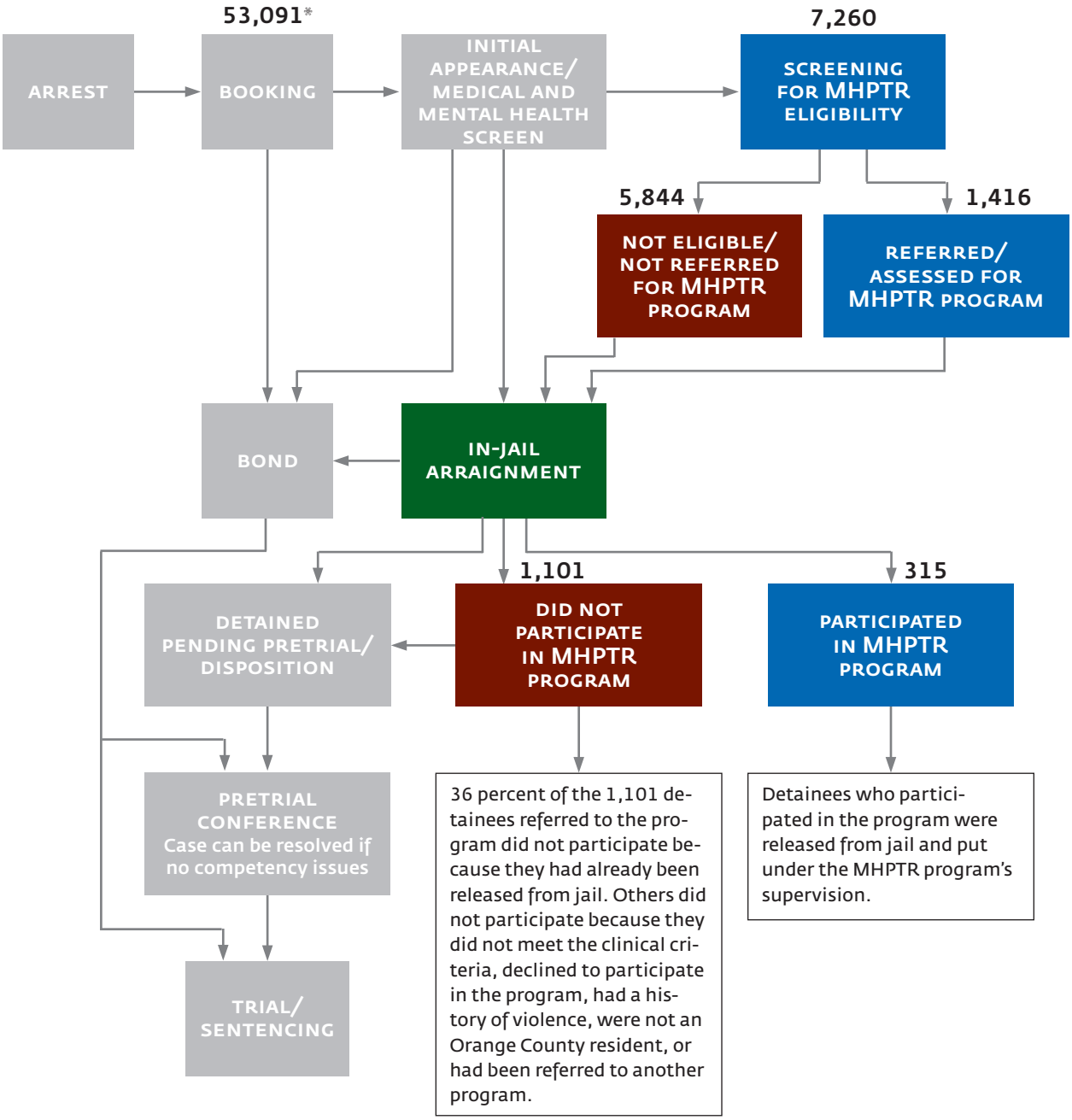
Identification of mental health pretrial release program participants



MHPTR = Mental health pretrial release

FIGURE 3.

