Jail Diversion for People with Mental Illness in Washington State

A Study Conducted for the
State of Washington Office of Financial Management

November 21, 2016

Joplin Consulting
Lore Joplin
ljoplin@outlook.com
Contract No. K1911
with
Ann Sihler
Brian Enslow, Arbutus Consulting, LLC
Benjamin Chambers, Darn Write!
Nancy Griffith

Contents

Appendixes

Acknowledgements

We would like to thank the individuals listed below for participating in this study. The ideas, information, and perspectives they contributed through phone and in-person interviews were critical to the development of recommendations that will help further Washington's efforts toward effective jail diversion for individuals with mental illness.

Statewide Interviews

Bob Crittenden	Office of Governor Jay Inslee
MaryAnne Lindeblad	Health Care Authority
Nathan Johnson	Health Care Authority
Carla Reyes	Department of Social & Health Services (DSHS)
Thomas Kinlen	Behavioral Health Administration, Office of Forensic Mental Health
Ingrid Lewis	Behavioral Health Administration, Office of Forensic Mental Health
Simone Vijoen	Behavioral Health Administration, Office of Forensic Mental Health
Barry Ward	Behavioral Health Administration, Office of Forensic Mental Health
Jessica Shook	Behavioral Health Administration, Division of Behavioral Health & Recovery
David Reed	Behavioral Health Administration, Behavioral Health & Managed Care
Al Bouvier	Western State Hospital
Randall Strandquist	Eastern State Hospital
Jim Mayfield	DSHS Research & Data Analysis Division
Annmarie Aylward	Department of Corrections, Community Corrections Division
Jody Becker-Green	Department of Corrections, Operations
Kevin Bovenkamp	Department of Corrections, Health Services
Clela Steelhammer	Department of Corrections, Legislative and Policy Coordination
Sandy Stith	Washington State Legislature, Senate Ways and Means
Andy Toulon	Washington State Legislature, House Ways and Means
Kevin Black	Washington State Legislature, Senate Human Services
Sue Rahr	Washington State Criminal Justice Training Commission
Tom McBride	Washington Association of Prosecuting Attorneys
Ann Christian	Washington Council for Behavioral Health
Juliana Roe	Washington State Association of Counties
Ned Newlin	Washington Association of Sheriffs and Police Chiefs
David Lord	Disability Rights Washington
Alison Carl White	Better Health Together
DeDe Sieler	Clark County Department of Community Services
Judge Sean O'Donnell	King County Superior Court
Jackie Van Wormer	Spokane Law & Justice Council
Kristin O'Sullivan	City of Spokane
Diane Swanberg	King County Behavioral Health and Recovery Division

National Scan

Lindsay Stover	Multnomah County (Oregon) Forensic Diversion Program
Joanne Fuller	Multnomah County Health Department
Judge Edward J. Jones	Multnomah County Circuit Court
Jennifer Ferguson	Maricopa County Adult Probation
Laura Cohen	Multnomah County Law Enforcement Assisted Diversion (LEAD)
Paula Tokar	Los Angeles County Sheriff's Department
Mary Marx	Los Angeles County Department of Mental Health
Elizabeth Neighbors	Lake's Crossing Center, Statewide Forensic Program (Nevada)
Cody Phinney	Nevada Division of Public and Behavioral Health

Maureen McDonnell	TASC, Inc.
Vanessa Seaney	Community Partners, Inc. (Tuscon, Arizona)
Kathleen Maurer	Connecticut Department of Corrections, Corrections Health Director
Travis Parker	Policy Research Associates
Henry Steadman	Policy Research Associates
Steve Rosenberg	Community Oriented Corrections Health Services (COCHS)
Daniel Mistak	Community Oriented Corrections Health Services (COCHS)
Dr. Patrick Fox	Colorado Department of Human Services
Chis Farentinos	Unity Center for Behavioral Health (Portland, Oregon)

Jail Diversion Practices

Ric Bishop	Clark County Sheriff's Office
Bryan Farrell	Clark County Mental Health Court
Vanessa Gaston	Clark County Community Services
Jerod Sanford	Lifeline Connections (Clark County)
Linda Shaw	Clark County District Court
Rea L. Culwell	Columbia County
Dimita Warren	Blue Mountain Counseling (Columbia County)
Marin Fox Hight	Cowlitz County Corrections Department
Stephen Sultemeier	Franklin County Sheriff's Office
Travis Davis	Grays Harbor County Jail
Jose Briones	Island County Correctional Facility
Jackie Henderson	Island County Human Services
Jill Johnson	Island County Board of Commissioners
Tracie Bick	Jefferson County District Court
Adam Marquis	Discovery Behavioral Health Care (Jefferson County)
Steven Richmond	Jefferson County Sheriff's Office
Robert Balkema	Kirkland Police Department
Penny Bartley	South Correctional Entity (King County)
Mike Desens	City of Enumclaw Jail
Roxane Payne	Kitsap County Sheriff's Office
Mark Rufener	Kitsap County Sheriff's Office
Karen Nygaard	Kitsap County Jail
Martiann Lewis	Kitsap Mental Health Services
Paula Hoctor	Kittitas County Sheriff's Office
Robert Bianchi	Klickitat County
Jonathan Meyer	Lewis County Prosecuting Attorney's Office
Jessica Stickley	Cascade Mental Health (Lewis County)
Chris Tawes	Lewis County Jail
Lyle Hendrickson	Lincoln County Sheriff's Office
Edward K. Shannon	City of Puyallup Police Department
Rebecca Clark	Skagit County Public Health
Jessica Ellis	North Sound Mental Health Administration (Skagit County)
Charles Wend	Skagit County Sheriff's Office
Sandra Altschuler	Spokane County Superior Court
Barbie Folden	Spokane County District Court
Larry H. Haskell	Spokane County Prosecuting Attorney's Office
Mary Logan	Spokane County Municipal Court
Kristina Ray	Spokane County Jail
Jacqueline Van Wormer	Spokane Law & Justice Council
Teresa Brooks	Northeast Washington Alliance Counseling Services (Stevens County)
Loren Hartman	Stevens County Sheriff's Office
Staci Coleman	Thurston County Mental Health / Veterans' Court
Ian Harrell	Behavioral Health Resources (Thurston County)

Brad Stewart	Thurston County Jail
Joannie Kuhlmeyer	Wahkiakum County Sheriff's Office
Anne Deacon	Whatcom County Health Department
Wendy Jones	Whatcom County Sheriff's Office
Maritza Davis	Yakima City Jail
Courtney Hesla	Central Washington Comprehensive Mental Health (Yakima County)
Cynthia Martinez	City of Yakima
Chris Beutice	City of Walla Walla Police Department
Mike West	Walla Walla County Corrections

King County Site Visit

Mike West	King County Department of Adult and Juvenile Detention
Mike Stanfill	King County Correctional Facility
Dan Satterberg	King County Prosecuting Attorney Office
Manka Dhingra	King County Prosecuting Attorney Office, Therapeutic Alternative Unit
Rebecca Vasquez	King County Prosecuting Attorney Office, Criminal Division
Jim Vollendroff	King County Behavioral Health and Recovery Division
Jesse Benet	King County Behavioral Health and Recovery Division
Jeanne Camelio	King County Hospital and Forensic Services Division
Anita Khandelwal,	King County Department of Public Defense
Betty McNeely	Seattle Municipal Court Resources Center
Rich Cook	Seattle Municipal Court
Kris Nyrop	Public Defenders Association
Chloe Gale	REACH
Susan Collins	University of Washington
Najja Morris	Evergreen Treatment Services
LEAD Operation Work Group	
Natalie Walton-Anderson	King County Prosecuting Attorney Office
Scott Lindsay	City of Seattle, Office of the Mayor
Peter Holmes	City of Seattle Attorney's Office
Randy Vanzandt	Department of Corrections, Community Corrections Division
Daniel Malone	Crisis Solutions Center
Maggie Hostnick	Crisis Solutions Center

Pacific County Site Visit

Katie Oien Lindstrom	Pacific County, Health & Human Services
Rosanne McPhail	Pacific County Health Department
Mark D. McClain	Pacific County Prosecuting Attorney's Office
Pat Matlock	Pacific County Jail
Tessa Clements	Pacific County Health Department, Therapeutic Courts
Lisa Farvour	Great Rivers Behavioral Health Organization
Marc Bollinger	Great Rivers Behavioral Health Organization
Geri Marcus	Willapa Behavioral Health
Jennifer Magnuson	Willapa Behavioral Health

Pierce County Site Visit

Michael Kawamura	Pierce County Assigned Counsel
Janet Rhoton	Pierce County Jail
Patti Jackson-Kidder	Pierce County Jail
Al Rose	Office of the County Executive, Justice Services
Bea Dixon	Optum Pierce BHO
Allie Franklin	Optum Pierce BHO

Tracy Card	Greater Lakes Mental Healthcare
Deanna Carron	Greater Lakes Mental Healthcare

Snohomish County Site Visit

Cammy Hart-Anderson	Snohomish County Human Services
Shelly Yale	Snohomish County Prosecuting Attorney's Office
Janelle Sgrignoli	Snohomish County Superior Court, Specialized Courts
Tony Aston	Snohomish County Jail
Nikki Behner	Snohomish County Jail, Health Services

Yakima County Site Visit

Paul Kelley	Yakima County Department of Assigned Counsel
Rick Weaver	Comprehensive Healthcare
Courtney Hesla	Comprehensive Healthcare
Ed Thornbrugh	Comprehensive Healthcare
Ed Campbell	Yakima County Department of Corrections

Acronyms and Abbreviations

ACA	Affordable Care Act
ACH	Accountable Community of Health
BHO	behavioral health organization
BHRD	Behavioral Health and Recovery Division
CAD	Certified Application Counselors
CCO	community corrections officers
CDMHP	county-designated mental health professional
CH	Comprehensive Healthcare
CJCC	Criminal Justice Collaborating Council
CMS	Centers for Medicare and Medicaid Services
CMS	Centers for Medicare and Medicaid Services
COCHS	Community Oriented Corrections Health Services
CRC	Crisis Response Center
CSH	Corporation for Supportive Housing
CST	competency to stand trial
DCHS	Department of Community and Human Services
DDC	drug diversion court
DMHP	designated mental health professional
DOC	Department of Corrections
DRS	Diversion and Reentry Services
DSHS	Department of Social and Health Services
E&T	evaluation and treatment
EBDM	evidence-based decision-making
EDIE	Emergency Department Information Exchange
EMR	electronic medical records
ER	emergency room
FFP	Federal Financial Participation
FPL	federal poverty level
FTA	failure to appear
FUSE	Frequent Users Services Enhancement
HCA	Health Care Authority
HIE	Health Information Exchange
HUMS	high utilizers of multiple systems
ICMH	Integrated Community Mental Health Program Waiver
ICMT	Intensive Care Management Team
ITA	Involuntary Treatment Act
JBRS	Jail Booking and Reporting System

JLARC	Joint Legislative Audit and Review Committee
LCSW	licensed clinical social worker
LRA	least restrictive alternative
LRO	less restrictive order
MAC	Medicaid administrative claiming
MAM	Medicaid administrative match
MAT	medication-assisted treatment
MIDD	Mental Illness and Drug Dependency
OCRP	outpatient competency restoration programs
OFMH	Office of Forensic Mental Health Services
ORCS	Offender Reentry Community Safety
PACT	Program for Assertive Community Treatment
PIHP	Prepaid Inpatient Health Plans
PITA	prevention, intervention, treatment, aftercare
PSA	Public Safety Assessment
QMHA	qualified mental health associate
RAC	recipient aid category
RCW	Revised Code of Washington
RHO	Returning Home Ohio
RMHC	regional mental health court
RSN	regional service networks
SAMHSA	Substance Abuse and Mental Health Services Administration
SIM	State Innovation Models
SSI	Supplemental Security Income
TCM	targeted case management
WSIPP	Washington State Institute for Public Policy

Section 1

Introduction

Currently, the demand for mental health treatment in Washington far outstrips supply, including in jails, where the proportion of people who have a mental illness is significantly higher than it is in the general population. A recent Washington study showed that, among people entering jail who were enrolled in Medicaid or recently had been, 55 percent had a psychotic disorder and/or a mental health diagnosis such as depression, anxiety, or bipolar disorder; this compares to just 34 percent of the general adult Medicaid population (Henzel et al. 2016).

Additional data are available about pretrial detainees waiting in Washington jails for court-ordered services from the Washington State Department of Social and Health Services (DSHS) (Trueblood Diversion Plan 2016). These are people who have been charged with a crime but who may not be able to understand the judicial process or the charges against them, or they may not be able to aid in their own defense. Among this population:

- 70 percent had had at least two arrests during a recent 12-month period.
- 67 percent had had between two and five referrals since 2012 for services to restore their competency to stand trial.
- 62 percent had received outpatient mental health services during a recent 12-month period, and 50 percent had received residential services.
- 55 percent had a substance use diagnosis, but few had received substance use treatment services during a recent 12-month period. Only 3.2 percent of respondents had received outpatient treatment during a recent 12-month period, and 2.6 percent had received residential treatment.
- 46 percent ranked housing as the most helpful diversion service, followed by medication management (13 percent of respondents), case management (15 percent), and employment (8 percent).
- 43 percent were eligible for Medicaid.

These data suggest that people with mental illness are cycling in and out of Washington's criminal justice system, many of them without receiving treatment. If these individuals match national profiles of people with mental illness who are in jail, they are likely to have a substance abuse disorder, be poor or homeless, and have been repeatedly sexually and physically abused (Steadman 2014). They may also have a chronic physical health problem that will shorten their life by 13 to 30 years (DeHert et al. 2011). Historically they have lacked health insurance, in spite of their high physical and behavioral health care needs—needs that have remained largely unaddressed because of their social conditions, such as poverty, unemployment, low educational achievement, low literacy rates, and homelessness (Hanig 2015).

When people with mental illness are arrested, it usually is not for violent behavior but for low-level nuisance crimes, like shoplifting, trespassing, disorderly conduct, and theft (Monahan and Steadman 2012)—or, if they have been arrested before, for technical violations of their community supervision, like possessing alcohol or missing an appointment with their community corrections officer. Once they are in jail, they are vulnerable to intimidation and assault. They may act out or

break jail rules because the jail environment has exacerbated the symptoms of their mental illness, and this behavior prolongs their incarceration (Council of State Governments 2002). When they finally are released, their chance of being rearrested is higher than it is for someone without mental illness.

Clearly, diverting more of these individuals from jail to community-based mental health treatment could aid them in living in the community, rather than returning repeatedly to jail. Diversion has the potential to cut criminal justice system costs, reduce recidivism, and provide more effective mental health treatment for offenders. It also would represent a more humane response to individuals in jail who have a mental health disorder.

Washington counties, law enforcement agencies, jails, courts, and health care providers already operate a number of programs that are specifically designed to deflect or divert people with mental illness from detainment in county and/or city jails, sometimes by connecting them to appropriate crisis, treatment, and "wraparound" services that help them address their underlying needs. But the available data on justice-involved people who have mental illness, combined with the high demand for mental health services generally, raises questions about the capacity and effectiveness of the current programs and whether the state could or should be doing more. Accordingly, the Washington State Office of Financial Management (OFM) engaged Joplin Consulting to identify opportunities to enhance or expand jail diversion for people in the state who have mental illness. OFM also is interested in knowing whether federal Medicaid funds could be more effectively leveraged to pay for components of jail diversion programs, especially since a broad swath of Washington's justice-involved population became newly eligible for Medicaid in 2010 as a result of the Affordable Care Act (ACA).

To answer these questions, Joplin Consulting conducted a study of jail diversion opportunities for people with mental illness in Washington state. The study was part of a larger, comprehensive assessment of Washington's mental health system requested by Governor Jay Inslee, but it focused specifically on people with mental illness who become involved in the criminal justice system or are likely to do so because of behaviors that lead to encounters with law enforcement. Jail diversion itself can take many forms. It can occur before booking (such as when a police officer encounters someone in the field and refers them to services instead of jail, thus "deflecting" them from the criminal justice system) or after booking (such as through pretrial release or participation in a mental health or other specialty court). It typically involves one or more of the following:

- Mobile mental health outreach teams
- Combined law enforcement/mental health clinician co-response teams
- Crisis stabilization center
- Pretrial release program
- Co-located mental health case management/referral services in court
- Therapeutic and community courts
- Specialty mental health outpatient programs
- Supportive, case-managed housing
- Peer-based support/case management

For this study, Joplin Consulting reviewed and recommended best practices to safely and appropriately divert people with mental illness from the criminal justice system. With the assistance of consultants Ann Sihler, Brian Enslow, Benjamin Chambers, and Nancy Griffith, Joplin Consulting did the following:

- Reviewed the literature and conducted phone interviews with national experts to identify nationally recognized jail diversion programs for individuals with mental illness. For findings from this review, see Appendix A.

- Reviewed the literature and conducted phone interviews with national experts to identify promising practices in the use of Medicaid funding to support components of jail diversion for individuals with mental illness. For findings from this review, see Appendix B.

- Used phone interviews to survey 54 people, representing 20 county jails, four city jails, and the SCORE regional jail, about current jail diversion practices in Washington. For findings from this inventory, see Appendix C.

