WHITE PAPER I

When Political Will Is Not Enough: Jails, Communities and Persons with Mental Health Disorders

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Background

Outrage at the inappropriate use of jails for persons with serious mental illness (SMI) is not new. In the mid-1980s, The National Coalition for Jail Reform issued its pamphlet, "The New Mental Institution" observing "mentally ill people often end up in jail because there is no other place for them in our communities." In 1990, the National Coalition for the Mentally Ill in the Criminal Justice System convened a meeting on these issues and concluded that "in addition to a large number of people circulating through the jail, these people tend to be highly visible. Jails are locally based. Their detainees are picked up on nearby streets by law enforcement personnel who live in the same communities. These facilities are not distant prisons, staffed by strangers, which hold offenders for years at a time. Finally, the dollars that pay for jails come from county and municipal budgets. This means that increases in their costs become easily identifiable components of a property tax bill. Jails are not nebulous institutions. They are highly visible facilities whose problems have immediate local impacts" (Steadman, 1990).

In our 1989 book, *The Mentally Ill in Jail: Planning for Essential Services*, we talked about "the jail under siege" as jail populations surged and how persons with SMI were contributing to this crisis by being inappropriately housed there.

Best estimates (Steadman, McCarty & Morrissey, 2009) are that of the approximately 12 million admissions to U.S. jails each year, about 17% (2 million) have active symptoms of SMI when booked into the jail. In addition, approximately 75%–80% of these detainees also have co-occurring substance use disorders. Another key issue fills out the "trifecta" for these justice-involved persons with SMI. Nearly all, both men and women, have lifetime histories of sexual and physical abuse.

Just as the outrage about the inappropriate use of jails is not new, the solutions about what to do are not new either. The issue is how to implement what we know and how to capitalize on emergent evidence-based practices for community-based alternative services that enhance both public health and public safety goals. Putting this knowledge into practice is the challenge.

One core principle has proven effective in guiding knowledge-to-practice transfers. In regard to justice-involved persons with mental illness that principle is: The jail is a community institution, and the mentally ill inmate is a community problem. Detainees, on average, spend very short periods of time in jail. Further, except for the "megajails" in the major metropolitan areas, it is impractical given their mission and fiscal constraints to consider developing a comprehensive set of mental health services within jail. In other words, jails must form partnerships with other community agencies who also serve many of the same individuals when they are outside jail.

"To establish appropriate services for such persons requires that the jail be seen as but one agency in a continuum of county services. Indeed, some mental disturbance is a function of the incarceration experience itself, which can be quite frightening and depressing. However, the more common mental health problems are presented by persons whose existing problems are exacerbated by jail or whose current acute episodes have precipitated their arrest and incarceration. As such, the jail is attempting to perform its custodial function of safe pretrial detention while addressing the mental health problems of a community member whose access to services is often highly restricted. Obviously, an adequate response cannot be expected if the mental health service needs are defined simply as the jail's problem. The jail is a community institution, and the mentally disturbed inmate is a community problem" (Steadman, McCarty & Morrissey, 1989)

In the 25 years since that was written, some communities in the U.S. have taken this principle and operationalized it in the form of responsive service systems that have resulted in fewer persons with SMI entering jail and fewer returning to jail as often after release. The large majority of U.S. communities, however, are still wrestling with how to effectively do this while properly balancing individual rights, public protection, and constricting economies.

All of this is not to say that these issues have been ignored. At the federal-level, the Substance Abuse and Mental Health Services Administration (SAMHSA) has taken a lead role in funding community diversion initiatives. From 2002 to 2009 SAMHSA funded 37 localities under its Targeted Capacity Expansion (TCE) initiative to create jail diversion programs. From 2008 to 2015, 13 states under the Jail Diversion Trauma Recovery Priority to Veterans were funded to develop diversion options for veterans and other justice-involved persons with trauma histories. From 2011 to 2014, Adult Treatment Court Collaboratives were funded in 11 jurisdictions to focus on coordination of arraignment, dispositional and treatment courts in innovative ways to divert persons with mental health disorders. This program will expand in 2014 under the title, Behavioral Health Court Collaboratives for 14 new jurisdictions, each with four years of funding. Currently (2013−2016) three jurisdictions have been funded to operate pre-booking diversion programs. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation has provided technical assistance to all of these programs.