Entry into mental health pretrial release program

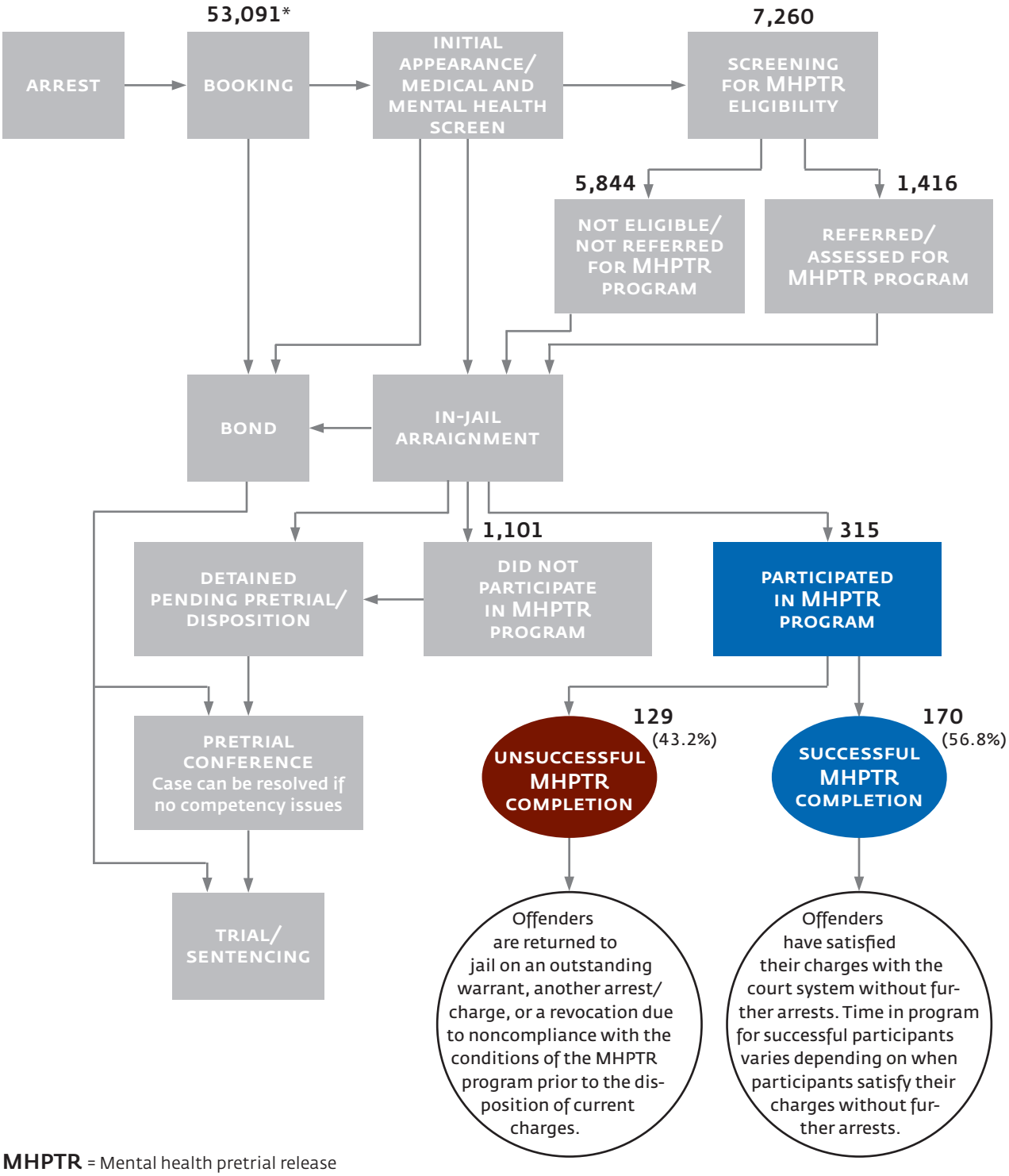


MHPTR = Mental health pretrial release

* = Numbers in the figure represent the number of individuals involved with each event in the Orange County criminal justice and mental health systems over a two-year study period.