- Conducted site visits at King, Pierce, Yakima, Snohomish, and Pacific counties, where we interviewed 48 people to learn more about diversion practices in those counties. For findings from these site visits, see Appendix C.

- Conducted phone or in-person interviews with more than two dozen state-level stakeholders and policy makers to identify (1) legal, financial, or other barriers that limit the ability of local government agencies and mental health systems to divert individuals with mental illness from jails, and (2) possible solutions to these challenges. Interviewees included representatives of Washington state agencies, state associations, and legislative staff (see Acknowledgements). For findings from these interviews, see Appendix D.

- Developed recommendations for improving or expanding mental health jail diversion in Washington, based on the professional literature; conversations with national experts; Washington-specific data collected through phone interviews, in-person interviews, and site visits; and professional judgement. For a list of recommendations, see Section 4.

In total, Joplin Consulting interviewed more than 170 people for this study and reviewed or sought specific information from upwards of 100 written or online data sources.

The following sections summarize key findings, based on our review of the literature and interviews conducted by phone and in person. The state-level interviews played a significant role in informing the recommendations presented in Section 4. For characterizations of the prevalence of particular practices in Washington jails, we extrapolated based on the data we collected on the 25 counties we interviewed or visited.

More detailed information, including interviewees' suggestions for change, is presented in the report appendixes.

Section 2

Key Findings: Washington Inventory, Site Visits, and Interviews

We began this study with an eye toward jail diversion techniques: What diversion programs are in place in Washington for people with mental illness? How well are the programs working? What do the literature and other jurisdictions say about the types of diversion that are most effective? We quickly realized that, in many cases, the type of diversion is less important than the availability of services that individuals can be diverted to.

Many Washington counties, including rural ones, already have diversion programs in place at one or more points within the criminal justice system, with some counties having a rich array of programs. Even so, virtually all of the interviewees for this study described limited capacity in the resources available to divert people to, across the continuum of care. Examples of needed resources include crisis stabilization centers; outpatient and residential mental health treatment facilities; supportive housing; case management; and substance abuse treatment for people who have co-occurring disorders. There is a high need for increased capacity in each of these services, which are crucial in stabilizing people with mental illness, engaging them in treatment, and providing them the support and structure they need to address their underlying problems and avoid future arrest. Residential treatment and supportive housing particularly are lacking, especially in rural areas, yet are a critical need.

Yet positive things also are happening. Several of the counties we visited are taking steps to identify people who are mentally ill and using large amounts of resources in the crisis system, jails, and state hospitals, so that these individuals can be prioritized for treatment and services, either when they first come into contact with a law enforcement officer or when they are being released from jail. Roughly half of Washington jails are enrolling eligible inmates in Medicaid before release, so that they can access medication and treatment immediately once they are in the community. And a number of jails and behavioral health providers are coordinating closely to ensure that providers can identify and access their members who are in jail, to facilitate transition planning and provision of treatment and services upon release. These are practices that can be expanded and incentivized as Washington proceeds with its health care reform, in which the integration of physical and behavioral health care will drive efficiencies and improvements in care, including for justice-involved individuals who have mental illness.

This section summarizes key findings from the Washington inventory, site visits, and interviews we conducted. The reader is encouraged to read Appendixes A, B, and C for more specific information and Section 4 for recommendations that are based on the totality of our information gathering.

Limited Availability of Crisis Services

Although mental health crisis services are present in parts of Washington, they are not widely available. Our survey suggests that fewer than half of Washington counties have a readily available, frequently used 24-hour mobile crisis team, and even fewer have a crisis stabilization/triage center. Both mobile response teams and crisis stabilization/triage centers are key front-line tools and early points of diversion for people experiencing a mental health crisis. Diverting people at this stage can keep them from becoming involved with the criminal justice system at all.

Mobile crisis teams and crisis stabilization/triage centers are less likely to be available in rural counties than in urban areas. Even in communities that do have these important resources, admission policies for crisis centers (such as restrictions against people who have outstanding warrants or are facing certain charges) limit their use by people with mental illness who have come into contact with law enforcement. Interviewees reported that designated mental health professionals (DMHPs), who are the only people authorized to make decisions about involuntary commitment, also are in short supply, in part because of workforce capacity issues.

- *Crisis stabilization/triage centers are secure, voluntary residential centers that provide subacute mental health services for people who cannot manage their symptoms on their own yet do not need a hospital stay to become stable. The centers typically are set up for easy law enforcement drop-off but also receive people directly from hospital emergency departments.*

- *Mobile crisis teams consist of mental health professionals who can be called to the scene 24/7 to intervene appropriately and effectively when someone is experiencing a mental health crisis. Team members assess and, if possible, de-escalate the situation, sometimes connecting the person in crisis to emergency, stabilization, treatment, or supportive community services.*

Low Use of Evidence-based Screening and Risk Assessment Tools

Of the jails we surveyed, fewer than 10 percent use a formal screening tool to identify incoming inmates for mental illness, and only 20 percent use a formal pretrial risk assessment tool to assess inmates' risk of (1) failing to appear for court hearings or (2) committing a new crime if they are released before trial. Reliable, evidence-based mental health screening and pretrial risk assessment tools are available and relatively inexpensive to implement. Together, they provide ways to accurately identify people with mental illness who can safely and appropriately be diverted to community-based treatment or other services as they await trial.

Without the use of such tools, jails almost certainly are missing opportunities to divert and/or treat people with mental illness, either because the individuals have not been identified as mentally ill or because their charge keeps them from being released, regardless of their actual risk to the community (which typically is low). Counter to common stereotypes, most people with serious mental illness are arrested for low-level nuisance crimes, not violence. The evidence indicates that, when their behavior does include violent crimes, the violence usually is related not to their mental illness but to other factors, such as substance abuse (Monahan and Steadman 2012).

Insufficient Enrollment of Jail Inmates in Medicaid before Their Release

Our information gathering suggests that fewer than half of Washington jails currently are enrolling eligible inmates in Medicaid before their release, even though this is a best practice to ensure that people with mental illness can access medication and treatment immediately once they are in the community. Some interviewees for this study did not view Medicaid enrollment as a responsibility of the jail at all. Of the Washington counties that do enroll inmates in Medicaid, half of them have a contracted staffer to do this; in others, the work is done by discharge/reentry planners, medical staff, or pretrial staff.

As time passes and more people become enrolled in Medicaid as the result of their involvement with other justice or social service systems, it is expected that more people will be entering the jail who are already enrolled in Medicaid. Thus, over time, the costs associated with enrolling inmates in Medicaid while in jail are expected to drop. (This assumes that Medicaid benefits are suspended

when someone is incarcerated, rather than terminated. Washington state is moving toward full implementation of a suspension policy starting in July 2017; see Section 2 of this report.)

Weaknesses in Mental Health Courts

Participation in mental health courts is low in the counties we visited for this study. In Seattle, for example, interviewees reported that only 25 people chose to participate in the city's Municipal Mental Health Court during the first half of 2016, out of 415 people who were referred. Defendants in Washington often opt out of mental health court because the period of court supervision can be much longer than if they were adjudicated in a traditional court: up to two years, versus five or six days in jail in some cases. Participants also may be required to abstain from alcohol or drugs or meet other criteria that, for practical purposes, are difficult and overly stringent for people who may already be struggling with basic life skills.

> ➢ *Mental health courts use a multidisciplinary team to provide behavioral health care and other services in lieu of incarceration or traditional case processing. Participation in mental health court usually is on a post-plea basis (Center for Health and Justice at TASC 2013).*

Mental health courts in general have other weaknesses as a method of diversion, including that the actual diversion occurs well after someone has entered jail and become involved in the criminal justice system. This means that considerable system costs have been incurred before the diversion even happens, and being in jail may cause the person with mental illness to destabilize or be traumatized. Additionally, the costs of operating a mental health court are relatively high (Steadman et al. 2014), yet the courts often do not follow the research-based principle of focusing this high-cost resource on defendants who are of higher criminogenic risk (i.e., at risk of reoffending). Instead, courts often have charge-based criteria for participation, with many courts accepting only misdemeanants. Research indicates that systems should reserve their most intensive resources for offenders who are at high risk of reoffending (The Pew Center on the States 2009). It also indicates that, regardless of charge type, for low-risk offenders, less intensive services are more effective and less costly than mental health courts (King and Pasquarella 2009, as cited in Griller 2011).

Although mental health courts aid some individuals, given their drawbacks, they should not be relied upon as a major method of diverting people with mental illness from jail.

Attention to High Utilizers of Multiple Systems (HUMS)

Most of the counties we visited have begun identifying high utilizers of jails, but few are focusing on high utilizers of multiple systems (HUMS), meaning people with chronic physical and/or behavioral health disorders who are repeatedly showing up in jails, hospital emergency rooms, and/or shelters, presumably because their behavioral health needs are not being met through less expensive means. The counties are examining the level of jail resources that HUMS use and considering ways to assess and address these individuals' needs (for mental health treatment, chemical dependency treatment, supportive housing, etc.). In some cases, counties are seeing value in addressing these tough cases, and are choosing to provide more appropriate and individually targeted services, such as intensive jail transition/discharge planning, case management, and wraparound services, in an attempt to reduce HUMS' intensive use of costly public services.

Additional study and analyses of the costs of programs designed specifically for HUMS are needed. Although the costs are significant in the short term, they very well could be less than the current costs associated with HUMS cycling repeatedly through jails and emergency rooms. The sheer

number of HUMS identified by different counties gives an idea of the scale of the problem and, by extension, the possible cost savings if the needs of these individuals could be effectively addressed:

- Snohomish County has identified 200 people who have been booked into jail at least seven times over a recent 18-month period. This represents more than 900 bookings per year attributable to HUMS.

- King County estimates that, at any given time, there are 2,000 HUMS in the county who have been booked into the county jail at least four times in a single year. This represents a minimum of 8,000 bookings a year attributable to HUMS. Of those, an estimated 40 percent also had been booked into the municipal jail at least once, making for a total of 11,200 bookings in a single year.

- Spokane County has identified individual HUMS who have gone to the emergency room upwards of 35 times over a few months' time.

Uneven Coordination Among Jails, Providers, and Health Plans

From county to county, there is considerable variation in the arrangements that jails and behavioral health organizations (BHOs) have for mental health service providers to identify and access their members who are in jail. In some counties, jails and the BHO have established methods (sometimes informal) to identify members who have been detained, and the providers have easy access to inmates in order to coordinate transition planning and provide other services. In other counties, the level of coordination between the jail and the BHO is much less. Successful coordination often appears to rest on the efforts of a few committed local leaders. In these cases, consistent, structured mechanisms need to be in put place to ensure ongoing coordination as personnel change.

Effective coordination requires several elements:

- **The sharing of booking information with providers**, so that they know when their members are in jail. It is expected that, by July of 2017, jail booking data will be transmitted electronically to the state, but there is no timeline for when or how those data will then be communicated to providers. Additionally, the Washington Health Care Authority currently is working to develop a clinical data repository[1] that may be able to serve as the mechanism to ensure that providers know when their clients are incarcerated; implementation is expected in 2020.

- **Easy access of providers to the jail,** so that they can meet with inmates and coordinate transition planning. Currently, some jails restrict provider access to the jail or have screening criteria that exclude certain provider staff, such as peer support specialists who may have a criminal history.

- **Incentive for providers to connect with inmates and** provide services while inmates are in jail. Washington's move toward value-based purchasing is an opportunity to incentivize providers to ensure a successful transition of their members out of jail and into appropriate

[1] https://www.onehealthport.com/cdr-overview.

treatment and supportive services in the community. The forensic population has the potential to be overlooked in the transition to full health care integration.

- **Adequate community-based resources at discharge,** so that departing inmates with behavioral health needs have immediate access to treatment and supportive services.

Related to this issue is the fact that the jails and the behavioral health system have varying access to electronic records and use inconsistent definitions. Currently the Washington Department of Corrections and most Washington jails do not use electronic medical records. Most do not have access to the medical and treatment records of inmates who have mental illness, including records related to medication. Better records management and data sharing between providers and the jails would (1) increase care coordination, and (2) provide aggregate data that could be used to analyze the jail population for the purposes of targeting future initiatives and investments.

Inadequate Community-based Resources to Divert People To

Communities in Washington use a variety of techniques, approaches, and programs to divert people with mental illness from jail, but there was broad agreement among interviewees that their communities do not have enough resources to divert people to. Supply does not come close to meeting demand. Without adequate mental health treatment and supportive services to divert people to, jail diversion programs often do little but put people with mental illness back out on the street, without the housing, medication, treatment, or social supports that they need to change the behaviors that got them arrested in the first place. According to interviewees, the following resources are especially lacking:

- Outpatient and residential mental health treatment
- Supportive, service-rich housing
- Case management services
- Treatment for chemical dependency, which sometimes masks mental illness or results from an effort to self-medicate for mental illness

People with mental illness who are in jail typically have complex, interrelated problems. These individuals often are poor and/or homeless, many have been repeatedly sexually and physically abused, and up to 80 percent of them suffer from co-occurring substance abuse disorders (Steadman 2014). Some interviewees for this study described these issues as large, societally based problems that the jails are being asked to solve because the community mental health system has not been adequately funded. Yet jails are not therapeutic environments and, in most cases, do not hold individuals in custody long enough to address inmates' underlying problems. Community-based resources are necessary but largely lacking.

Limited Time Allowed for Competency Restoration for Misdemeanors

By Washington code, in cases where a misdemeanor defendant has been evaluated and determined not competent to stand trial, the time allowed to restore that person to competency generally ranges from 14 to 29 inpatient days (or 45 days for defendants charged with domestic violence). However, in practice the actual time period available for competency restoration is less than the upper limit because time used to complete the competency evaluation is subtracted from the time allowed for restoration. The Revised Code of Washington (RCW) does allow for a longer period of 90 days for

competency restoration on an outpatient basis, but outpatient competency restoration generally is not done because of a lack of resources in the community.

In contrast, for defendants charged with felonies who are determined not competent to stand trial, the statute allows either 45 or 90 days for restoration of competency, depending on the level and type of felony.

For most misdemeanor defendants, the 29-day restoration period is not enough to complete the competency evaluation, begin necessary medication, and actually be restored to competency. As a result, large numbers of defendants are being evaluated, treated for an insufficient amount of time, and then deemed not restorable. Depending upon the seriousness of the crime, whether the defendant is still in jail, and the recommendation of the forensic psychologist who completed the competency evaluation, the judge may order a DMHP to evaluate the defendant to be "flipped" from the legal to the civil commitment system, resulting in what may be unnecessary commitments of people who actually could be restored to competency if they were treated long enough.

Section 3

Key Findings: Literature and Environmental Scan

This section discusses research results on the effectiveness of various types of jail diversion and ways to leverage Medicaid funding for diversion-related activities, based on both a literature review and interviews with national experts. The section closes by highlighting features of jail diversion programs across the nation that might be of interest to Washington policy makers, either for potential replication in the state or to illustrate key diversion concepts and practices.

More information on the effectiveness of jail diversion, potential Medicaid funding for diversion-related activities, and national program models is presented in Appendixes A and B.

Effectiveness of Jail Diversion

Data on the effectiveness of jail diversion programs for people with mental illness are sometimes mixed—presumably in part because there is such variety in who participates in diversion programs, how the programs operate, and their goals, which could be to reduce recidivism, avoid conviction (and therefore the consequences of a record), connect people with treatment and services, enhance public safety, reduce jail crowding, or save money.

Clearly, additional research is needed on the effectiveness of jail diversion programs, particularly on which program components are associated with specific outcomes. However, many approaches to jail diversion for people with mental illness show some promising outcomes, particularly when they are paired with sufficient and appropriate community-based treatment and housing resources.

Reduced Criminal Justice System Involvement and Increased Connection with Mental Health Treatment Services

Evidence from the limited research that has been conducted suggests that, in general, diverting people with mental illness from jail to community-based services has the potential to (1) engage defendants in mental health treatment, (2) reduce criminal justice system costs, and (3) reduce involvement in the criminal justice system. Each approach to jail diversion offers different types of benefits, depending on where within the criminal justice system the diversion occurs.

The most common benefits are reduced criminal justice system involvement and greater connection with mental health treatment services.

Table 2-1 summarizes the effectiveness of four specific types of diversion for which research results were readily available:

- **Specialized law enforcement responses**, such as co-response teams, in which a police officer and a mental health professional respond to calls together.

- **Pretrial diversion**, such as voluntary, post-charging diversion programs in which formal adjudication is avoided and charges are dismissed upon completion of a specific set of requirements, such as participating in treatment, completing community service, and paying restitution.

- **Mental health courts**, which use a multidisciplinary team to provide behavioral health care and other services in lieu of incarceration or traditional case processing. Participation in mental health court usually is on a post-plea basis (The Center for Health and Justice at TASC 2013).

- **Assertive community treatment (ACT) teams**, which provide direct treatment, rehabilitation, and support services in the community to people who have severe mental illness, are functionally impaired, and have a high risk of inpatient hospitalization. Forensically oriented ACT teams focus specifically on preventing the arrest and incarceration of people with severe mental illness.