During this same period, the Mentally Ill Offender Treatment and Crime Reduction Act has funded 254 grants in 46 states, each ranging from $100,000−$250,000, under the Justice and Mental Health Coordination program for planning, implementation and expansion initiatives. Funded through the Bureau of Justice Assistance, these localities have been eligible for technical assistance from the Council of State Governments Justice Center.
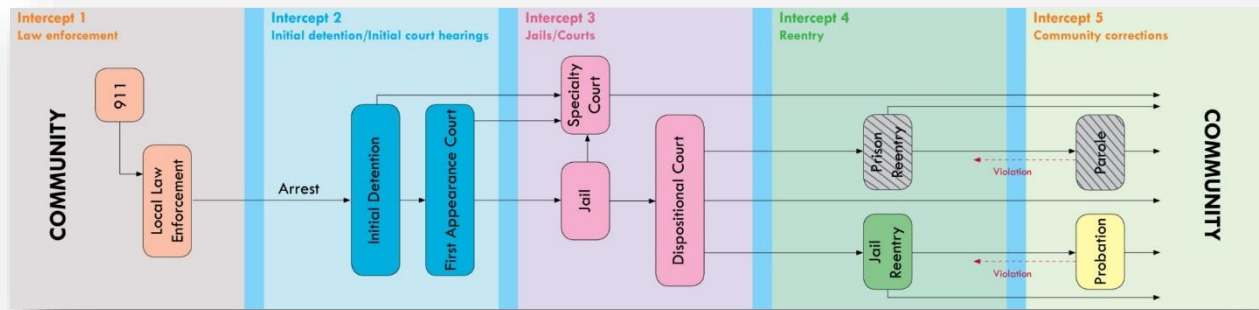
A few of these initiatives have collected some evaluation data showing improvement on clinical factors and reductions in subsequent numbers of arrest and fewer jail days. Most of these initiatives were funded as federal 'seed-money' pilot projects that usually phased-out after grant dollars were expended. Some have successfully addressed sustainability by coming up with alternative funding streams for discrete projects. Only a handful have had a more macro-level impact that reshaped the way the community deals with justice-involved persons with SMI. The implication from these few success stories is that what's needed is a more macro focus on bringing a community to scale; not just sustaining or expanding a particular, successful program.

It is simply not enough for stakeholders interested in jail-mental health issues to want to do the right things. They need to know how to do things and how to continually refine their actions as new obstacles occur. This is especially true when responding to community needs around persons with mental health disorders who are involved with the criminal justice system. What is needed is a combination of willing collaborators, accurate facts, proven steps to achieve goals, and on-going assistance to achieve success.

The Sequential Intercept Model as a Planning Tool

It can be challenging in addressing the issues of detainees with SMI in the jail to avoid getting bogged down in the specifics of jail operations. Screening, classification, general population or specialized housing, administering medications and other routine jail mechanics can each absorb huge amounts of time in thinking about the issues of detainees with SMI. However, to begin to effectively analyze and discuss these issues it is essential to have a broader view of where the jail fits in the processing and detention of citizens who are charged with or convicted of crimes. One tool that has been developed that facilitates a clearer, broader picture is the Sequential Intercept Model.

As seen below, the model is a schematic of the criminal justice system that is broken into five segments, or intercepts. The Sequential Intercept Model was first published by Munetz and Griffin (2006) having been developed in conjunction with SAMHSA's GAINS Center staff. The intercepts are seen as

Intercept 1 — Law enforcement | Intercept 2 — Initial detention/Initial court hearings | Intercept 3 — Jails/Courts | Intercept 4 — Reentry | Intercept 5 — Community corrections

COMMUNITY — 911 — Local Law Enforcement — Arrest — Initial Detention — First Appearance Court — Specialty Court — Jail — Dispositional Court — Prison Reentry — Jail Reentry — Parole — Probation — Violation — COMMUNITY

locations in which persons with mental illness can be identified, diverted, treated and returned to the community.