FIGURE 4.

Completion of mental health pretrial release program



MHPTR = Mental health pretrial release

* = Numbers in the figure represent the number of individuals involved with each event in the Orange County criminal justice and mental health systems over a two-year study period.

People who completed the MHPTR program successfully differed from people who did not complete the program in that they:

- Were less likely to have severe substance abuse problems at booking
- Were more likely to have been arrested for a misdemeanor offense

Three groups of individuals were tracked for 18 months from the time they were arrested and booked into the jail: 1) individuals who successfully completed the program (n = 59), 2) individuals who did not successfully complete the program (n = 43), and 3) individuals who did not participate in the program (n = 217). The difference in the sizes of these groups and the original samples of individuals who successful and unsuccessfully completed the program, as well as for those individuals who did not participate in the program, was due to a lack of follow-up data on many of these individuals 18 months after their initial arrests.

For all three groups, researchers calculated the average number of arrests, jail days, and days spent in the community. For individuals who participated in the program and either completed the program successfully or unsuccessfully, researchers also calculated the number of program participation days. The average jail and program costs of each group during the tracking period were calculated to estimate the potential cost-benefit of the program.

Estimates for jail cost were based on the per diem cost estimate for FY 2000–2001 as cited in the final JOC report in 2002. It is important to note that this cost estimate is an average cost for all inmates; people with mental illness often require medications and other treatment needs and have a higher-than-average length of stay.

The cost of participation for individuals who successfully completed the program was, on average, $7,000 per person during the study period. The cost for individuals who did not participate in the program was $8,454 each. As expected, the combination of jail days and program days for individuals who did not successfully complete the program led to higher average costs for these offenders ($10,909) than the cost for individuals who did not participate in the program.

In addition to the findings mentioned above, other limitations of the study are worth noting:

1. Successful completion of the program only required participants to comply with court conditions and program requirements; there were no clinical outcome indicators to determine if the program was successful at sustaining individuals' engagement in treatment and improving their mental health outcomes.
2. Individuals who successfully completed the program were charged with less severe crimes and had fewer arrests than both the unsuccessful and did not participate groups.

Despite these limitations, the analysis suggests that increasing the number of individuals who successfully completed the MHPTR program should decrease what the county spends annually to incarcerate the growing number of people with mental illness. Whether expansion of this program enables county officials to cut jail spending altogether is

JAIL AND PROGRAM COST FOR STUDY GROUPS

GROUP	GROUP SIZE	# DAYS IN JAIL (AVG. PER PERSON)	TOTAL JAIL COST AT $68.73 PER DAY	# DAYS IN PROGRAM (AVG. PER PERSON)	PROGRAM COST AT $65 PER DAY	TOTAL COST FOR GROUP OVER 18 MONTHS	AVERAGE COST PER PERSON OVER 18 MONTHS
Successful	59	47	$190,588	58	$222,430	$413,018	**$7,000**
Unsuccessful	43	119	$351,691	42	$117,390	$469,081	**$10,909**
Did not participate	217	123	$1,834,472	0	0	$1,834,472	**$8,454**

a different matter. Various factors independent of this program influence the jail's budget, including the size of the jail population, its projected growth, capital costs, and staffing requirements.

Nevertheless, the study demonstrates that the program could potentially generate actual savings to the county, if the county:

1. Modifies the process through which detainees are referred to the program to both target an eligible population at the outset and thereby reduce wasted assessment costs, and minimize the number of days individuals spend in jail while awaiting program assignment
2. Increases the success rate for program participants.

VI. Looking Ahead: Challenges and Opportunities

The preceding sections describe a significant and impressive commitment by Orange County's elected officials and the administrators of the county's jail and mental health and substance abuse treatment systems to improve the response to people with mental illness in contact with the criminal justice system. Despite the limitations of the analysis of the MHPTR, the results demonstrate that this commitment is helping successfully engage some people with mental illness who are booked into the county jail in community treatment. In addition, the study clearly highlights various challenges and opportunities for the county, which are reviewed below.