Table 2-1
Research Results: Potential Benefits of Jail Diversion of People with Mental Illness

Type of Diversion	Specialized Law Enforcement Responses	Pretrial Diversion	Mental Health Court	Assertive Community Treatment (ACT)
Research quantity/quality	Limited	Little on recidivism	Limited, short-term, contradictory results	Limited
Potential benefit:				
Reduced SWAT use	yes			
Fewer officer injuries	yes			
Connection to treatment	yes	yes	yes	
Reduced hospitalization				yes
Reduced CJ involvement	yes	yes	yes	yes
CJ cost savings	yes	yes	maybe	
Positive outcomes		yes		yes
Reduced court docket		yes		
Reduced overcrowding		yes		

NOTE: This table shows only demonstrated correlations between diversion types and potential benefits. Thus, a blank cell in the table does not necessarily mean that the associated benefit does not occur, just that it has not been demonstrated in research (which has been limited for all of the types of diversion).

Cost Savings

Research on the potential cost savings of jail diversion for people with mental illness has yielded conflicting results. In some cases the true costs of a given diversion program are obscured by cost shifting in the short term, both between the criminal justice system and behavioral health system (such as when someone receives inpatient or outpatient mental health treatment instead of spending time in jail) and between state or local programs and federal programs (such as when someone receives treatment funded through Medicaid instead of local government dollars). Although the expectation is that these programs result in long-term cost savings in the physical and behavioral health system and the criminal justice system, long-term outcome and cost data on these programs are rarely available.

Research results on the cost savings of particular types of jail diversion programs should be viewed with caution and examined thoroughly before being used as the basis for public policy decisions. Policy makers will need to consider how to balance the benefits of possible long-term cost savings and more humane treatment of people with mental illness with short-term cost shifting.

Supportive Housing and Employment

For most justice-involved individuals with mental illness, stable housing is essential to success in the community. Supportive housing (i.e., housing that is paired with case management) increases the chances of avoiding future encounters with law enforcement.

Supportive housing can be defined as permanent, affordable housing that is connected with individualized support services that are intended to help residents maintain residential stability (Fontaine et al. 2012 and Aidala et al. 2013). Supportive housing programs include services such as intensive case management and care coordination, clinical supervision, mental health and/or substance abuse treatment, and vocational and employment services. Often services are provided with low client-to-staff ratios.

Evidence is strong that, for people with a history of homelessness and mental illness, supportive housing reduces the use of jails, emergency services, and shelters, plus it cuts down on the costs of operating these facilities (Burt and Anderson 2005, Culhane, Metraux, and Hadley 2002, and Culhane et al. 2007, as cited in Fontaine et al. 2012).

Studies in Ohio and New York that explored the effects of supportive housing on people reentering the community from jail or prison, particularly for those with mental illness or other behavioral health problems, concluded that supportive housing significantly reduces the likelihood of rearrest and reincarceration. It also reduces the number of jail admissions and days spent in jail (Fontaine et al. 2012 and Aidala et al. 2013) and doubles the chances that program participants stay housed, for up to two years (Aidala et al. 2013). Research on the cost savings of the Ohio and New York programs yielded conflicting results.

Leveraging Medicaid Funding for Jail Diversion-related Activities

Historically, the justice-involved population was among the largest groups without health insurance, yet many members of that population have high physical and behavioral health care needs. They are more likely than the general public to suffer from mental illness, substance use disorders, and/or chronic disease, and often their health needs have been unaddressed because of their social conditions (e.g., poverty, unemployment, low educational achievement, low literacy rates, and homelessness) (Hanig 2015).

The 2010 implementation of the Affordable Care Act (ACA) has implications for justice-involved individuals who have a mental illness. Specifically, the ACA included provisions for the expansion of the Medicaid-eligible population to include all adults below a specified income threshold. It also required that insurance plans treat mental health and substance use disorder benefits on equal footing as medical and surgical benefits (i.e., with parity). This made many individuals involved with the criminal justice system eligible for Medicaid coverage for the first time, such that, in theory, their behavioral health needs could be treated. In fact, the number of people entering jail in Washington state who were enrolled in Medicaid—either at the time of booking or shortly before—increased from 31 percent in 2013 to 58 percent in September 2014; this trend is expected to continue.

Still, six years after implementation of the ACA, despite funding availability, there continue to be structural, capacity, and system inefficiencies that serve as major barriers to delivering behavioral health treatment to justice-involved individuals. Reducing such barriers could expand opportunities to divert individuals with mental illness from the criminal justice system, assuming that key

Medicaid-related provisions of the ACA remain in place during the coming years of the new federal administration.

Medicaid Enrollment before Leaving Jail

Many people with mental illness cycle in and out of jail, in part because, upon release, they lack access to housing, case management, and treatment services in the community. However, if they are enrolled in Medicaid before release, they tend to receive more services and stay in the community longer than people with mental illness who are not on Medicaid (Bazelon Center for Mental Health Law 2009, Morrissey et al. 2007 as cited in McKee et al. 2015, and Hanig 2015). Potential benefits include increased access to care, better health, and reduced expense by the state (Bazelon Center for Mental Health Law 2009). This is particularly true for people with mental illness, who have a relatively high rate of recidivism (Morrissey et al. 2007 as cited in Bazelon 2009, Community Oriented Corrections Health Services 2013). In Washington state, a study found that justice-involved individuals who enrolled in Medicaid upon release from jail were more likely to access community mental health and substance abuse services than were justice-involved individuals not enrolled in Medicaid (Community Oriented Corrections Health Services [COCHS] 2015b).

Although enrolling inmates with mental illness in Medicaid before they leave jail clearly supports more immediate access to medication, mental health treatment, case management, and other services, implementing this policy is not without obstacles. Common issues include coding challenges, the difficulty of sharing information between jails and community-based providers, and the sometimes short time frames for enrolling an inmate when changes in custody are quick or unpredictable (Ryan et al. 2016).

Even when people are enrolled in Medicaid, they may not take the necessary steps to access care. Many people newly enrolled in Medicaid have not had health insurance before and therefore lack basic health insurance literacy, i.e., they do not necessarily understand what insurance is, what conditions it covers, how to use it, and how to connect with a health care provider. Or they face obstacles related to bias against people with a criminal history, a lack of culturally appropriate services, or the need to address more immediate priorities, such as food and housing (Ryan et al. 2016). For these reasons, Medicaid enrollment should be considered only a preliminary step in connecting departing inmates who have mental illness with appropriate care and treatment.

Suspending Rather Than Terminating Medicaid Benefits

Medicaid law requires that federal payments for services be discontinued once someone is in a jail or prison (unless they are in an inpatient hospital for more than 24 hours). However, Medicaid eligibility rules differ from those concerning federal payment for services. The law does not actually require that individuals in jail or prison lose their Medicaid eligibility, but it does not allow for payments for services furnished to them while in jail. This means that states can temporarily suspend an incarcerated person's benefits without the individual being totally terminated from the Medicaid program (letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives, April 6, 2000 as cited in Bazelon Center for Mental Health Law 2009). Both the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services have urged states to suspend, rather than terminate, Medicaid enrollment when people enter jail or prison (McKee et al. 2015).

Suspending rather than terminating Medicaid eligibility when someone is incarcerated may make it easier for the state to receive Medicaid reimbursement for care when a detainee is in a hospital, nursing facility, psychiatric facility, or intermediate care facility for more than 24 hours (McKee 2015).

With suspension, it is also easier to connect inmates to providers before their release and to reinstate benefits at release. This allows providers to facilitate inmates' immediate access to medication, behavioral health treatment, health care, and other services when they return to the community.

In Washington state, Governor Inslee signed SSB 6430 into law on March 31, 2016. The law became effective on June 9, 2016, and requires the Washington State Health Care Authority (HCA) to "suspend, rather than terminate, medical assistance benefits by July 1, 2017, for persons who are incarcerated or committed to a state hospital." A progress report is due to the Governor and Legislature by December 1, 2016. Currently multiple work groups and stakeholders are engaged in meeting the requirements of this legislation. For example, HCA is developing an interface with the Department of Corrections (DOC) and the Jail Booking and Reporting System (JBRS) that will allow inmates' benefits to be suspended instead of terminated. This work is on track to meet the July 1, 2017, deadline.

Medicaid Administrative Claiming (MAC) and Targeted Case Management (TCM)

Through a practice known as Medicaid Administrative Claiming (MAC), or Medicaid administrative match (MAM) in Washington, some Medicaid funds are available for non-service-activity expenses related to the administration of mental health, social service, and public health programs (Community Oriented Corrections Health Services [COCHS] 2015b). Through MAC, public safety entities can be reimbursed for activities such as enrolling justice-involved individuals in Medicaid and connecting them with community-based health care services. (Community Oriented Corrections Health Services [COCHS] 2015b).

Activities reimbursable through MAC fall into four categories:

- **Medicaid eligibility intake**, such as helping a client fill out a Medicaid application. Helping someone gather documentation needed to complete a Medicaid application is reimbursable, as is time spent filling out the application or responding to questions from local and state agencies (including courts) regarding the application. (Community Oriented Corrections Health Services [COCHS] 2015 and 2015c)

- **Medicaid outreach,** such as informing a client where he or she can receive mental health treatment and helping schedule an appointment. Educating and informing people about Medicaid and how and where they can enroll are reimbursable, as is time spent linking someone with a health care service such as mental health treatment. (Community Oriented Corrections Health Services [COCHS] 2015a and 2015c)

- **Arranging transportation to a Medicaid-covered service,** such as driving or arranging transportation for a client to a detox center for services. Coordinating a person's transportation to a doctor's office or other health care provider is reimbursable, along with the actual cost of providing that transportation. (Community Oriented Corrections Health Services [COCHS] 2015a and 2015c)

- **Referral, coordination, and monitoring,** such as a probation officer monitoring his or her client's progress in a substance abuse treatment program. Reimbursable activities include following up to determine whether a person sought the health care treatment they were referred to and discussing the individual's health care status and needs with clinicians, therapists, case managers, and others. (Community Oriented Corrections Health Services [COCHS] 2015a and 2015c)

An additional federal Medicaid program—TCM, or targeted case management—also reimburses state and county agencies, local public entities, and contracted community-based organizations for the costs that they incur while providing TCM services. Many of these entities already are performing reimbursable activities. Covered case management activities fall into four categories:

- Assessment
- Development of a care plan
- Referral and related services
- Follow-up and monitoring (Community Oriented Corrections Health Services [COCHS] 2015a)

Both MAC and TCM have many detailed requirements. Additionally, they may be most viable or cost-effective under fee-for-service versus capitated health plans and in large facilities where the volume of clients is high. In Washington state, the Department of Corrections (DOC) intends to soon begin implementing MAC reimbursement for Medicaid enrollment activities.

Program Models

Joplin Consulting reviewed the practices and outcomes data for jail diversion programs around the country that national experts had identified as serving as promising models for people with mental illness. There is no one-size-fits-all model for effective diversion programs. Together, the programs we reviewed use a wide variety of jail diversion components. Individually, each program is tailored to the needs and opportunities of the local community.

Interviews we conducted with program administrators and agency staff suggest that program successes are attributable not just to the use of a specific diversion approach or technique but to significant investments in services and resources, sometimes combined with strong leadership and extensive stakeholder involvement during the planning stages. Several communities also have established interdisciplinary bodies that serve as vehicles for ongoing, collaborative problem solving regarding jail diversion and behavioral health services. These bodies are similar to Washington's law and justice councils but include representatives from the physical and behavioral health fields.

Program components that may be of particular interest are listed below, by topic. For detailed descriptions of programs, along with available outcome data, see Appendix A.

Law Enforcement/Emergency Services Components

- The pairing of specially trained law enforcement officers and mental health professionals to co-respond on-scene to situations involving people with mental illness, with the goal of referring people to services when appropriate (San Diego Psychiatric Emergency Response Team).

- Law enforcement diversion of low-level drug and prostitution offenders into intensive, community-based social services (Seattle LEAD program).
- Co-located inpatient and outpatient behavioral health clinics, a 23-hour observation/triage area, a sobering/detox center, and a county court, for both juveniles and adults (Pima County Crisis Response Center, in Arizona).
- Recovery-oriented peer support specialists and system navigators for crisis center residents, to provide support at the crisis center and during transition to the community at discharge (Pima County Crisis Response Center, in Arizona).
- Consolidation of psychiatric hospital beds, psychiatric emergency facilities, and community-based mental health navigators, housing resources, and service providers (Unity Center, in Portland, Oregon).

Court Components

- Mental health clinicians located in court at arraignment, to develop diversion and treatment plans and recommend them to the judge (Connecticut Community Forensic Services Program).
- Mental health assessments and case management conducted at a licensed satellite mental health clinic located at the courthouse, in a converted attorney-client conference room (Bridgeport Treatment Pathway Program, in Connecticut).

Jail Components

- Twenty-four-hour in-jail crisis consultation and triage by mental health professionals, via telephone, who can (1) assess detainees' suicide and mental health risk, (2) recommend implementation of appropriate jail protocols, (3) provide follow-up mental health care in the jail, and (4) make recommendations regarding in-custody care, medication, and post-discharge care (Kentucky Jail Mental Health Crisis Network).
- Statewide funding of in-jail staff positions designated for the provision of behavioral health screenings, assessments, and treatment in jail for detainees with mental health, substance use, or co-occurring disorders, using evidence-based practices (Colorado Jail-based Behavioral Health Services).
- Implementation of evidence-based criminal justice practices and the use of actuarial tools to inform decisions about arrest, pretrial release, probation supervision, and case management (Eau Claire, Wisconsin).
- Transfer of jail inmates who are identified as seriously mentally ill and in need of acute-care services to a community-based crisis stabilization center within 48 hours of arrest (Miami-Dade County Criminal Mental Health Project).
- Re-evaluation of defendants held on bond to assess their treatment needs and develop a supervision plan to present to the court for possible bond modification (Connecticut Jail Re-Interview).
- Medicaid reimbursement for parole and probation services, through the use of targeted case management (Nevada Forensic Diversion).

Competency-related Components

- A competency specialty court that serves as a single point of contact for services related to competency and restoration (Nevada Forensic Diversion).

- In-jail competency restoration program operated by an independent contractor that uses the same restoration programming as the state hospital (Arapahoe County Jail-Based Competency Restoration, in Colorado).
- Short-term, in-jail competency restoration program for people who it is believed can be restored to competency in 90 days or less, without the need for forced medication (San Bernardino In-Jail Competency Restoration, in California).
- Residential community-based competency restoration center, offering a continuum of care during the commitment period and after reentry into the community, including monitoring to ensure that treatment and support services are maintained (Miami-Dade Forensic Alternative Center).
- Six- to 12-month community-based competency restoration program with behavioral health screening and assessment, individualized restoration/diversion plans to address basic needs (housing, food, and clothing), behavioral health treatment, legal skills education, connection to community-based care, systems navigation, and forensic case coordination (Multnomah County Mental Health and Addiction Services Division Forensic Diversion Program, in Oregon).

Transition and Residential Components

- Peer support specialists meeting with low-risk inmates who have a mental illness when they are released from jail, to provide support and encouragement and connect them with services (Maricopa County Criminal Justice Engagement Team, in Phoenix).
- Secure residential treatment facilities for people with mental illness, with a goal of stabilizing both psychiatric and medical issues (Cascadia Secure Residential Treatment, in Portland, Oregon).

Section 4

Recommendations

Jail diversion for people with mental illness takes place at the intersection of the criminal justice and mental health systems, where multiple stakeholders, professional disciplines, interests, and cultures come into play—from the law enforcement officer on the street to the community health worker. In between are jails, prosecutors, public defenders, courts, community corrections officers, state hospitals, crisis and residential treatment facilities, insurance companies, health care providers, social workers, case managers, and others, all of whom play a part in successfully diverting people with mental illness from jail to community-based treatment.

The recommendations presented below reflect this complexity and, if implemented, would involve changes in behavioral health services, jails, courts, the workforce, and data and information management.

The recommendations are grouped into three tiers, with the highest priority recommendations presented in the first tier. These are the recommendations that are likely to have the greatest impact. Although the recommendations are numbered individually, this is for convenient reference and does not reflect meaningful differences in feasibility and probable impact. What is important is the tier that each recommendation falls into.

First-tier recommendations should be given the most serious consideration for implementation.

First-Tier Recommendations

Community-based Solutions

1) **Increase the availability of low- and no-barrier, supportive housing for people with a criminal history, substance use disorder, and/or mental illness.**

   Why: Without stable housing and wrap-around services, people struggling with homelessness and mental illness who have been diverted from jail will not be successful in the community and likely will have additional encounters with law enforcement.

   Evidence is strong that, for people with a history of homelessness and mental illness, supportive housing reduces the use of jails, emergency services, and shelters and cuts down on the costs of operating these facilities (Burt and Anderson 2005, Culhane, Metraux, and Hadley 2002, and Culhane et al. 2007, as cited in Fontaine et al. 2012). Supportive housing combines permanent, affordable housing with individualized support services, such as intensive case management and care coordination, clinical supervision, mental health and/or substance abuse treatment, and vocational and employment services.

   In Washington, interviewees for this study indicated that there is a pervasive lack of housing for justice-involved individuals with behavioral health problems. Housing was ranked as a top diversion need by 46 percent of pretrial detainees waiting for court-ordered competency restoration services—higher than medication management, case management, or employment (Trueblood Diversion Plan 2016).