As a planning tool, the Sequential Intercept Model rests on two core principles:

1. Minimize the inappropriate penetration of persons with mental illness into the criminal justice system
2. The unit of analysis to successfully address criminal justice–mental health problems is the community

In looking across the five intercepts at the community it is apparent that the jail is at a critical juncture, Intercept 3. It is central, but moderately deep into the criminal justice system. It is clear to everyone who has analyzed the CJ-MH issues that it is in everyone's best interest to avoid penetration as far as the jail, if appropriate. The person with SMI, criminal justice professionals, taxpayers, and family members are all better off if alternatives at Intercepts 1 and 2 are available to link the person with SMI to community-based services. If planning moves "upstream," fewer people with SMI will be arrested and more people who are charged can be diverted after 24-28 hours incarcerated via first appearance court and linkage to community based services after charges are dismissed or while awaiting disposition.

In this model the prison is in Intercept 4 along with the local jail. For our purposes here, we are focusing on the pathways to and from the local jail as they are connected to the community. Reentry planning from the jail and relationships to community corrections (probation) and mental health services will be the issues here. The Sequential Intercept Model remains a useful planning tool nonetheless. It highlights the "upstream" possibilities to reduce the use of the jail for persons with SMI and points out how probation via technical violations can directly affect the number of persons with SMI being booked into the jail.

Putting the jail into a community context shifts the focus to what needs to be done. In doing so, it is important to keep what is needed from being unnecessarily complicated.

The goals for any community vis-à-vis the jail really come down to three:

1. Keep people out of the criminal justice system who do not need to be there
2. Provide constitutionally adequate services when people are incarcerated
3. Link people to services at the "backdoor" of the jail to prevent them from returning

The Sequential Intercept Model is a tool to help think through how to accomplish these three fundamental goals. It works both as a roadmap and as a flow chart that can be used to map all of the community mental health programs that are and can be linked to the components of the criminal justice system overall and to the jail in this particular context.

Bringing the Community to Scale

A concept often heard when a pilot program has been successfully implemented and has some evaluation outcome data to support its effectiveness is "bring the program to scale," i.e. extend it to the entire population that could benefit from it.

I would suggest that this is the wrong core concept for solving the jail SMI problem. Looking at the Sequential Intercept Model, bringing any one program within any one intercept to scale will not effectively address the full array of issues to accomplish the three fundamental community goals discussed above. Filling in one intercept point with a proven program could help, but the ultimate goal is to "bring the community to scale", i.e. have programs at all five intercepts that minimize inappropriate penetration into the criminal justice system, facilitate constitutionally adequate services in the jail, and link detainees leaving the jail to community-based services. All five intercepts need to operate in synch being linked not only to the programs within each intercept, but also linking all the intercepts to one another.

It is our perspective that the absence of this concept of "bringing the community to scale" has compromised the successful solutions to CJ-MH issues even when pilot programs with both federal and state dollars have produced positive public safety and public health outcomes. Rarely do we see communities recognize that having one or two proven programs alone will not solve the problems. With the community as the basic unit of analysis and with the Sequential Intercept Model as a schematic to see where gaps are and where priorities can be set to cover all intercepts over time there is reason for optimism. These problems are not intractable.

It is important to recognize that in almost every jurisdiction that has made significant progress in bringing their communities to scale, a core element has been the development of a task force or core committee. These groups are highly diverse, often with judicial leadership, that include law enforcement,

correctional administrators, mental health service providers, probation, housing specialists, entitlement specialists, family members, consumers, faith community representatives, among various other stakeholders. This group meets regularly from the planning phase through program implementation and program operations. Often membership expands as other key partners get identified as important and as a more comprehensive approach to the issues of SMI in the jail takes shape.

Diversion

In the context of justice-involved persons with SMI, diversion means avoiding or radically reducing jail time by referring a person to community-based services. Such programs may or may not also include continuing supervision. On the Sequential Intercept Model intercepts, diversion is primarily happening at Intercepts 1 and 2. However, problem-solving dispositional courts are in Intercept 3 and diverting probationers with SMI from being reincarcerated for technical violation would be in Intercept 5. To achieve our Core Principle 1, minimizing inappropriate penetration into the criminal justice system requires programs at all of these diversion points.

In a national survey of jail diversion programs Morris and Steadman (1994) identified six key features of successful programs. The first three are

- *coordinating services* at the community level with a high level of cooperation among all parties,
- *regular meetings* of all the key players, and
- *boundary spanners* who are responsible for linking the judicial, correctional, and mental health pieces of a program.