A. Challenges

The analysis of the MHPTR program suggests ways that county officials can modify the program to increase its impact. Those recommendations signal the kinds of strategies county officials could assume as they attempt to reduce the percentage of the jail population with mental illness, which has not seemed to decline significantly in recent years. Indeed, to make meaningful inroads, county officials will need to confront the challenges described below.

Diversion to What?

Scholars of jail diversion regularly point out that the intervention on which the success of diversion hinges is not the process of identification and connection to services, but the actual treatment and supports that an individual receives. Put another way, jail diversion depends on answering the question of "diversion to what"? In Florida generally, and Orange County specifically, this question is particularly difficult to answer. According to one measure, Florida ranks 48th among the 50 states in terms of per-capita mental health spending.[15] Within that context, officials in Orange County have long observed that there is a disparity of resources in their area of the state. For example, officials there note that the state funding formula provides 10 crisis stabilization beds for every 100,000 citizens, but that in 2003, Orange County, with a population of 900,000, had only 50 such beds.[16]

This recognition of insufficient resources does not contradict the previous assertion that significant funds have been applied to the problem in Orange County. Rather, those funds have been deployed to identify individuals with mental illness and prevent them from either becoming involved in the criminal justice system or removing them from that system. But when the service system to which they are connected is under-funded and generally incapable of providing comprehensive, long-term support, the ultimate impact of those diversion efforts is necessarily limited.

Criminal justice and mental health officials have joined together to address this issue both in Orange County and the state of Florida. Leaders from across the county have worked closely with state legislators

15 *http://www.nami.org/gtstemplate.cfm?section=grading_the_states*

16 Central Receiving Center First Year Report, June 2004.

to bring more treatment resources to the community. And statewide, Florida is home to Florida Partners in Crisis, a nationally known cross-systems advocacy effort that brings criminal justice and treatment professionals together to advocate for additional funding and other joint priorities. These efforts notwithstanding, the lack of evidence-based services in Orange County and across the country cannot be understated, nor can their impact on the success of the efforts described in this case study.

Targeting Interventions to the Jail Population

Unlike most jails, the majority of people incarcerated in Orange County—approximately 77 percent—have been charged with felonies. The percentage of detainees with mental illness who are charged with felonies and those charged with misdemeanors essentially mirrors the general incarcerated population. Yet the initiatives described in this case study target low-level, non-violent, misdemeanants.

In Orange County, as in many jurisdictions, county officials are concerned about the political implications of targeting anyone for diversion from jail other than very low-level offenders. On the other hand, since the majority of individuals with mental illness in the Orange County Jail were charged with felonies, it seems unlikely that efforts targeted at misdemeanants could have a significant impact on the portion of the jail population with mental illness.[17]

But even when designing programs that focus on the target population of low-level misdemeanants who would ordinarily be booked into the jail, officials have found that their new initiatives end up serving different categories of people. For example, CRC was envisioned as a location where law enforcement officers could take individuals who "might otherwise be taken to jail or an emergency department."[18] Yet law enforcement officers report through regular surveys that only about seven percent of the individuals they bring to the CRC would have otherwise been brought to the jail.[19] The CRC has become the locus for individuals with mental illness and/or substance abuse issues who are found to be dangerous to themselves or others under Florida's Baker Act and/or Marchman Act and are being involuntarily committed to treatment. Between 75 to 80 percent of those admitted to the CRC are done so under those state laws.[20]

That is not to say that providing a place where law enforcement can take such individuals is unimportant. To the contrary, officer satisfaction with the CRC is extremely high, due in no small part to the impressively low average time of 12 minutes required for an officer to drop off an individual to staff at the receiving facility. Furthermore, the CRC served more than 4,000 clients in 2005, and has been operating at full capacity almost since the day it opened.[21] Nevertheless, with its current approach, the CRC's operation does not proportionately respond to the high numbers of people with mental illness among the jail population and as such, does not serve as an alternative to jail incarceration for the majority of this population.