   It can be challenging to house people who have a criminal history, substance use disorder, and/or mental illness because of high housing costs, a general lack of housing stock (some communities are seriously undersupplied), and a lack of low- and no-barrier housing (i.e., housing that accepts people with a criminal record and/or who are not alcohol and drug

free). Yet providing supportive, service-rich housing is an essential step if individuals are to address their underlying problems and stop cycling in and out of jail.

How:

- Allocate state funding for local capital projects to increase housing stock.
- Provide incentives to landlords to serve this population.
- Increase funding for supportive housing services by accessing Medicaid (non-waiver) or general fund dollars.

2) Increase capacity across the continuum of mental health treatment delivery, especially with residential treatment.

Why: There was broad agreement among interviewees that their communities do not have enough treatment resources that people with mental illness can be diverted to. Without community-based treatment, jail diversion programs would do little but put people with mental illness back out on the street, where they do not have the housing, medication, treatment, or social supports they need to change the behaviors that got them arrested in the first place.

Particularly lacking, say interviewees, is residential treatment capacity for people with mental illness. Subacute residential treatment facilities typically have case managers and onsite programming but offer a lower level of care than E&Ts, which are secure treatment facilities suitable for people who meet criteria for involuntary commitment. Increasing access to subacute residential and structured, step-down care for people with mental illness could decrease the flow of patients to the state hospital by stabilizing them in the community.

How:

- Allocate state funding for regional capital projects for residential behavioral health treatment.
- Build or retrofit existing buildings to increase capacity in this area across the state.

3) Increase the capacity and accessibility of crisis stabilization and 23-hour observation facilities.

Why: Interviewees expressed strong support for front-end diversion (i.e., diversion that happens before booking at the jail), yet law enforcement officers often have limited options for responding on scene to someone who is experiencing a mental health crisis. In many communities (especially rural ones), the only places an officer can take someone is the hospital emergency room or jail. Hospitals will often refuse to admit the patient and jail is not an appropriate milieu for people experiencing a mental health crisis.

Crisis stabilization centers and 23-hour observation facilities serve as an alternative that is more appropriate and can be just as efficient as an officer dropping someone off at the jail. Such facilities should have the added benefit of being able to connect individuals with appropriate treatment or services at discharge. Interviewees reported that, currently in Washington, crisis centers are underutilized by people with mental illness who have come into contact with law enforcement, in part because of admissions criteria that sometime exclude people who have outstanding warrants or are facing certain charges.

How:

- Remove access barriers at crisis stabilization centers, such as criteria that exclude people with outstanding warrants or certain types of charges (fire setting or sex offenses, for example).

- Establish regional 23-hour crisis observation facilities that are linked to psychiatric beds and residential and outpatient follow-up care. Allocate state funds for regional capital projects for these facilities. The Unity Center for Behavioral Health in Portland, Oregon, includes a 23-hour observation facility slated to open early in 2017; capital costs for the center (to remodel an existing building) were funded from state and local general funds, private donations through a local hospital foundation, and local hospitals.

Jail-based Solutions

4) Better identify detainees who have mental illness.

Why: Detainees with mental illness often are not identified as such during the booking process. In most jails, detainees are flagged for follow-up by mental health professionals only if the transporting law enforcement officer mentions it as a possible need. Because most jails do not use a formal, evidence-based mental health screening tool at booking, these inmates often go unidentified. They may be housed inappropriately (i.e., in the general jail population instead of in specialized housing), and may begin to decompensate because of a lack of treatment. Identifying inmates with mental illness earlier in the intake process would increase opportunities for assessment, diversion, and treatment.

How:

- Expand the use of formal, evidence-based mental health screening tools at booking. As indicated, follow up with comprehensive assessments by mental health professionals.

- In jails that lack onsite mental health professionals, pair the use of an evidence-based screening tool with phone or video consultation (such as via telepsychiatry) with mental health professionals who are available 24/7.

5) Create incentives for jails, mental health providers, and health plans to cooperate to ensure that all Medicaid-eligible inmates with mental illness are identified early, enrolled in Medicaid, receive robust assessment and transition services, and access physical and behavioral health services immediately upon release.

Why: Enrollment in Medicaid while an inmate is still in jail ensures that (1) any inpatient hospital stays of 24 hours or longer can be more efficiently reimbursed by Medicaid, (2) inmates are enrolled with a health plan that can provide transition planning to prepare for reentry to the community, and (3) departing inmates can access medication and treatment immediately once they are released to the community.

Robust transition services support successful reentry to the community. Strong reentry services contribute to reduced recidivism, increased public safety, and lower criminal justice and health system costs. Overall, the evidence shows that enrolling eligible inmates in Medicaid before their release from jail is associated with quicker access to outpatient care, greater use of outpatient care, and reduced use of inpatient care (Lin et al. 2013).

Our information gathering suggests that fewer than half of Washington jails currently are enrolling eligible inmates in Medicaid before their release, and that some jail staff do not view Medicaid enrollment as a responsibility of the jail. Yet enrolling eligible inmates in Medicaid before their release is a best practice that allows people with mental illness to access medication and physical and behavioral health treatment immediately once they are in the community. Washington's health care integration initiative creates new opportunities for jails and mental health providers or health plans to cooperate in enrolling inmates and seeing that they make a successful transition to Medicaid-funded treatment and services upon release.

How:

- Automate the suspension and reactivation of Medicaid benefits as people are booked into and released from jail. Washington already is on track to implement suspension (versus termination) of Medicaid benefits upon incarceration, beginning in July 2017.

- Use contract provisions with providers and health care plans to mandate the provision of in-jail transition planning and integrate financial disincentives, such as holdbacks, for jail bookings of plan members (similar to emergency department visits or hospital readmissions). For in-jail transition planning, include performance measures such as the following:

    - Enroll 100 percent of eligible detainees in Medicaid within 24 hours of booking.

    - Meet with and develop a transition plan for detainees within 72 hours of booking.

    - Connect departing inmates with appropriate physical and behavioral health providers and ensure that they attend appropriate appointments within 72 hours of release.

- Develop the infrastructure for an electronic information exchange that alerts health plans when their enrollees are booked in jail.

- Encourage providers to use peer support specialists to support people with mental illness who leave jails, to assist with case management; escort people to court, treatment, and initial care appointments; and provide other support services. (See the Maricopa County, Arizona, example in Appendix A.)

- Establish statewide guidelines for jail access by providers, including peer support specialists. Currently, screening criteria for providers vary significantly across counties, with some jails excluding peer support specialists who have criminal histories, for example.

- Establish statewide standards for the provision of medication to inmates being released from jail. Current practices in Washington vary greatly from jail to jail.

Court-based Solutions

6) **Where practicable, implement a community-based competency restoration process to divert individuals with severe, acute, and chronic mental health issues from jail and unnecessary hospitalization.**

Why: In community-based competency restoration programs, participants reside in the community while they participate in restoration and other treatment. Case plans are individualized and the level of housing and treatment is tailored to the needs of each person. Some people may be sufficiently stable to remain in their apartment, but others may need more structured housing, such as a sub-acute or transitional housing facility. Community-based restoration programs reduce the use of state hospital and jail beds. They also decrease unnecessary disruption in the lives of people with severe mental illness and allow for services to be individualized and be more culturally appropriate.

How:

- Model programming, including legal skills education, on existing programs at the state hospital or on other jurisdictions' community-based restoration programs.
- Integrate a continuum of residential and treatment options into community-based competency restoration programs to allow for individualized case plans that ensure participants are safely housed, treated, and supervised.

7) **Modify the competency restoration process to reduce the volume of unnecessary evaluations and jail wait times and more effectively support access to treatment for those who need it.**

Why: Interviewees indicated that there is significant room for improvement in the misdemeanant and non-violent, low-level felony competency-to-stand-trial (CST) processes, as well as the process used for "flipping" those cases to the civil involuntary treatment act (ITA) process.

Before 1999, only defendants charged with felonies were eligible for competency restoration. But in 1999, Washington modified the CST code to include certain misdemeanors. To be eligible for misdemeanant restoration a defendant needs to have one of the following: (1) a history of one or more violent acts, (2) a pending charge of one or more violent acts, (3) previous acquittal by reason of insanity for a crime involving physical harm to another, or (4) a previous finding of incompetence to stand trial for a crime involving physical harm to another (Leong 2006).

It is a fairly low standard to meet the determination of CST. A defendant can meet the standard by having knowledge of the charge and its possible consequences, being able to communicate with their attorney to develop a defense, having knowledge of courtroom procedures and personnel, and being able to efficiently use this knowledge in either a trial or a plea bargain scenario.

"Flips" occur when a person charged with either a misdemeanor or felony is found both not competent to stand trial and not restorable through the process outlined in the RCW. Depending on the seriousness of the crime, whether the person is still in jail, and the recommendation of the forensic psychologist who completed the competency evaluation,

the judge may order a DMHP to evaluate the person for a "flip" from the criminal process to the civil ITA process.

Interviewees indicated that (1) for many misdemeanants who are evaluated as not competent to stand trial, the amount of time the RCW allows for restoration is not enough, (2) some misdemeanants and people charged with low-level felonies are being referred for competency evaluations unnecessarily, and (3) some misdemeanant and low-level felony competency cases would be more appropriately handled through diversion to community-based treatment, assisted outpatient treatment (AOT), or the ITA process, and (4) many end up going through the ITA process after multiple attempts at restoration. These issues contribute to backlog and wait times for both evaluation and restoration beds at the state hospital, thus extending the time these individuals wait in jail, increasing case processing time and costs, and further damaging the mental health status of the defendants, all for relatively low-level charges (often the result of medication non-compliance).

How:

- When competency evaluations are requested by the parties to a case, use a competency prescreening tool (administered by a mental health practitioner) to evaluate the need for a competency evaluation. Interviewees for this study reported that approximately 60 percent of competency evaluation orders result in findings of not competent. A competency screening process currently being used in Snohomish County has reduced the number of full evaluations and the wait time for evaluations. Following an order from the court, a mental health professional employed by the jail conducts a competency prescreen and then submits a written report to the prosecutor, public defender, and the court.[2]

- Consider eliminating the competency restoration process for misdemeanants and people charged with low-level, non-violent felonies. Instead, prescreen those cases (as described above) and divert people who are possibly not competent to stand trial to community-based treatment, or for evaluation through the civil AOT or ITA processes (whichever is the appropriate and less restrictive alternative). This option is only valid if the continuum of community-based treatment capacity is sufficient to treat these individuals.

- If eliminating the CST restoration process is not possible, change the CST code (RCW 10.77.088) to exclude people with issues such as traumatic brain injury, dementia, and developmental disabilities from the CST restoration process.

Second-Tier Recommendations

Community-based Solutions

8) Establish a mechanism to fund street outreach and engagement activities by peer support specialists/community health workers.

Why: Interviewees indicated that 50 percent of involuntary commitments under Washington's Involuntary Treatment Act (ITA) involve people who have not yet been engaged in mental health treatment. If peer support specialists can conduct outreach and develop trusting relationships with the unserved 50 percent, those individuals can be

[2] Rule 4.11 https://snohomishcountywa.gov/DocumentCenter/View/4225

connected to needed treatment or support services and thus possibly avoid future encounters with law enforcement and/or involuntary commitments.

How: Explore options for Medicaid funding of outreach and engagement activities or fund with state dollars.

9) Increase collaborative planning between criminal justice partners and representatives of physical and behavioral health organizations.

Why: Washington is embarking on a health care reform initiative that will integrate the delivery of physical health, mental health, and substance use disorder services for Medicaid clients, including many who are involved in the criminal justice system. Although physical and behavioral health organizations have been involved in planning for this integration, criminal justice system stakeholder involvement appears to have been limited. For example, only one of the nine Accountable Community of Health (ACH) pilot programs focuses on justice-involved individuals. (That program is Better Health Together's Pathways Hub Pilot, which will connect people transitioning out of the Ferry County jail and their families to stabilizing services.)

Most justice-involved individuals soon will become clients of integrated health organizations. Collaborative planning would increase cross-system understanding, allow for more advocacy for the needs of justice-involved clients, and encourage information sharing and coordination between jails and providers regarding assessment, medication, treatment, and transition planning for inmates with chronic and acute health care needs, mental illness, and/or substance abuse disorders.

How:

- Require that criminal justice leadership take a seat at the table with the Accountable Communities of Health and on other health integration planning initiatives.

- Change Revised Code of Washington (RCW) 72.09.300 to include physical and behavioral health representation on the local law and justice councils.

Jail-based Solutions

10) Identify and prioritize detained high utilizers of multiple systems (HUMS) for robust transition planning and wraparound services upon release.

Why: High utilizers of multiple systems (HUMS) are people who continually cycle in and out of both the criminal justice and physical and behavioral health crisis systems, making frequent use of jails, courts, hospital emergency rooms, and shelters. HUMS represent a relatively small proportion of the community but use a large amount of system resources. King County, for example, has estimated that at any given time there are 2,000 high utilizers of the jail in the county, meaning people who have been booked into the county jail at least four times in a single year. This represents a minimum of 8,000 bookings a year attributable to high utilizers, not counting additional booking at the municipal jail.

By expanding this analysis to include high utilizers not just of jails but also of physical and behavioral health systems, jurisdictions would be able to target these individuals for specific services, reduce system costs, and better meet the needs of the individuals.

Several counties we visited already are examining the level of jail resources used by high utilizers but few have expanded that analysis to include multiple systems.

How:

- Provide counties with funding and technical assistance to identify HUMS and analyze data about them to better understand the unmet needs that drive their intensive use of jails and crisis resources. (Some counties already have completed this work, although their analyses often focused only on high utilizers of the jail.)

- Where practicable, implement a single case manager structure for HUMS, such as the Pathways Community Hub model of community care coordination.

- Provide health literacy education to HUMS.

Court-based Solutions

11) Support the establishment of pretrial release programs statewide.

Why: Pretrial release programs that use evidence-based risk assessment tools to guide release decisions provide a mechanism to assess and identify defendants who can safely be released to the community while awaiting trial. Because jail stays disrupt defendants' jobs, housing, and family connections and contribute to recidivism (especially for low-risk defendants and those with mental illness), pretrial release programs can help decrease failure-to-appear rates and new crimes. Additionally, monetary bail systems that do not consider risk in release decisions allow high-risk defendants to go free, thus decreasing public safety.

Information gathering for this report indicates that although some Washington jurisdictions have supervised pretrial release programs, few of them use formal risk assessment tools.

There have been concerns about the potential racial bias of assessment tools. However, bias can be mitigated by using tools that are validated as race and gender neutral, such as the Laura and John Arnold Foundation's Public Safety Assessment (PSA) tool. The PSA evaluates the likelihood that if a defendant is released before trial, s/he will (1) commit a violent crime, (2) commit any new crime, or (3) fail to appear for court. In determining a detainee's risk score, the PSA does not use information such as housing, zip code, or employment that are believed to contribute to racial bias. Instead, the PSA's algorithm includes factors such as whether the current offense is violent, whether the person had a pending charge at the time of arrest, whether the person has a prior misdemeanor conviction, whether the person has a prior felony conviction, whether the person has a prior conviction for a violent crime, the person's age at the time of arrest, whether the person failed to appear at a pretrial hearing within the last two years, whether the person failed to appear at a pretrial hearing more than two years ago, and whether the person has previously been sentenced to incarceration. The PSA does not consider factors that could be discriminatory such as race, gender, level of education, socioeconomic status, and neighborhood. It is available at no cost and is currently being used in 29 jurisdictions, including statewide in Arizona, Kentucky, and New Jersey. Although the data from jurisdictions using the PSA indicate that the instrument is both race and gender neutral (Laura and John Arnold Foundation), and that it does not exacerbate bias, the tool does not eliminate or neutralize years of systemic bias that has led to higher rates of justice system involvement by people of color.

The Washington State Minority and Justice Commission and Washington trial judges have expressed interest in exploring pretrial reform across the state. The Washington State District and Municipal Court Judges' Association and Washington State Superior Court Judges' Association both have recently voted in favor of applying for participation in 3DaysCount, "a nationwide initiative to reduce unnecessary arrests that destabilize families and communities, replace discriminatory money bail with practical, risk-based decision-making, and restrict detention (after due process) to the small number of people who pose a genuine threat to public safety" (Pretrial Justice Institute). The initiative works with states to "improve state statutes and court rules, improve state constitutions, implement statewide evidence-based tools, and empower and mobilize community" (Pretrial Justice Institute). These three entities are exploring the formation of a task force focused on pretrial reform. Such a cooperative effort bodes well for taking steps toward building a pretrial system that includes a consistent and research-based approach to pretrial assessment and release strategies.

How:

- Support the cooperative efforts of the judiciary as they convene a task force focused on pretrial reform.

12) Modify specialty court policies and practices to better reflect the evidence regarding their effectiveness and to increase participation and efficiency.

Why: Specialty courts provide a method of diverting individuals from the traditional case processing system. Drug, mental health, co-occurring, competency, and community courts all serve special populations with high needs. Participating in a specialty court is voluntary. It usually requires that an individual regularly attend court, participate in treatment, be under supervision, receive intensive case management, complete community services, and pay fees, fines and restitution. If a defendant fulfills all of the requirements specified by the court, his or her charges may be dismissed or reduced.

Often the requirements of participating in the specialty court process and the length of participation are disincentives to participation. Defendants may instead choose to plead guilty to the charges in traditional court and serve their sentence, which often is a much shorter amount of time. This was the case in the counties we visited for this study, where participation in mental health courts is low. In Seattle, for example, interviewees reported that only 25 people chose to participate in the city's Municipal Mental Health Court during the first half of 2016, out of 415 people who were referred.