In order to effectively divert detainees with mental illnesses from jail to appropriate mental health treatment, it is crucial that the agencies within a jurisdiction learn to work together even when their goals and expectations may appear to conflict. An adequate response cannot be expected if the mental health service needs of the inmate are defined simply as the jail's problem.

The right people need to be around the table early and often to get the program started. Key agency participants are the sheriff's department, the county mental health department, the county board of supervisors, the district attorney's office, the public defender's office, judges, the probation department, substance abuse treatment providers, housing providers (both public and private), and the county jail. Once the program is off the ground, the key players should continue to meet regularly to coordinate services and share information about problems, resources, and other issues that may come up.

Boundary spanners represent a key element for effective communication between agencies. A boundary spanner is a core position responsible for directly managing the interactions between the correctional, mental health, and judicial staff. This position can help to overcome obstacles that arise due to the differing views, and issues and policies inherent in coordinating the resources of three systems toward a singular goal. The key is finding an experienced person or persons who are trusted and recognized by the key players and can promote understanding and communication among them to accomplish the goal. In the programs visited, the "boundary spanner" ranged from the program director, to a case manager, to court- or jail-based mental health workers.

In addition to the three factors just discussed, three additional core factors of effective diversion noted by Morris and Steadman were

- a *strong leader* with the ability to foster excellent working relationships among the key players,
- aggressive, *early identification* in the first 24 to 48 hours of detention, and
- *case managers* who are somewhat nontraditional with cultural diversity and prior experience in both criminal justice and mental health.

By far the most important component of the diversion programs identified was the distinctive case management services. What is most distinctive is the cultural diversity in the case managers and the effect that has on the clients in the program. In one program the case managers' ethnicity closely resembled that of the jail's population. There were two women and two men case managers, each of a different group that was heavily represented among the jail's detainees.

Traditionally, a "case manager" is someone with a Master's degree in social work or even a licensed psychologist. However, in diversion programs, the most effective case managers had diverse backgrounds – and many did not have a college degree. The key is that the case managers have experience and a level of understanding of the people, their values, and their behavior in the criminal justice and mental health system. Their duties are as varied as their backgrounds and can include any or all of the following, such as

- identification and outreach,
- direct consultation to the courts,
- planning for services,
- linking client to services/aftercare,
- client advocacy,
- monitoring of service delivery, and

- direct service provision.

Recognizing that the jail cannot stand alone in the provision of services to members of the community who have mental disabilities and come into contact with the criminal justice system is fundamental to developing effective programs.

Constructive use of available mental health resources can be accomplished both through in-jail mental health services and through diversion. Clearly the best method for ensuring that services are delivered is to combine diversion of mentally ill detainees with appropriate provision of in-jail mental health services. Alone, neither is as effective as when both are appropriately structured and integrated with one another. In other words, effective mental health treatment depends upon components both within the jail and in the community.

Limits of Jail Responsibility

Earlier, I noted that the second of the three goals for every community in regard to persons with SMI in jail was to provide constitutionally adequate services. This goal is actually a legal requirement. Estelle v. Gamble (429 U.S. 97, 103 (1976)) established the requirement for adequate medical care under the Eight Amendment's prohibition of cruel and unusual punishment. If a jail administrator exhibits "deliberate indifference to serious medical needs" they can be liable for tort damages.

Exactly what standards are necessary to prove "deliberate indifference" is addressed in other case law (e.g. Farmer v. Brennan, 511 U.S. 825 (1994)), but for our purposes the key question is what is "adequate medical care" for detainees with SMI. The American Psychiatric Association's report, "Psychiatric Services in Jail and Prisons" proposes that jails are required to have universal screening for mental illness at intake, treatment, and discharge planning. If the treatment section of this report is read carefully the emphasis is really on keeping the detainee safe while incarcerated to get their charges resolved or their sentences completed. The focus is not on comprehensive treatment targeting long term benefit for the detainees when they return to the community. That responsibility is emphasized in the "back door" activities of the jail in the form of reentry planning and linking to community-based programs. It is interesting to note, that a national survey of jails (Steadman & Veysey, 1997) found jails did little reentry linkage, mostly offering referrals.