Similar problems with target populations challenge the MHPTR program and the PACT diversion initiative. The issues with ineffective referral processes for MHPTR discussed above have also surfaced in the PACT program. Of the more than 500 individuals referred to and assessed for that program in two years, only 38 have been accepted. In fact, at the time of this writing, the program has only 14 participants, even though its capacity is 30.

The reasons for this under-enrollment are complex and not yet clear. Screening procedures, public safety concerns, and inadequate coordination between jail staff, treatment professionals, and the court all likely contribute. But beyond these operational questions, the broader issue remains

17 Joblonksi, P. "Orange County Department of Corrections: A statistical Analysis of OCCD Mental Health Inmates" January 30, 2004.

18 CRC First Year Report, p. 4.

19 All officers are required to complete a survey at individuals' intake to the CRC. Several questions reference diversion decisions.

20 CRC Annual Report 2006

21 CRC Annual Report 2005.

that the criminal justice and treatment systems have been unable to decide on a target population that a) can be easily identified and b) the criminal justice system is willing to divert. Regardless, these operational and philosophical issues are ones which will need to be explored if the county wants to maximize the impact of these programs.

Oversight Structure

The commitment to ongoing communication among agency directors, middle managers, and staff across the Orange County criminal justice and treatment systems is impressive. But while some mechanisms for reporting and oversight exist, they often appear duplicative and unclear. For example, The CRC Governing Board comprises many of the same leaders as the CJCC, and has taken an active role in issues outside the direct purview of the CRC's operations. Nevertheless, it has no formal authority over either the implementation of the JOC's recommendations, or over the many related issues that lie in the gray area between the various county agencies that share a common population.

There are some in the county who hope the CRC board continues to expand its oversight responsibilities, while others want it to remain narrow in focus. Criminal justice, mental health, and substance abuse partners in the county will need to address this disagreement, and the broader uncertainty of how their joint efforts will be managed, if their collaboration is to be effectively sustained.

Data System Integration

The lack of any significant data system integration across the criminal justice system, and between the criminal justice and mental health systems, makes it difficult for criminal justice and mental health systems to operate their initiatives effectively and efficiently. For example, Lakeside Alternatives and the corrections department have no system for identifying when a mental health client is initially booked into the jail, and thus must rely heavily on self-report information to inform any potential diversion treatment plan in advance of any medical or mental health screening. Furthermore, the existing state of these information systems makes it difficult for county officials to study the impact of their other criminal justice/mental health initiatives, and thus build on the analysis of the MHPTR program.

B. Opportunities

Unlike many reports issued by commissions that adorn bookshelves, the impact of the JOC report is inspiring: the report prompted the creation of the CRC, the launch of a new diversion program, and the ongoing collaboration between agency directors and staff of key stakeholders across the criminal justice, mental health, and substance abuse systems in Orange County.

In fact, by 2005, the cross-system collaboration in Orange County had evolved sufficiently to make a complex evaluation of the MHPTR program possible. The evaluation has confirmed that—for a subset of inmates—collaboration can improve the response to detainees with mental illness and the operation of the county's criminal justice system generally. The information system issues described above notwithstanding, county officials are looking to conduct similar, rigorous analyses of other criminal justice/mental health initiatives they have established.

At the same time, county partners seek to expand the continuum of strategies at the intersection of their systems. Their plans for a Preferred Living System and the expedited case processing system are two such examples. Just a cursory review of the planning documents for those initiatives shows that many of the same officials who have been involved in various other initiatives during the past four years continue to work together on these new strategies.

As in any jurisdiction that has made progress on these issues, strong, committed leadership has been at the heart of their efforts. Orange County Mayor (formerly called Chairman) Richard Crotty has made criminal justice and mental health issues a priority, as have the CEO of Lakeside Alternatives Jerry Kassab, the Jail Chief Tim Ryan, Chief Judge Belvin Perry, and the Vice President of the Florida Hospital, Rich Morrison.