Additionally, the costs of operating a mental health court are relatively high (Steadman et al. 2014), yet the courts often do not use criminogenic risk level (i.e., risk of reoffending) as a criterion of participation. Instead, courts often have charge-based criteria for participation, with many courts accepting only misdemeanants. Research indicates that systems should reserve their most intensive resources for offenders who are at high risk of reoffending (The Pew Center on the States 2009). It also indicates that, regardless of charge type, for low-risk offenders, less intensive services are more effective and less costly than mental health courts (King and Pasquarella 2009, as cited in Griller 2011).

Modifying the policies and practices of Washington's specialty courts to better align with risk-based principles would potentially improve outcomes and make the courts a more cost-effective option for diverting people with mental illness from jail.

How:

- In counties with high volumes of competency cases, consider establishing competency courts, to more efficiently process these cases.

- Use recovery models as the basis for the work of specialty courts, rather than abstinence models. For example, operate courts understanding that relapse is part of the recovery process, and allow for medication-assisted therapy (MAT). MAT is an evidence-based practice that helps people address their substance abuse disorder, stabilize, and be able to take further steps toward recovery. (Presumably MAT will become easier to administer starting in February 2017, when new Department of Health and Human Services policies go into effect that will allow nurse practitioners and physician assistants to prescribe buprenorphine, a medication used to treat opioid addiction.[3])

- Change the eligibility requirements for participation in specialty courts to focus on medium- and high-risk offenders, with an emphasis on felony charges. Determine participation based on the results of actuarial risk assessments, rather than solely on charge type, so as to make better use of resources (i.e., focus these specialty court-related resources, which are relatively expensive, on the highest risk offenders). Currently in most specialty courts, eligibility criteria are based on charges and the courts accept only misdemeanants.

- Where practicable, establish co-occurring courts, which can more efficiently and comprehensively address the complex needs of the many defendants who have co-occurring mental health and substance use disorders.

Third-Tier Recommendations

Community-based Solutions

13) Increase understanding locally and at the state level of which services are in place and which are missing at the various points where the criminal justice and mental health systems intersect.

Why: The state has not brought together mental health and criminal justice stakeholders in a coordinated effort to examine how the two systems intersect, the needs of justice-involved people with mental illness, and the availability of forensic-focused services for people with mental illness.

How: Conduct a statewide and regional intercept mapping process with healthcare, behavioral health, law enforcement, and criminal justice stakeholders to clearly identify needs and system gaps at each intercept point and to develop a comprehensive plan to address those gaps at the state and regional levels.

14) Provide 24/7 telephonic psychiatric consultation to law enforcement in the field, especially in more rural areas.

Why: Law enforcement officers in rural areas do not have access to as many services as those in more urban areas. Crisis services such as mobile crisis units and law enforcement/mental

[3] http://www.hhs.gov/about/news/2016/11/16/additional-steps-expand-opioid-treatment.html.

health clinician co-response teams, in particular, are much less available in rural areas. Interviewees indicated that, when faced with people on scene who are experiencing a mental health crisis, officers in rural areas would benefit from phone-based consultation with mental health professionals to support appropriate response and de-escalation attempts.

How: Establish a professionally staffed consultation line (available 24/7 to rural counties) that provides law enforcement officers with immediate, direct access to mental health professionals, for information and consultation regarding people with mental illness who they encounter in the field.

15) Replicate King County's Law Enforcement-Assisted Diversion (LEAD) program in other large urban areas.

Why: LEAD is a front-end diversion program in which law enforcement officers, criminal justice professionals, and behavioral health providers collaborate to successfully divert low-level drug and prostitution offenders from jail and into intensive case management and supportive services. Although LEAD does not specifically target people with mental illness, many of its participants suffer from severe mental illness; this overlap is consistent with the high rate of co-occurring mental illness and substance use disorders that interviewees described in the potential diversion population. Outcome evaluations of LEAD have shown success in King County as a means of diverting people from jail before arrest, reducing recidivism, and increasing their stability and success in the community. The program has the potential to provide similar benefits in other large urban areas in Washington, particularly where low-level criminal activity that is related to mental illness and/or substance abuse disorders is concentrated in certain geographical areas.

How:

- Fund replication pilots in larger, more urban jurisdictions across the state.
- Direct the Washington State Institute for Public Policy (WSIPP) to conduct a cost/benefit analysis of the LEAD program to inform potential expansion and multi-site replication. LEAD is being replicated in jurisdictions across the country, but not within Washington.

Jail-based Solutions

16) Increase leveraging of Medicaid funding for jail diversion and reentry program components, such as enrollment in Medicaid, assessment, care plan development, service referral, and monitoring.

Why: Washington is not taking full advantage of Medicaid administrative match (MAM) and targeted case management (TCM) opportunities as they relate to jail and Department of Corrections (DOC) inmates who are eligible for Medicaid, are transitioning to the community, and need care connections. Some opportunities to leverage Medicaid funding are being explored or are in the early stages of development.

How:

- Direct the Washington Health Care Authority (HCA) to more thoroughly explore opportunities to use MAM and TCM in jails, DOC prisons, and community corrections.

- As the DOC implements MAM reimbursement for Medicaid enrollment activities, replicate that process in large jails and/or make those services available remotely to jails through DOC.

17) For people on community supervision who are mentally ill and commit a technical violation of their probation, encourage the use of alternatives to jail as sanctions.

Why: DOC's Community Corrections Division's swift and certain policies state that offenders may be sanctioned to jail for technical violations of their probation. Confining offenders with mental illness in jail as a consequence for technical violations may not achieve the same benefit as it does for the general population. Instead, detention may contribute to decompensation and worsening of conditions related to mental illness, without having a cautionary effect.

How: Modify swift and certain policies for community supervision to encourage (1) the use of alternative sanctions, such as participation in treatment programs, for individuals with severe mental illness, and (2) increased cooperation and information sharing between community corrections officers and community-based providers.

18) Require E&Ts and other acute residential facilities to accept jail detainees who have been evaluated and referred by a DMHP.

Why: Interviewees reported that DMHPs sometimes resist conducting evaluations of jail inmates because, after determining that an inmate meets criteria for involuntary commitment under the ITA, it is often very challenging, if not impossible, to find a mental health facility willing to admit that person. Requiring facilities to admit these individuals would allow jails (with a DMHP's referral and judge's order) to temporarily transfer inmates who are decompensating to a more appropriate facility.

How: Build incentives to serve clients who have been evaluated and referred by a DMHP into provider and health plan contracts.

Court-based Solutions

19) Keep people who slap or spit on a nurse, physician, or health care provider who is performing his or her nursing or health care duties from being charged with assault in the third degree (a Class C felony) and instead charge them with assault in the fourth degree (a gross misdemeanor).

Why: Interviewees indicated that the recent revision of Washington code to include caregivers as a protected class has resulted in the inappropriate detainment in jail of elderly people and people with dementia, traumatic brain injuries, or severe mental illness who spit at or slapped their facility caregivers. Jail representatives described several such cases, including one in which an 80-year-old woman with dementia slapped a caregiver in a nursing home and so was arrested and detained in the jail. Jails are not equipped to provide the necessary care to this type of inmate, who is vulnerable to victimization from other inmates and must be isolated, has high medical and behavioral health needs, and often has mobility challenges.

How: Change Revised Code of Washington (RCW) 9A.36.031, which defines assault in the third degree as a Class C felony, to eliminate Section (1) (i): "Assaults a nurse, physician, or

health care provider who was performing his or her nursing or health care duties at the time of the assault."

Training- and Workforce-based Solutions

20) Increase mental health, law enforcement, and criminal justice professionals' cross-disciplinary understanding of how Washington's criminal justice and behavioral health systems work.

Why: Interviewees indicated that mental health, law enforcement, and criminal justice professionals lack understanding of how systems other than theirs function. As jurisdictions expand their use of co-response teams, mobile crisis teams, and diversion to behavioral health treatment providers, cross-disciplinary understanding will become increasingly important. For greatest effectiveness, professionals in each field need to be able to interact and learn more about how the three systems intersect.

How: Develop and integrate cross-system educational curricula into existing training opportunities, both for new employees and as continuing education requirements.

21) Support organizational culture change for law enforcement agencies.

Why: Although crisis intervention training (CIT) can help individual officers develop the skills needed to interact more effectively with people with mental illness, these skills often fade if the organization does not fully support, value, and reward them. Building organizational support for this new way of interacting with people in the community often requires substantial culture change. Organizational development and change management literature indicates that targeting supervisors and mid-managers for corresponding leadership and related skill development can help achieve this type of change.

How: Fund statewide leadership development training for law enforcement supervisors and managers.

22) Increase educational opportunities for behavioral health professionals who serve justice-involved individuals who have mental illness.

Why: Behavioral health professionals often receive no specific training in how to address the complex needs of justice-involved individuals who have behavioral health needs.

How:

- For mid-career behavioral health professionals who are serving justice-involved clients, develop and deliver training on the complex needs of these individuals.

- Partner with universities to (1) develop certificate programs for behavioral health services for justice-involved populations, and (2) offer practicum opportunities in agencies that serve this population.

Data and Information Management Solutions

23) Improve the availability and sharing of electronic medical records (EMRs) in jails and prisons.

Why: DOC and many jails do not use electronic medical records (EMRs) and instead still rely on paper files. This makes it difficult to efficiently access information about a detainee's

physical and behavioral health history from previous stays or from other facilities. Not having EMRs also hampers the sharing of information between incarceration facilities and community-based treatment providers.

Using EMRs to quickly and efficiently share appropriate information about detainees would improve the transition from an institution to community-based treatment and help maintain a continuum of care for people with mental illness.

How:

- Purchase EMR systems for DOC and those jails that currently lack them, so that DOC and jails have efficient access to information on inmates' physical and behavioral health histories and can share that information appropriately with other facilities and community-based providers.

- Explore the use of SureScripts ePrescribing system as a mechanism to share prescribing information between criminal justice and community-based providers as an interim solution until an electronic health information exchange is established.

- Develop the infrastructure for an electronic health information exchange between DOC, jails, and community providers that informs these entities of the types of services and medications that inmates enrolled in Medicaid have accessed in the community.

24) Analyze existing data to better understand the needs of the justice-involved population—including people with mental illness—and identify current system capacity and service issues.

Why: The state needs to better understand the physical and behavioral health needs of the justice-involved population, including people with mental illness. Currently, it is difficult to know the volume of treatment needs for this population, how many justice-involved individuals are eligible and enrolled in Medicaid, how long it takes them to access services once they have transitioned from incarceration facilities back to the community, and whether their wait times for care are longer than those of the general population.

These questions must be answered if the criminal justice and physical and behavioral health systems are to be held accountable for providing the accepted standard of care to justice-involved individuals. The DSHS Research and Data Analysis Division (RDA) has indicated that most of the relevant data are available. However, RDA does not have the ongoing data sharing agreements with jails across the state that would be needed to access and analyze the data.

How:

- Direct RDA to establish ongoing data use agreements with jails.

- Direct RDA to analyze Medicaid, jail, and DSHS data to better understand the impacts of state funding changes and Medicaid expansion on the population of people with mental illness who are being jailed. What percentage of people in jail are eligible for Medicaid, and what percentage of inmates with mental illness are eligible for Medicaid? Are they enrolled? Have they accessed services? Why or why not? Are their wait times longer than those of the non-justice-involved population? What does this say about the

availability and effectiveness of behavioral health treatment for the justice-involved population?

Section 5

References

Aidala, A.A., W. McAllister, M. Yomogida, and V. Shubert. 2013. Frequent Users Service Enhancement 'Fuse' Initiative: New York City Fuse Ii Evaluation Report. Columbia University, Mailman School of Public Health.

Alakeson, V., N. Pande, and M. Ludwig. 2010. "A Plan To Reduce Emergency Room 'Boarding' Of Psychiatric Patients." Health Affairs. September 2010, Vol. 29, No. 9, 1637-1642. Available at http://content.healthaffairs.org/content/29/9/1637.full.

Almquist, L., and E. Dodd. 2009. Mental Health Courts: A Guide to Research-Informed Policy and Practice. Council of State Governments Justice Center. Supported by the MacArthur Foundation. Available at https://www.bja.gov/Publications/CSG_MHC_Research.pdf.

Bazelon Center for Mental Health Law. 2009. The Effect of Incarceration on Medicaid Benefits for People with Mental Illness. Developed under a grant from the Department of Education, NIDRR grant number H133B080029. Available at http://www.bazelon.org/Where-We-Stand/Access-to-Services/Medicaid/Medicaid-Policy-Documents.aspx.

Bazelon Center for Mental Health Law. 2010. Supported Employment Fact Sheet. Available at http://www.bazelon.org/LinkClick.aspx?fileticket=IVd2OXBERnI%3D&tabid=350.

Brodsky, M. 2012. Residential Treatment — When to Consider It, What to Look For. Social Work Today. March/April 2012 Issue. Vol. 12, No. 2, P. 8. Available at http://www.socialworktoday.com/archive/031912p8.shtml.

Broner, N., D.W. Mayrl, and G. Landsberg. 2005. "Outcomes of Mandated and Non-Mandated New York City Jail Diversion for Offenders with Alcohol, Drug, and Mental Disorders." The Prison Journal 85(1):18-49.

Buntin, J. 2015. "Miami's Model for Decriminalizing Mental Illness in America." Governing the States and Localities. August 2015. Available at http://www.governing.com/topics/public-justice-safety/gov-miami-mental-health-jail.html.

Burt, M., and J. Anderson. 2005. AB.2034 Program Experiences in Housing Homeless People with Serious Mental Illness. Oakland, CA: Corporation for Supportive Housing. http://documents.csh.org/documents/ca/csh_ab2034.pdf. (Accessed January 25, 2006.)

Camilletti, C. 2010. Pretrial Diversion Programs: Research Summary. Bureau of Justice Assistance, U.S. Department of Justice. Available at https://www.bja.gov/Publications/PretrialDiversionResearchSummary.pdf.

Carabello, K. 2013. Jail-Based Restoration of Competency Program Fact Sheet. Testimony provided March 28, 2013, by Ken Carabello, Vice President of Operations, Liberty Healthcare Corporation. Available at http://www.leg.state.nv.us/Session/77th2013/Exhibits/Senate/JUD/SJUD623F.pdf.

Center for Problem-Oriented Policing. 2005. Psychiatric Emergency Response Team and Homeless Outreach Team: San Diego Police Department. Available at http://www.popcenter.org/library/awards/goldstein/2005/05-12.pdf.

Clifasefi, S.L., H.S. Lonczak, and S.E. Collins. 2016. LEAD Program Evaluation: The Impact of LEAD on Housing, Employment and Income/Benefits. Harm Reduction Research and Treatment Center University of Washington – Harborview Medical Center. March 31, 2016. Available at http://static1.1.sqspcdn.com/static/f/1185392/27047605/1464389327667/housing_employment_evaluation_final.PDF?token=%2BGd%2BQD%2Fc0lpefHydWkfxkJklt60%3.

Cohen, R. 2013. OLR Research Report: The Affordable Care Act and Prisoners, August 13, 2013. Available at: http://www.cga.ct.gov/2013/rpt/2013-R-0288.htm.

Collins, S.E., H.S. Lonczak, and S.L. Clifasefi. 2015. LEAD Program Evaluation: Criminal Justice and Legal System Utilization and Associated Costs. Harm Reduction Research and Treatment Lab University of Washington – Harborview Medical Center. June 24, 2015. Available at http://static1.1.sqspcdn.com/static/f/1185392/26401889/1437170937787/June+2015+LEAD-Program-Evaluation-Criminal-Justice-and-Legal-System-Utilization-and-Associated-Costs.pdf?token=2kAXwtFY99Ctvp2ho5LCwhiTk2Y%3D.

Colorado Department of Human Services. Jail Based Behavioral Health Services (JBBS). Available at https://sites.google.com/a/state.co.us/cdhs-behavioral-health/home/community-behavioral-health/programs-and-services/services-for-people-involved-in-criminal-justice/jail-based-behavioral-health-services-jbbs. Viewed November 4, 2016.

Community Oriented Corrections Health Services (COCHS). 2013. Frequently Asked Questions (FAQs): The Affordable Care Act (ACA) and Justice-Involved Populations. May 2013. Available at http://cochs.org/files/ACA/COCHS_FAQ_ACA.pdf.

Community Oriented Corrections Health Services (COCHS). 2015. Frequently Asked Questions (FAQs): The Medicaid Administrative Claiming (MAC) Program. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_MAC.pdf.

Community Oriented Corrections Health Services (COCHS). 2015. Frequently Asked Questions: Medicaid Administrative Claiming FAQs For District Attorneys. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_FAQ4_DAs.pdf.

Community Oriented Corrections Health Services (COCHS). 2015. Issue Paper: Medicaid Claiming and Public Safety Agencies. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_Public_Safety.pdf.

Community Oriented Corrections Health Services (COCHS). 2015a. Frequently Asked Questions (FAQs): The Medicaid Administrative Claiming (MAC) Program. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_MAC.pdf.

Community Oriented Corrections Health Services (COCHS). 2015b. Issue Paper: Medicaid Claiming and Public Safety Agencies. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_Public_Safety.pdf.