It may be setting an impossible standard for jails to attempt long term treatment impacts with rapid turnover (approximately 750,000 jail detainees on any given day, but 12,000,000 bookings per year), strained budgets, and a workforce whose primary goal is security. This reality suggests that not only should we be committed to working on diversion of persons with SMI earlier in the criminal justice

system, but also we should expect less in the way of comprehensive treatment in the jail. Meeting constitutional standards is achieved if detainees with SMI are held safely and have no harm imposed upon them because of their disorders. This is not to say that to provide a safe environment does not require some programming. It is to say that practically such programming cannot be too ambitious and its outcomes should target in-jail functioning rather than longer term behavioral changes in the community after release.

The Changing Landscape

As we look towards solutions to reducing the number of persons with mental health disorders in U.S. jails, there is nothing more important than the January 1, 2014 full implementation of the Affordable Care Act (ACA). The best estimates are that in the 25 Medicaid expansion states and the District of Columbia roughly 25-30% of persons released from jails could enroll in Medicaid and in non-expansion states 20% could enroll in Marketplace health plans (Regenstein & Rosenbaum, 2014). In some states the estimates are even higher. Washington officials estimate that approximately 160,000 people released annually from Washington jails will be eligible for Medicaid in 2014. Previously only 20% were Medicaid eligible and around 112,000 had no state funded health care coverage (Somers, Nicolella, Hamblin et al., 2014).

Another way of looking at the impact of ACA on jail populations is to see that about 27% of the 13 million U.S. citizens newly eligible for health insurance—or some 3.5 million persons--will be justice involved (Patel, Boutwell, Brockman & Rich, 2014).

What all of these statistics mean is that large numbers of justice-involved persons with mental health disorders who could not previously pay for services could now have insurance. Further, with the federal Parity law requiring equal benefit coverage for mental health and physical illnesses, there could be access to a whole new array of behavioral health services. This means that if eligible <u>and</u> enrolled, whether they are diverted from jail or released from jail post-disposition, they will be desirable clients who can pay for community-based services; services that will not be reimbursable if they remain in jail.

An example of services that may evolve influenced by ACA coverage is the Houston, TX Jail Inreach Project operated by the Houston Health Care for the Homeless (Held, Brown, Frost et al., 2012). They frame that program in the context of Patient-Centered Medical Homes. Other states, particularly New York, are framing this concept as Health Homes as envisioned by Accountable Care Organizations. Regardless of the label, the concept is that there will be targeted integrated behavioral and physical health programs with care coordination specifically for justice involved persons covered under ACA.

It is a time of opportunity. Criminal justice professionals need to be at the table as the sequela of the ACA get played out. The specific needs and system issues of the justice involved population need to be front and center, not just in conversations about jail management, but also in the broad community discussions of implementing ACA.

Pivotal Factors

From the material above it should be clear that we know much about how to bring a community to scale around these SMI issues and the local jail. In fact, a number of locales around the U.S. have been quite successful in creating comprehensive, integrated responses. One way to move forward towards broader implementation is to look at how these locales have achieved these goals. Framing this investigation is the concept of pivotal factors. What produced successful programming in these locales when so many other jurisdictions, with the same information available, have either failed in their efforts or have yet to try as a result of perceived barriers?

We believe that now is the time for a qualitative analysis of where these locales began, where they are today, and what were the pivotal factors that got them to where they are. It is much less about the technology. It is much less about political will. It is ultimately about how to do it. It is about strategic planning, leadership, implementation, and operation across multiple systems that historically rarely worked together. It is about showing localities how to think differently in their planning, resource creation and sharing, and grasping the core planning concept of the community as the core unit of analysis.

Meeting with Exemplars

So given all of this uncertainty as to what is in the 'blackbox' of up-scaling communities, we are convening a carefully selected group of sites that have been able to do that over several years to identify what exactly they did, with/for whom, and with what outcomes.

In October, 2014 eight jurisdictions will be invited to send two person teams to a two-day meeting to generate the pivotal factors to success with a community-wide response to SMI and local jails. From their presentations on their baseline status, their situation today, and their assessment of what were the pivotal factors that got them there, we will distill these results and integrate them into a usable tool kit for other locales to use. While there are other methodologies that would rely more on quantitative data, our approach will generate timely data that is based on recent system change initiatives that are capable of generating generalizable principles for action from which specific guidelines for policies, practices and procedures can flow.

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