Staff in Orange County do not take this leadership for granted. In fact, when asked about their concerns for the future, mental health and corrections managers expressed concern about whether their efforts could sustain a loss of any of these key leaders. This concern is hardly academic—the CRC alone receives more than $1 million in annual support from the county, and that request is soon to be increased.

A leadership change is, of course, inevitable. But any new personnel at the tops of these agencies, regardless of their orientation toward issues at the intersection of the criminal justice and treatment systems, would step into a climate where collaboration has become ingrained into the daily workings of the various partners. And it is this systematic breaking down of barriers, as much as the influx of any new resources or the development of new landmark reports, which bodes well for Orange County as it continues to address the many challenges that lie ahead.

VIII. Dimensions of Collaboration

The work in Orange County prior to and in response to the JOC report is rooted in collaboration between the criminal justice system and the mental health and substance abuse treatment systems. All of the initiatives described in this case study are joint endeavors between a criminal justice agency—usually the Orange County Corrections Department—and local treatment providers, in particular Lakeside Alternatives.

Along with supporting the efforts in Orange County and other jurisdictions, the CSG/NIC technical assistance project from which this case study emerged is intended to help corrections and mental health agencies across the country better understand what cross-system collaboration entails. The chart below describes the collaboration in Orange County according to four dimensions: systems, services, knowledge, and resources. Within those four dimensions, the chart identifies different aspects of collaboration and how they have played out in Orange County. This analysis is not meant to be comprehensive, but rather to provide a framework that may guide corrections and mental health agencies in other jurisdictions striving to better serve their shared population.

	ACTIVITIES	CHALLENGES	LOOKING AHEAD
SYSTEMS			
Joint oversight	Several cross-system oversight groups have shepherded various initiatives in the county.	The lack of one clear oversight mechanism has hampered coherent planning and program effectiveness.	County officials continue to examine possibilities for a more unified oversight structure.
Target population	Each of the collaborative initiatives has a slightly different target population, although all focus on non-violent, misdemeanor offenders.	The general target population does not appear to coincide with the drivers of the jail population. The various diversion initiatives have had trouble developing screening and referral practices that quickly get the target population into programs and services.	The individual diversion programs plan to continually review their target populations and screening and referral procedures.

	ACTIVITIES	CHALLENGES	LOOKING AHEAD
SERVICES			
Commitment to provide services	Both the Department of Corrections and mental health and substance abuse treatment providers have made serving their shared population a top priority.	There are not nearly enough treatment services in the community to meet the needs of the target population.	The partners continue to work with state officials to expand the treatment capacity in the county.
Data sharing at client level	Data sharing about individual clients happens regularly through the various jail diversion initiatives.	Outside of the diversion programs, data sharing is much less common.	Information Technology staff from the Department of Corrections and Lakeside Alternatives—the community mental health treatment provider—are exploring ways to link their data systems.
Systemic data sharing	Little to no systemic data sharing occurs between the criminal justice and treatment systems.	Data systems are not integrated.	
KNOWLEDGE			
Information on demographics and service needs	Each agency collects data separately on the target population.	The lack of a systematic ability to cross-reference data prevents partners from developing a common assessment of the demographics and service needs of their shared population.	
Program evaluation	A systematic evaluation of one diversion initiative has been undertaken with the help of outside expertise.	The evaluation has identified further issues for examination. In addition, no such evaluation has been completed for the other diversion initiatives.	Corrections and mental health partners hope to analyze systematically all of their joint programs.
Impact evaluation	An impact evaluation of the same diversion initiative has also been conducted.		The impact evaluation suggests that the program is cost effective and should be expanded pending additional resources.
RESOURCES			
Joint funding	The county government, local hospitals, corrections department, and community treatment providers have all committed substantial funding to various projects.	The hospitals' commitment to one initiative will end in 2006, and the county will be asked to pick up the funds.	
Resources leveraged	In the last two years, the county has received more than $2 million in federal funds for initiatives related to criminal justice, mental health, and substance abuse. Another $2 million has been contributed by the local homeless funding agency.		

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