Community Oriented Corrections Health Services (COCHS). 2015c. Frequently Asked Questions: Medicaid Administrative Claiming FAQs For District Attorneys. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_FAQ4_DAs.pdf.

Cook, J.A., et. al. 2005. Results of a Multisite Randomized trial of Supported Employment Interventions for Individuals With Severe Mental Illness, Archives of General Psychiatry, May 2005.

Council of State Governments. 2002. Criminal Justice/Mental Health Consensus Project. Document No. 197103. June 2002.

Cowell, A.J., A. Aldridge, N. Broner, and J.M. Hinde. 2008. A Cost Analysis of the Bexar County, Texas, Jail Diversion Program. Report 2: An Analysis of Cost-Shifting between the Treatment and Criminal Justice Systems. Prepared for Leon Evans, President/Executive Officer, The Center for Health Care Services. RTI Project Number 0209991.000. May 2008.

Cox, S.M., D. Mitchell, and R. Tirnady. 2010. The Final Report of the Evaluation of the Court Support Services Division's Mental Health Case Management Pilot Project. Department of Criminology and Criminal Justice, Central Connecticut State University. June 2010. Available at http://www.jud.ct.gov/cssd/research/Ev_CSSD_MentalHealth_CMPP.pdf.

Culhane, D.P., S. Metraux, and T. P. Hadley. 2002. "Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing." Housing Policy Debate 13: 107–162.

Culhane, D.P., W. Parker, B. Poppe, K. Gross, and E. Sykes. 2007. "Accountability, cost-effectiveness, and program performance: Progress since 1998." In Toward Understanding Homelessness: The 2007 National Symposium of Homelessness Research, edited by D. Dennis, G. Locke, and J. Khadduri. Washington, DC: U.S. Department of Health and Human Services and U.S. Housing and Urban Development.

De Hert, M., C.U. Correll, J. Bobes, M. Cetkovich-Bakmas, D. Cohen, I. Asai, J. Detraux, S. Gauman, H. Möller, D.M. Ndetei, J.W. Newcomer, R. Uwakwe, and S. Leucht. 2011. Physical Illness in Patients with Severe Mental Disorders. I. Prevalence, Impact of Medications and Disparities in Health Care. Educational module in World Psychiatry. Feb 2011; 10(1): 52–77.

Disability Rights California. Placement of Individuals Found Incompetent to Stand Trial: A Review of Competency Programs and Recommendations. Publication #CM52.01. Available at http://www.disabilityrightsca.org/pubs/CM5201.pdf.

Eau Claire County. 2016. Criminal Justice Report – 2015 CJCC Review. Available at http://co.eau-claire.wi.us/home/showdocument?id=11102.

Fan, Z.J., B.A. Lucenko, S. Estee, B.E.M. Felver, C. Black, D. Mancuso. Improving Employment Outcomes for People with Mental Health Disorders in Washington State. Prepared in collaboration with Melodie Pazolt, Behavioral Health Program Administrator, Division of Behavioral Health and Recovery, Behavioral Health Administration.

Fazel, S., G. Gulati, L. Linsell, J.R. Geddes, and M. Grann. 2009. "Schizophrenia and Violence: Systemic Review and Meta-analysis." PLoS Medicine, 6, e1000120.

Ferguson, J. Research analyst, Maricopa County Adult Probation. Personal communication. November 1, 2016.

Fontaine, J., D. Gilchrist-Scott, J. Roman, S. Taxy, and C. Roman. 2012. Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home—Ohio Pilot Project. The Urban Institute Justice Policy Center. August 2012.

Fox, Patrick. Chief medical officer, Colorado Department of Human Services. Personal communication. October 24, 2016.

Gilger, Lauren. 2016. 24 Hours From Arrest To Release To Services For Seriously Mentally Ill In New Program. Available at http://kjzz.org/content/368554/24-hours-arrest-release-services-seriously-mentally-ill-new-program. September 22, 2016.

Griller, G.M. 2011. The Quiet Battle for Problem-Solving Courts. National Center for State Courts. Available at http://www.ncsc.org/sitecore/content/microsites/future-trends-2011/home/Specialized-Courts-Services/3-1-The-Quiet-Battle-for-Problem-Solving-Courts.aspx.

Hanig, D. 2015. New Tools to Improve Health of Jail-involved Population. October 1, 2015. Available at https://www.optum.com/resources/library/justice-involved.html.

Hanig, D. 2015. New Tools to Improve Health of Jail-involved Population. October 1, 2015. Available at https://www.optum.com/resources/library/justice-involved.html.

Health Care Finance Agency Program Issuance Transmittal Notice Region IV (Mar. 6, 1998) (transmitting policies set forth in the December 1997 policy letter to Medicaid agencies in AL, FL, GA, KY, MS, NC, SC, and TN.

Henzel, P.D., J. Mayfield, A. Soriano, and B.E.M. Felver. 2016. Behavioral Health Needs of Jail Inmates in Washington State. Report to the Washington State Office of Financial Management's Statistical Analysis Center, Thea Mounts, Director, and Keri-Anne Jetzer, Forecast Analyst. DSHS Research and Data Analysis Division, Olympia, Washington. RDA Report 11.226. January 2016.

Highland Community News. 2015. San Bernardino County to Expand its Jail-Based Restoration of Competency Program. August 20, 2015. Available at http://www.highlandnews.net/news/public_safety/san-bernardino-county-to-expand-its-jail-based-restoration-of/article_6754c8ca-4755-11e5-97ae-e7c4bc4dade2.html.

Huckelberry, C.H. 2013. Memorandum to the Honorable Chairman and Members, Pima County Board of Supervisors, re: Crisis Center Annual Report. February 26, 2013. Available at http://webcms.pima.gov/UserFiles/Servers/Server_6/File/Government/Administration/CHHmemosFor%20Web/February%20Memos/February%2026,%202013%20-%20Crisis%20Response%20Center%20Annual%20Report.pdf

Immarigeon, R., and J. Greene. 2008. Diversion Works: How Connecticut Can Downsize Prisons, Improve Public Safety and Save Money with a Comprehensive Mental Health and Substance Abuse Approach. A Better Way Foundation Report. Commissioned by the Drug Policy Alliance. April 2008. Available at http://www.drugpolicy.org/sites/default/files/DiversionWorks.pdf.

Joseph P. Morrissey, Gary S. Cuddeback, Alison Evans Cuellar & Henry J. Steadman, The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons With Severe Mental Illness, 58 Psychiatric Services 794, 799-800 (2007).

Kentucky Cabinet for Health and Family Services. Kentucky Jail Mental Health Crisis Network. Available at http://dbhdid.ky.gov/dbh/jail-triage.aspx. Viewed November 1, 2016.

Kessler, R.C. et al. (1999) as cited in Council of State Governments, 2002, Criminal Justice/Mental Health Consensus Project. Document No. 197103. June 2002.

Kessler, R.C. et al. 1999. "A Methodology for Estimating the 12- Month Prevalence of Serious Mental Illness." In Mental Health United States 1999. Edited by R.W. Manderscheid and M. J. Henderson. Rockville, MD: Center for Mental Health Services, 1999.

King, R.S., and J. Pasquarella. Drug Courts: A Review of the Evidence. 2009. The Sentencing Project. April 2009. Available at http://www.sentencingproject.org/wp-content/uploads/2016/01/Drug-Courts-A-Review-of-the-Evidence.pdf.

Laura and John Arnold Foundation. Public Safety Assessment. Available at http://www.arnoldfoundation.org/initiative/criminal-justice/crime-prevention/public-safety-assessment/. Viewed November 15, 2016.

Leifman, S. 2009. "Eleventh Judicial Circuit Criminal Mental Health Project." Future Trends in State Courts 2009. National Center for State Courts. Available at http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/201.

Leong, G.B. 2006. "Commentary: Restorability of Incompetence to Stand Trial-Implications Beyond Predictive Equations." The Journal of American Academy of Psychiatry and the Law. March 2006, 35 (1) 44-46. Available at http://jaapl.org/content/35/1/44.full.

Letter from Associate Regional Administrator, Division of Medicaid and State Operations, Region II, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State (September 14, 2000), confirmed in a Letter from Secretary of Health and Human Services to Congressman Charles Rangel, (October 1, 2001).

Letter from Associate Regional Administrator, Division of Medicaid and State Operations, Region II, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State (September 14, 2000), confirmed in a Letter from Secretary of Health and Human Services to Congressman Charles Rangel, (October 1, 2001).

Letter from Robert A. Streimer, Dir., Disabled and Elderly Health Programs Grp., Ctr. for Medicaid and State Operations, Dep't of Health & Human Servs., to All Associate Regional Adm'rs., Div. for Medicaid and State Operations 1 (Dec. 12, 1997)

Letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives (April 6, 2000). See also Letter from Associate Regional Administrator, Division of Medicaid and State Operations, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State (September 14, 2000).

Letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives (October 1, 2001).

Letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives (April 6, 2000). See also Letter from Associate Regional Administrator, Division of Medicaid and State Operations, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State (September 14, 2000).

Letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives (October 1, 2001).

Lin, H., L. Frisman, and C. Gallagher. 2013. Expedited Medicaid Restoration in Connecticut, American Public Health Association Annual Meeting, Boston, MA. November 2013.

Lin, H., L. Frisman, and C. Gallagher. 2013. Expedited Medicaid Restoration in Connecticut. American Public Health Association Annual Meeting, Boston, MA. November 2013.

Maurer, K., Health Services Director, Connecticut Department of Corrections. Personal communication. September 27, 2016.

McKee, C., S. Somers, S. Artiga, and A. Gates. 2015. State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration. Issue brief. August 2015. Available at http://cochs.org/files/medicaid/issue-brief-state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration.pdf.

McKee, C., S. Somers, S. Artiga, and A. Gates. 2015. State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration. Issue brief. August 2015. Available at http://cochs.org/files/medicaid/issue-brief-state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration.pdf.

Monahan and Steadman. 2012. "Extending Violence Reduction Principles to Justice-involved Persons with Mental Illness." In J.Dvoskin, J. Skeem, R. Novaco, and K. Douglas (Eds). Applying Social Science to Reduce Violent Offending (pp. 245-261). New York: Oxford University Press) and Fazel et al. (2009) and Steadman (1998) as cited in Monahan and Steadman (2012).

Monahan, J., and H. Steadman. 2012. "Extending Violence Reduction Principles to Justice-involved Persons with Mental Illness." In J.Dvoskin, J. Skeem, R. Novaco, and K. Douglas (Eds). Applying Social Science to Reduce Violent Offending (pp. 245-261). New York: Oxford University Press.

Monhan, J. 2011. "Mandated Psychiatric Treatment in the Community—Forms, Prevalence, Outcomes and Controversies." In Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects. First Edition. Edited by T. Kallert, J. Mezzich, and J. Monahan. John Wiley & Sons, Ltd.

Morrisey, J., and P. Meyer. 2008. Extending Assertive Community Treatment to Criminal Justice Settings. CMHS National GAINS Center. May 2006, updated August 2008.

Morrissey, J.P. 2013. Forensic Assertive Community Treatment: Updating the Evidence. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. October 2013.

Morrissey, J.P., G.S. Cuddeback, A.E. Cuellar, H. J. Steadman. 2007. The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons With Severe Mental Illness, 58 Psychiatric Services 794, 799-800 (2007).

Multnomah County Health Department. 2014. 2014 Report Card on Racial and Ethnic Disparities. December 12, 2014. Available at https://multco.us/file/37530/download.

Munetz M.R., and P.A. Griffin. 2006. "Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness." Psychiatric Services, 57:544-549. doi:10.1176/appi.ps.57.4.544).

Neighbors, Elizabeth. Director, Nevada Statewide Forensic Program. Personal communication. October 25, 2016.

Neighbors, Elizabeth. Director, Nevada Statewide Forensic Program. Personal communication. October 25, 2016.

New York State Office of Mental Health. 2005. Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. March 2005. Available at https://www.omh.ny.gov/omhweb/kendra_web/finalreport/.

Noreus, B. 2006. Connecticut's Criminal Justice Diversion Program. Maine Criminal Justice/Mental Health Brief #3. Prepared by the Diversion Re-Entry Steering Committee. January 2006. Available at the Maine Statistical Analysis Center website: http://muskie.usm.maine.edu/justiceresearch.

Pasadena Villa. "What Is the Difference Between Inpatient and Residential Mental Health Treatment?" Posted April 14, 2015. Available at http://www.pasadenavilla.com/2015/04/14/what-is-the-difference-between-inpatient-and-residential-mental-health-treatment/. Viewed November 17, 2016.

Peterson, J.K., J. Skeem, P. Kennealy, B. Bray, and A. Zvonkovic. 2014. "How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior among Offenders with Mental Illness?" Law and Human Behavior. Vol. 38, No. 5, 439-449.

Peterson, M., and P. Repard. 2015. "Are Cops Prepared to Deal with Mentally Ill?" The San Diego Union-Tribune. September 6, 2015. Available at http://www.sandiegouniontribune.com/news/crime-courts-fire/sdut-police-mentally-ill-training-pert-2015sep06-story.html.

Pretrial Justice Institute. 3DaysCount: Commonsense Pretrial. Available at http://projects.pretrial.org/3dayscount/. Viewed November 15, 2016.

Prins, S.J., and L. Draper. 2009. Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice. Council of State Governments Justice Center. Supported by the MacArthur Foundation. Available at https://csgjusticecenter.org/wp-content/uploads/2012/12/Community-Corrections-Research-Guide.pdf.

Promoting Independence and Recovery through Work: Employment for People with Psychiatric Disabilities, Briefing Document for the National Governors Association, Center For Best Practice (NGA) Webcast Transforming State Mental Health Systems: Promoting Independence and Recovery through Work: Employment for People with Psychiatric Disabilities, July 31, 2007.

Recovery Network of Programs. Treatment Pathway Program. Viewed November 14, 2016. Available at http://www.recovery-programs.org/services/addiction-treatment/outpatient-treatment/treatment-pathway-program/.

Reuland, M., M. Schwarzfeld, and L. Draper. 2009. Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice. Council of State Governments Justice Center. Supported by the MacArthur Foundation. Available at http://www.nccpsafety.org/assets/files/library/LE_Responses_to_Mental_Illnesses_-_Policy_and_Practice.pdf.

Ryan, J., L. Pagel, K. Smali, S. Artiga, R. Rudowitz, and A. Gates. 2016. Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States. Issue Brief. The Kaiser Family Foundation. Available at http://files.kff.org/attachment/Issue-Brief-Connecting-the-Justice-Involved-Population-to-Medicaid-Coverage-and-Care.

Ryan, J., L. Pagel, K. Smali, S. Artiga, R. Rudowitz, and A. Gates. 2016. Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States. Issue Brief. The Kaiser Family Foundation. Available at http://files.kff.org/attachment/Issue-Brief-Connecting-the-Justice-Involved-Population-to-Medicaid-Coverage-and-Care.

SAMHSA's Gains Center for Behavioral Health and Justice Transformation. "What Is Jail Diversion?" and "Types of Jail Diversion." http://gainscenter.samhsa.gov/topical_resources/jail.asp. Viewed Nov. 19, 2014.

SAMSHA's GAINS Center for Behavioral Health and Justice Transformation and the Council of State Governments Justice Center. 2012. A Checklist for Implementing Evidence-based Practices and Programs for Justice-Involved Individuals with Behavioral Health Disorders. August 2012.

San Diego County Grand Jury. 2016. PERT Psychiatric Emergency Response Team. Available at http://www.sandiegocounty.gov/content/dam/sdc/grandjury/reports/2015-2016/PERTReport.pdf.

Shah, J. Jail Based Behavioral Health Services Program (JBBS) Annual Report: FY 2015. Colorado Department of Human Services, Office of Behavioral Health. Available at https://drive.google.com/file/d/0B1-_ZOVijYoDUnBiU0dFUU5tSHJULTZ6RlUya2lXV2dRTWlv/view.

Sirotich, F. 2009. "The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of the Evidence." Journal of the American Academy of Psychiatry and the Law, 37:461-72, 2009.

Skolnik, S. 2007. "Reforms streamline competency court, save money." Las Vegas Sun. July 16, 2007. Available at http://lasvegassun.com/news/2007/jul/16/reforms-streamline-competency-court-save-money/.

Southwest Behavioral & Health Services. Criminal Justice Engagement Team. Brochure.

State of Connecticut Judicial Branch. Court Support Services Division, Adult Bail/IAR (Intake, Assessment, Referral). Available at http://www.jud.ct.gov/cssd/bail.htm. Viewed November 14, 2016).

State of Connecticut Judicial Branch. Court Support Services Division: Adult Bail/IAR (Intake, Assessment, Referral). Available at https://www.jud.ct.gov/cssd/bail.htm. Viewed September 27, 2016.

Steadman, H.J. 2014. When Political Will Is Not Enough Jails, Communities, and Persons with Mental Health Disorders. White Paper 1, prepared for John D. & Catherine T. MacArthur Criminal Justice Reform Initiative: Reducing the Overuse and Misuse of Jails in America Initiative. Policy Research Associates, Inc. July 2014.

Steadman, H.J. 2014. When Political Will Is Not Enough: Jails, Communities, and Persons with Mental Health Disorders. White Paper 1, prepared for John D. & Catherine T. MacArthur Criminal Justice Reform Initiative: Reducing the Overuse and Misuse of Jails in America Initiative. Policy Research Associates, Inc. July 2014.

Steadman, H.J., E. Mulvey, J. Monahan, P. Robbins, T. Grisso, L. Roth, and E. Silver. 1998. "Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods." Archives of General Psychiatry, 55, 393-401.

Steadman, H.J., L. Callahan, P. Clark Robbins, R. Vesselinov, T. G. McGuire, and J.P. Morrissey. 2014. Criminal Justice and Behavioral Health Care Costs of Mental Health Court Participants: A Six-Year Study. Psychiatric Services. Volume 65, Issue 9, September 2014, pp. 1100-1104. Published online: September 01, 2014. Available at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300375?trendmd-shared=0#_i6.

Steadman, H.J., L. Callahan, P. Clark Robbins, R. Vesselinov, T. G. McGuire, and J.P. Morrissey. 2014. Criminal Justice and Behavioral Health Care Costs of Mental Health Court Participants: A Six-Year Study. Psychiatric Services. Volume 65, Issue 9, September 2014, pp. 1100-1104. Published online: September 01, 2014. Available at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201300375?trendmd-shared=0#_i6.

Stewart, G., L. Gerritsen, E. Covelli, and K. Henning. 2012. Report on Police Interactions with Person in Mental Health Crisis. March 21, 2012.

Substance Abuse and Mental Health Services Administration (SAMHSA). 2014. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at http://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848.

The Center for Health and Justice at TASC. 2013. No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives. Chicago. Available at http://www2.centerforhealthandjustice.org/content/pub/no-entry-national-survey-criminal-justice-diversion-programs-and-initiatives.

The Florida Senate Interim Report 2012-108. Budget Subcommittee on Health and Human Services Appropriations. The Forensic Mental Health System. September 2011. Available at http://www.flsenate.gov/publishedcontent/session/2012/interimreports/2012-108bha.pdf.

The Pew Center on the States. 2009. Maximum Impact: Targeting Supervision on Higher-Risk People, Places and Times. Public Safety Policy Brief. No. 9, July 2009. Executive summary. Available at http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2009/maximumimpactwebpdf.pdf.

The Pew Center on the States. 2009. Maximum Impact: Targeting Supervision on Higher-Risk People, Places and Times. Public Safety Policy Brief. No. 9, July 2009. Executive summary. Available at http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2009/maximumimpactwebpdf.pdf.

Thomas, K.A., D.J. Rickwood, and G. Bussenschutt. 2015. Adult Step-up Step-down: A Sub-acute Short-term Residential Mental Health Service." International Journal of Psychosocial Rehabilitation. Vol 19(1) 13- 21. Available at http://www.psychosocial.com/IJPR_19/Adult_Step-up_Thomas.html.

Torrey, E.F. 2006. Surviving Schizophrenia : A Manual for Families, Patients, and Providers. Quill; 5th edition. April 1, 2006. ISBN: 0060842598.

Trueblood Diversion Plan. 2016. Submitted by the parties in Trueblood as Next Friend of A.B. et al v. Washington State Department of Social and Health Services (DSHS), Case No. C14-1178 MJP. Submitted to the Honorable Marsha J. Pechman, Chief United States District Judge United States District Court for the Western District of Washington at Seattle. August 19, 2016

Ventura, LA., C.A. Cassel, J.E. Jacoby, and B. Huang. "Case Management and Recidivism of Mentally Ill Persons Released from Jail." Psychiatric Services 49:10, Oct. 1998, 1330-37.

Washington Health Care Authority. 2014. Apple Health (Medicaid) Manual Incarceration Overview (updated November 10, 2014). Available at http://www.hca.wa.gov/medicaid/manual/Pages/90-110.aspx).

Zeller, S., N. Calma, and A. Stone. 2014. "Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments." Western Journal of Emergency Medicine. 2014 Feb; 15(1): 1-6. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935777/. Viewed November 17, 2016.

Appendix A:
Jail Diversion Literature Review

This document presents results from work that Joplin Consulting completed for Task 3 of Contract No. K1911 with the Washington State Office of Financial Management (OFM). Under the contract, Joplin Consulting reviewed best practices to safely and appropriately divert people with mental illness from the criminal justice system to community-based treatment and made recommendations to Washington state on how to increase jail diversion opportunities for people with mental illness.

Under Task 3, Joplin Consulting conducted and summarized a brief literature review and phone interviews with national experts to identify nationally recognized jail diversion programs for individuals with mental illness.

People with Mental Illness in Washington Jails

Nationally, the proportion of people in jail who have a mental illness is three times higher than among the general population (Kessler et al. 1999). A 2016 study in Washington state suggests that a similar disproportionality exists among people entering jail who are or recently have been enrolled in Medicaid. Among this group (which in 2013 represented 31 percent of all individuals entering jails in Washington), 55 percent had an identified mental health diagnosis, such as depression, anxiety, bipolar disorder, and/or a psychotic disorder. In contrast, only 34 percent of the general adult Medicaid population had such a diagnosis (Henzel et al. 2016).

Additional data are available from a recent survey of pretrial detainees waiting in Washington jails for the provision of court-ordered services by the Washington State Department of Social and Health Services (DSHS) (Trueblood Diversion Plan 2016). These are people who have been charged with a crime but who may not be able to understand the judicial process or the charges against them, or they may not be able to aid in their own defense. Among this population:

- 67 percent had had between two and five referrals for competency services since 2012.
- 70 percent had had at least two arrests during a recent 12-month period.
- 43 percent were eligible for Medicaid.
- 62 percent had received outpatient mental health services during a recent 12-month period.
- 50 percent had received residential mental health services during a recent 12-month period.
- 55 percent had a substance use diagnosis, but few had received substance use treatment serves during a recent 12-month period. A total of 3.2 percent of respondents had received outpatient treatment during a recent 12-month period, and 2.6 percent had received residential treatment.
- 46 percent ranked housing as the most helpful diversion service, followed by medication management (13 percent of respondents), case management (15 percent), and employment (8 percent).

These data suggest that people with mental illness are cycling in and out of Washington's criminal justice system, and that diversion could be a way to connect jail detainees who have mental illness with community-based mental health services that would support their ability to live in the community, rather than returning repeatedly to jail.

About Jail Diversion and Deflection

For the purposes of this study, jail diversion is a means of "avoiding or radically reducing jail time by referring a person to community-based services" (Steadman 2014 and Broner et al. 2005 as cited in Cowell et al. 2008), such as mental health and/or substance use treatment. Diversion is not the same as discharge planning (SAMHSA's Gains Center for Behavioral Health and Justice Transformation), which does not shorten jail time.

Jail diversion is usually a voluntary activity that an individual could be motivated to participate in for several reasons. For example, community-based mental health treatment might be more attractive than jail or psychiatric hospitalization, or treatment might be a condition of housing (Monahan 2011). Also motivating for some individuals is that charges often are reduced or dropped once he or she has completed a diversion program that involves community-based services, such as mental health or chemical dependency treatment.

Deflection is a subset of diversion and occurs early, at the initial encounter between the police officer and the person suspected of having a mental illness. In a deflection situation, the individual is not arrested, charged, or detained. Instead, he or she is referred or voluntarily transported to a treatment provider, thus avoiding involvement in the criminal justice system. This is also referred to as pre-arrest diversion.

Participants in Mental Health Jail Diversion Programs

Mental health jail diversion programs typically focus on people with serious mental illness—i.e., schizophrenia, major depression, and bipolar disorder—who are subject to arrest for trespassing, disorderly conduct, public intoxication, and similar low-level crimes. Often these behaviors are related to the underlying and sometimes untreated mental illness. Criminal violence by the seriously mentally ill usually is related not to the person's mental illness but to other criminogenic factors, such as substance abuse or personal history (Monahan and Steadman 2012; Fazel et al. 2009 and Steadman 1998 as cited in Monahan and Steadman 2012). In cases where criminal offenses are closely linked to symptoms of mental illness, most of the time the offenses are committed by people with bipolar disorder (Peterson et al. 2014).

Most seriously mentally ill people in jail have a variety of other problems. By some estimates, three-quarters of them also have substance abuse disorders (Steadman 2014). (This "dual diagnosis" creates challenges because treatment programs usually focus on either mental illness or substance abuse, not both.) They often are poor and/or homeless, and many have a lifetime history of sexual and physical abuse (Steadman 2014). In some jurisdictions they are predominantly people of color. And they have a variety of physical health problems (heart attack, stroke, hypertension, obesity, diabetes, metabolic syndrome, etc.) that contribute to a life span that is 13 to 30 years shorter than it is for the general population. During recent decades this mortality gap has widened. (De Hert et al. 2011).

Sequential Intercept Model

In conjunction with staff from SAMHSA's GAINS Center, M.R. Munetz and P.A. Griffin developed a conceptual model of the points of intersection between the criminal justice and the mental health systems (Munetz and Griffin 2006). In this so-called sequential intercept model, each category or "intercept" represents a potential point of diversion, as follows:

- Intercept 1: Law Enforcement/Emergency Services—
  Crisis intervention teams, co-response teams, deflection, citation and release, and arrest
- Intercept 2: Initial Detention and Court Hearings—
  Booking, pretrial release, initial detention, first court appearance

- Intercept 3: Jails/Courts—
  Court case processing, therapeutic courts, jail, prison
- Intercept 4: Reentry—
  Transition planning and reentry to the community from prison or jail
- Intercept 5: Community Corrections—
  Probation, parole, and post-prison supervision; includes community-based treatment services

Components of Jail Diversion Programs

Nationally, jail diversion programs for people with mental illness can have a variety of components:

- 911 triage with crisis hotline
- Mental health crisis hotline
- Mobile mental health outreach teams
- Law enforcement crisis intervention teams
- Combined law enforcement/mental health clinician co-response teams
- Hospital emergency room
- Hospital psychiatric unit
- Detox/sobering station
- 23-hour observation center/psychiatric emergency room
- Crisis stabilization center
- Urgent mental health walk-in clinic
- Drop-in day center
- Pretrial release program
- Co-located mental health case management/referral services in court
- Therapeutic and community courts
- Specialty mental health outpatient programs
- Supportive, case-managed housing
- Culturally specific services
- Peer-based support/case management

Effectiveness of Mental Health Jail Diversion Programs

Data on the effectiveness of jail diversion programs for people with mental illness are limited, and in some cases the available research provides contradictory results, presumably in part because there is so much variety in who participates in them, how the programs operate, and their goals, which could be to reduce recidivism, avoid conviction (and therefore the consequences of a record), connect people with treatment and services, enhance public safety, reduce jail crowding, or save money. Adding to the complications involved in data collection is the challenge of following people who are often homeless and disenfranchised for long periods of time.

Clearly, much more research is needed, particularly regarding which program components are associated with specific outcomes. Yet some research has been conducted, in various communities around the country.

The resulting evidence suggests that diverting more people with mental illness from jail to community-based services has the potential to provide more effective mental health treatment for offenders, cut criminal justice system costs, and reduce involvement with the criminal justice system, although not necessarily recidivism (i.e., people may be rearrested but for less serious charges, or they may spend fewer days in jail or not go on to prison). For example, a review of 21 case studies in the United States did not demonstrate that jail diversion programs reduced recidivism among the seriously mentally ill (Sirotich 2009). However, the review did show a correlation between participation in jail diversion programs and reduced time spent in custody. This correlation was strongest with (1) pre-booking programs, and (2) court-based post-booking programs, where mental health clinicians work within the courthouse (Sirotich 2009). Additionally, better probation

compliance has been observed with probation agencies that have small, exclusively mental health caseloads and that focus on problem solving, rather than threats of incarceration (Monahan 2011).

Evidence on the outcomes of specific types of jail diversion programs is summarized below.

Effectiveness of Specialized Law Enforcement Responses

The use of crisis intervention teams, co-response teams, and similar specialized law enforcement responses to people with mental illness has grown significantly since crisis intervention teams first appeared in the 1980s, yet the amount of research on these specialized law enforcement responses is modest; additional research is needed.

Research to date shows that, in most cases, law enforcement encounters with people with mental illnesses involve individuals who are exhibiting nuisance behavior (public drunkenness, loitering, etc.) and/or are suspected of committing low-level, misdemeanor crimes. Law enforcement officers also encounter people who have attempted or are threatening suicide. In rarer cases (i.e., less than 15 percent of calls), law enforcement officers encounter people with mental illness who are at risk of harming someone besides themselves (Reuland et al. 2009).

It is common for law enforcement officers to respond repeatedly to a relatively small number of individuals who are believed to have mental illness. In some communities officers spend an average of 1 to 2 hours or more per shift on calls concerning people suspected of having mental illnesses. The total amount of time spent on these calls can be high – more than the time spent on injury traffic accidents, burglaries, or felony assaults (Reuland et al. 2009).

Specialized law enforcement responses are associated with the following (Reuland et al. 2009):

- Fewer injuries to officers (up to a 32 percent decrease)
- More frequent officer transport of people to mental health facilities, such as a crisis stabilization center
- Greater access to crisis and non-crisis supports and services
- Fewer subsequent contacts with the criminal justice system (i.e., spending more time in the community without being arrested)
- Lower criminal justice costs and higher treatment costs
- A 50 to 58 percent reduction in the use of SWAT teams

King County's Law Enforcement Assisted Diversion (LEAD) program is an example of a collaboration between the law enforcement and behavioral health systems that provides pre-arrest diversion opportunities. LEAD offers harm reduction-oriented case management to people suspected of low-level drug and prostitution offenses, as an alternative to prosecution and incarceration. A 2016 evaluation conducted by the University of Washington Harm Reduction Research and Treatment Center concluded that LEAD participants were significantly more likely to have housing, employment, and legitimate income after their involvement with the program than before, and that these outcomes were associated with lower rates of recidivism (Clifasefi et al. 2016). LEAD also was associated with lower jail costs, with participants spending 39 fewer days in jail per year than a control group did (Collins et al. 2015). Although LEAD does not specifically target people with mental illness, program staff indicate that many participants suffer from severe mental illness.

Effectiveness of Pretrial Diversion Services

Pretrial diversion services often focus on people with mental illness, substance use disorders, or co-occurring disorders. Such programs are usually voluntary and provide alternative case processing for

people charged with a crime; once the individual has completed his or her personalized program, the charges are usually dismissed.

The evidence is consistent that participants in pretrial diversion programs that focus on mental illness and/or substance use have more positive outcomes than do eligible defendants who do not participate (Camilletti 2010). Overall, participants in pretrial diversion programs spend less time in prison, are less likely to be in jail or a treatment center a year after their crime, and, because they have avoided a criminal conviction, are more successful at finding employment and housing. Pretrial programs also have been shown to (1) reduce criminal justice costs in most jurisdictions, (2) save time, by diverting people and reducing court dockets, and (3) reduce overcrowding in jails and prisons (Camilletti 2010).

Effectiveness of Mental Health Courts

Mental health courts can focus on misdemeanors, felonies, or both. The focus may reflect the jurisdictional limitation of the court (i.e., municipal, district, or superior) or a specific policy choice. In a 2006 survey of 87 mental health courts, which included multiple levels of court jurisdictions, 40 percent were for misdemeanors only, 10 percent were felony only, and 50 percent handled both misdemeanors and felonies (Almquist and Dodd 2009).

As with other forms of jail diversion, high-quality research on the effectiveness of mental health courts (particularly over the long term, meaning longer than 1 year) has been limited. However, in one study, mentally ill defendants who chose mental health court reported less coercion and more satisfaction with the court process than did mentally ill defendants in criminal court. Afterwards they had fewer arrests and spent fewer days incarcerated (Monahan 2011).

Other research indicates the following:

- Mental health courts connect participants with treatment at higher rates than non-mental health courts do. This translates into more people continuing mental health treatment after the end of their program, fewer crisis interventions, and fewer days of inpatient treatment (Almquist and Dodd 2009).

- Participants in some courts have lower rates of recidivism generally and are less likely to be arrested for new crimes. Some evidence suggests that this effect continues after court supervision ends (Almquist and Dodd 2009). Research results vary by community but include lower arrest rates (by half), fewer new criminal charges, fewer criminal charges for violent crimes, a longer interval before new charges, and a greater likelihood that someone is in jail because of a probation violence or sanction, rather than a new crime (Almquist and Dodd 2009). A 2005 study in Clark County, Washington, found similar results, with a 75 percent reduction in arrests compared to before the program, a 62 percent reduction in re-arrest for probation violations, and a recidivism rate of less than one-third that of participants who were terminated from the program (Almquist and Dodd 2009).).

- Mental health courts have the potential to save money by reducing both recidivism and inpatient care, which is the most expensive treatment option (Almquist and Dodd 2009). However, additional research is needed to understand potential cost savings and how cost shifting may occur locally (from the criminal justice system to the mental health system) and between levels of government (local, state, and federal).

Despite these results, there are a number of concerns about mental health courts. Critics express concerns that mental health courts (1) require participants to stay under court supervision for longer than if they had been adjudicated in a traditional court, thus increasing the chance of violation and

rearrest because of the extended period of behavioral scrutiny, and (2) place unnecessary and overly stringent conditions on people with mental illness who may be struggling with basic living skills.

Additionally, specialty courts are relatively expensive. Many of them do not assess participants using an actuarial risk assessment tool and therefore serve defendants across the spectrum of recidivism risk. Research suggests that judicial involvement with high-risk offenders is more successful (and therefore more cost-effective) than with low-risk offenders (King and Pasquarella 2009, as cited in Griller 2011). Yet many mental health courts do not screen for risk and often focus on low-level offenders for whom the evidence indicates that less intensive services would be more effective, and cost less.

Effectiveness of ACT Teams

Assertive community treatment teams (ACT) provide direct treatment, rehabilitation, and support services in the community to people who (1) have severe mental illness, (2) are functionally impaired, and (3) have a high risk of inpatient hospitalization. ACT team members include psychiatric, nursing, addiction counseling, and vocational rehabilitation professionals who are available to clients 24 hours a day, seven days a week (Morrisey and Meyer 2008).

ACT teams have been well studied. They repeatedly have been shown to reduce psychiatric hospitalizations and promote housing stability (Morrisey and Meyer 2008). However, they are not consistently effective at reducing arrests or jail time, reducing symptoms, or improving clients' social adjustment, substance abuse, or quality of life (Morrisey and Meyer 2008). They also are expensive. An ACT team with a caseload of 60 people can cost $1 million a year. ACT is most cost-effective for clients who have had at least 48 days of psychiatric hospitalization in the previous year (Morrissey 2013).

A relative newcomer in the world of jail diversion is forensic assertive community teams (FACTs), which are an adaptation of ACT. FACT teams focus specifically on preventing the arrest and incarceration of people with severe mental illness. They operate much like ACT teams, except with forensic-oriented "add-ons" such as the following (Morrissey 2013):

- Enrolling only people with prior arrests and jail detentions
- Making re-arrest prevention an explicit goal
- Accepting referrals from criminal justice agencies
- Recruiting criminal justice agency partners
- Using court sanctions to encourage participation
- Engaging probation and law enforcement officers as members of the treatment team
- Adding residential substance abuse treatment units for people with dual diagnoses

Current evidence on the effectiveness of FACT is considered "moderately strong." However, research has been limited and additional studies are needed that are randomized and controlled, involve more sites, and use more similar client profiles.

Findings so far point to the following possible outcomes of FACT programs (Morrissey 2013):

- Significant reductions in arrests, jail days, hospitalizations, and hospital days
- Improvements in psychiatric functioning and engagement in substance abuse treatment
- Fewer jail bookings, greater outpatient contacts, and fewer hospital days
- Higher probability of avoiding jail in the post period

Morrissey refers to two studies on FACT cost savings. In one, the increased outpatient costs of FACT were offset by lower inpatient costs; the other (from 2004) reported reduced average costs, per client (Morrissey 2013).

The table below summarizes recent evidence on the effectiveness of mental health jail diversion programs in general, followed by outcomes associated with specific types of programs.

Summary: Effectiveness of Types of Jail Diversion Programs

	Specialized Law Enforcement Responses	Pretrial Diversion	Mental Health Court	Assertive Community Treatment (ACT)
Research quantity/quality	Limited	Little on recidivism	Limited, short-term, contradictory results	Limited
Potential benefit:				
Reduced SWAT use	yes			
Fewer officer injuries	yes			
Connection to treatment	yes	yes	yes	
Reduced hospitalization				yes
Reduced CJ involvement	yes	yes	yes	yes
CJ cost savings	yes	yes	maybe	
Positive outcomes		yes		yes
Reduced court docket		yes		
Reduced overcrowding		yes		

NOTE: This table shows only demonstrated correlations between diversion types and potential benefits. Thus, a blank cell in the table does not necessarily mean that the associated benefit does not occur, just that it has not been demonstrated in research (which has been limited for all of the types of diversion).

People with Mental Illness under Community Corrections Supervision

People with mental illness (most of whom have co-occurring substance use disorders) are "twice as likely as people without mental illness to have their community supervision revoked" (Prins and Draper 2009). The predictors of people with mental illness having their probation or parole revoked are similar to the predictors for people without mental illness, but people with mental illness have more of the risk factors, such as history of criminal behavior, anti-social personality pattern, pro-criminal attitudes, anti-social associates, poor use of leisure/recreation time, substance use, problematic circumstances at home, problematic circumstances at school or work.

People on community corrections who have serious mental illness should be supervised by specialized community corrections/probation officers who receive specific training in mental health issues and who carry smaller caseloads. The Connecticut Mental Health Case Management Project, which provides probation officers with 24 to 40 hours of specialized training per year, includes frequent client contact (at least three face-to-face appointments per month), as well as regular contact between the officer and the mental health treatment provider. An evaluation of the project found that the relationships between officers and their clients were more collaborative and focused on "increasing compliance with probation rather than enforcing the conditions of probation." Participants had a new arrest rate that was 25 percent lower than that of a matched comparison group. (Cox et al. 2010)

Additional Approach: Psychiatric Emergency Room Services

The use of dedicated regional psychiatric emergency services as an alternative to traditional hospital emergency rooms (ERs) for people experiencing a mental health crisis is gaining ground in the United States. In contrast to traditional hospital ERs, which typically have limited mental health services (if any), psychiatric emergency services offer round-the-clock psychiatric assessment, intensive treatment, and monitoring for up to 23 hours, on an outpatient basis. Most people experiencing a mental health crisis can be stabilized within that period of time and safely discharged to the community, rather than be admitted to a psychiatric hospital (Zeller et al. 2014).

Additionally, care at a regional psychiatric emergency center can cost less than being held at a hospital emergency room, where patients wait an average of 6.8 hours to 34 hours (depending on the state) before being transferred to a facility that can provide appropriate psychiatric services (Zeller et al. 2014). States that have psychiatric emergency services often allow law enforcement officers to initiate transfer of the patient to the center by ambulance (instead of doing it themselves). In California, the state Medicaid agency allows for a unique, facility-based billing code for "crisis stabilization" that provides a high enough hourly billing rate to pay for the psychiatric emergency services (Zeller et al. 2014).

Psychiatric ERs provide an important service, but they are only one element in the a continuum of care that is needed in the community. It is critical that patients leaving the psychiatric ER be connected to community-based residential or outpatient care. "Providing continuity of care through effective, accessible community mental health services, such as Assertive Community Treatment, can prevent people from cycling into and out of mental health crises" (Alakeson 2010).

Additional Approach: Subacute Residential Treatment

Subacute residential treatment is an interim level of care between outpatient mental health treatment and treatment at a locked psychiatric hospital. It takes place in a home-like environment where patients are still treated and monitored, but less intensively than in inpatient care (Pasadena Villa).

People can be referred to subacute residential care when they are released from a psychiatric hospital—as a "step-down" option that prepares them to transition to supportive housing or independent living—or if they are living in the community but have symptoms that are too intense for them to manage on their own yet are not severe enough to require inpatient hospitalization (in which case subacute residential treatment functions as a "step-up" option). Justice-involved individuals fall into both these categories and can also be referred to subacute residential treatment facilities by hospital emergency rooms, psychiatric emergency rooms, crisis stabilization centers, and acute residential treatment centers. In addition to providing mental health treatment in a less restrictive environment than a hospital, subacute residential treatment facilities begin transition planning early and often focus on functional skills (e.g., budgeting, domestic, and interpersonal skills), tailored personal support, and symptom management, so that patients can avoid hospitalization and return to independent living (Thomas et al. 2015).

High-quality residential treatment centers are accredited and/or licensed, have fully credentialed staff, have ready access to urgent and emergency care facilities, and can adjust their staffing capacity to match changing levels of acuity in the patient mix (Brodsky 2012).

Additional Approach: Supportive Housing

For justice-involved individuals with mental illness, stable housing is essential to success with medication, clinical care, and other aspects of community-based treatment that help people avoid future encounters with law enforcement.

Supportive housing should be permanent, affordable housing that is connected with individualized support services that are intended to help residents maintain residential stability (Fontaine et al. 2012 and Aidala et al. 2013). Supportive housing programs include services such as intensive case management and care coordination, clinical supervision, mental health and/or substance abuse treatment, and vocational and employment services. Often services are provided with low client-to-staff ratios.

The housing component of supportive housing can be either a single mixed-tenancy building that is operated as special needs housing (in which case the support services typically are located onsite), or it can consist of units located at multiple locations (with case services provided by mobile management and staff teams) (Aidala et al. 2013). Supportive housing units often are subsidized.

Evidence is strong that supportive housing reduces the use of jails, emergency services, and shelters by people with a history of homelessness and mental illness, and it cuts down on associated costs (Burt and Anderson 2005, Culhane, Metraux, and Hadley 2002, and Culhane et al. 2007, as cited in Fontaine et al. 2012). There is less evidence on the effects of supportive housing specifically on people reentering the community from jail or prison, particularly for those with mental illness or other behavioral health problems. Two studies in Ohio and New York explored this topic.

The Returning Home Ohio (RHO) program provided supportive housing to people being released from prison who had a developmental disorder, severe addiction, or mental illness, and who either were homeless at the time of their arrest or were at risk of being homeless upon release. Outcomes were as follows:

- Relative to a comparison group of similar individuals, participants in RHO were 40 percent less likely to be rearrested and 61 percent less likely to be reincarcerated, plus they stayed in the community for a significantly longer period of time before being arrested again (Fontaine et al. 2012).

- Participation in the RHO program did not reduce overall costs during the first year post-release. Participants had lower criminal justice system costs than the comparison group did but had higher costs for mental health and substance abuse treatment. In total, participation in the treatment group increased costs by more than $9,500 per person during that first year. Longer term cost analysis data were not available. (Fontaine et al. 2012).

In New York City, the Frequent Users Services Enhancement (FUSE) II initiative provided supportive housing to roughly 200 people who had been identified as being frequent users of jails, shelters, and hospitals. These people were cycling through public services repeatedly (Aidala et al. 2013).

To be admitted to the FUSE II program, participants had to have had four jail and four shelter stays during the previous five years. Additional criteria were imposed by the different housing providers, who focused on providing housing for people with recent substance abuse treatment, no substance abuse problems, or serious psychiatric diagnoses and recent mental health treatment. Outcomes measured over a 24-month period were as follows:

- At the end of the 24-month period, 86 percent of FUSE II participants were still in permanent housing, versus 42 percent of the members of a comparison group (Aidala et al. 2013).

- Program participants had fewer jail admissions and spent 40 percent fewer days in jail than the comparison group did (Aidala et al. 2013).

- Program participants also had significantly fewer ambulance rides, spent fewer days hospitalized for psychiatric reasons, and scored significantly better on measures of psychological stress and family and social support (Aidala et al. 2013).

- FUSE II intervention reduced average total costs for shelter days, jail days, and inpatient and crisis medical and behavioral health services (the latter reduction was attributed mostly to reduced psychiatric inpatient days) (Aidala et al. 2013).

Additional Approach: Supported Employment

Supported employment is an evidence-based practice for securing employment for people who have mental illness, many of whom are not employed even though they want and have the ability to work (Promoting Independence and Recovery through Work 2007, as cited in Bazelon Center for Mental Health Law 2010). By providing clinical and vocational support, supported employment programs help people with mental illness gain competitive employment. Services typically include career planning, assistance with the various steps needed to secure a job, assistance to employers in training the supported employee, and ongoing support. Programs often focus on providing comprehensive assessment and integrating rehabilitation and mental health (Bazelon Center for Mental Health Law 2010).

There is little evidence on the effectiveness of supported employment specifically for justice-involved individuals with mental illness. However, for other people with psychiatric disabilities, supported employment is associated with higher rates of employment, higher income, and more hours worked than for a comparison group (Cook et al. 2005 as cited in Bazelon Center for Mental Health Law 2010). In Washington state, a study of adults with mental illness showed positive results for those who received supported employment through a Medicaid Supported Employment Program in the mid-2000s. (The program has since been discontinued). Relative to a comparison group, participants in the supported employment program were employed at higher rates and made greater use of non-crisis, community-based outpatient mental health services. Moreover, they had fewer arrests. Clients who received the most hours of supported employment services had the strongest outcomes (Zan et al.).

Additional research is needed to understand (1) the effectiveness of supported employment on justice-involved individuals with mental illness, and (2) the specific types and amounts of supported employment services that contribute to reduced criminal activity among people with mental illness.

Program Model Examples

Law Enforcement/Emergency Services Programs

San Diego PERT (Psychiatric Emergency Response Team)

- **Overview:** The San Diego County PERT teams began operating in 1996. Together, specially trained law enforcement officers who are paired with mental health professionals

respond on-scene to situations involving people with mental illness. The goal of the program is to refer people with mental illness who come into contact with police to the most appropriate service available, in the least restrictive environment possible. The 30 PERT teams represent a partnership between the San Diego County Police and Sheriff departments, San Diego County Mental Health, and PERT, Inc., a non-profit organization.

- **Training:** Participating officers, deputies, and mental health professionals are specially selected and complete an initial introductory four-hour training session before beginning with PERT and then complete a 40-hour block of training. The training includes modules about on-scene assessment; emergency response; mental illness; community-based organizations, programs, and services available throughout San Diego; and other topics related to mental health, substance abuse, homelessness, and crisis response. In addition to this initial training, PERT, Inc. provides ongoing mental health training for law enforcement.
- **Outcomes:** In fiscal year 2015, PERT intervention averted hospitalization or incarceration in the majority of the 6,211 cases served, with 3,026 (49 percent) taken to hospitals under a 72-hour hold, and 3,185 (51 percent) receiving referrals to community resources. (San Diego County Grand Jury 2016).

Seattle Law Enforcement Assisted Diversion (LEAD) Program

- **Pre-booking diversion:** LEAD diverts low-level drug and prostitution offenders into intensive, community-based social services.
- **Police referral.** Officers have a high degree of discretion and can divert people to a LEAD case manager without making an arrest. The case manager does initial screening at the precinct.
- **Intensive "hands-on" work:** Case managers meet the client "where they're at," provide social services, use motivational interviewing to help clients identify their personal goals, and support clients as they work toward their goals.
- **"Harm reduction approach":** LEAD provides emotional, practical, and financial support without requiring abstinence from drugs and alcohol. Services and benefits are not time limited, and there are no punitive sanctions for non-compliance.
- **Outcomes:** After referral to the program, LEAD participants were 89 percent more likely to obtain housing, 46 percent more likely to be on the employment continuum, and 33 percent more likely to have legitimate income or benefits than they were before their referral.

Pima County (Arizona) Crisis Response Center

- **Overview:** The Crisis Response Center (CRC), which is operated by ConnectionsAZ, is a Level 1 inpatient facility and an outpatient behavioral health clinic for both adults and children. The center's goals are to reduce incarceration, emergency room visits, psychiatric hospitalizations, and recidivism.
- **Strategic location:** The CRC is located directly adjacent to University Physicians Hospital's behavioral health center. An enclosed walkway connects the two facilities, allowing for easy, secure transfer of clients back and forth as needed.
- **Multiple services (including juvenile)**: The center houses a crisis hotline, a 23-hour observation/triage area for adults and juveniles, and a separate 15-bed short-stay, subacute area where people can access intensive treatment for up to five days. A sobering/detox facility is available next door.

- **Co-located court:** Also located at the facility is a branch office of the county court that hears mental health court, drug court, and competency cases for people at the CRC.
- **Peers:** The center contracts with the peer-run agency Helping Ourselves Pursue Enrichment, Inc. (HOPE, Inc.) to provide 24/7/365 recovery-oriented peer support and community navigation services for CRC residents. Services include supporting CRC residents and their families while they access crisis services and providing transition support after discharge. HOPE staff also operate a phone "warm line" through the CRC call center for individuals not in crisis, but in need of support and information.
- **Immediate impact:** In the first six months of opening (in 2011), the crisis line received an average of 8,736 calls per month. By August 2012, monthly call volume was 11,347. In September 2012, the CRC served 855 adults and 170 youth.
- **Law enforcement drop-offs**. Data from 2013 show an average of 12 to 15 drop-offs a day by law enforcement officers, each requiring an average of 10 minutes of the law enforcement officer's time. Law enforcement and other partners were involved in the initial planning, design, and operation of the center and continue to meet monthly to refine policies and procedures.
- **Avoiding involuntary evaluation**: In 2012, CRC served 1,666 individuals under an Application for Emergency Admission for Evaluation (i.e., an involuntary treatment evaluation). Fifty-six percent of those individuals (936 people) did not need court-ordered evaluation after receiving crisis services at the CRC and were instead diverted to community services (Huckelberry 2013).

Unity Center for Behavioral Health in Portland, Oregon

- **Psychiatric emergency service**: A new behavioral health center opening in 2017 will offer 23-hour monitoring and treatment of people experiencing a behavioral health crisis. After rapid assessment by a social worker, nurse, and psychiatrist, patients will be released to a living room-like milieu staffed by nurses, mental health therapists, social workers, and peer support specialists. Goals are to stabilize acute systems, engage patients in treatment, and avoid unnecessary psychiatric hospitalizations.
- **Ambulance transport**: State rules were changed to allow transport to the center by ambulance, instead of police officers.
- **Co-located services**: The center also will have 102 inpatient beds, for adults and adolescents, and enhanced partnerships with community organizations that provide behavioral health and substance abuse disorder services. Eventually the Unity Center will serve as a central hub for county and community-based mental health navigators, housing resources, addition service providers, and peer support agencies throughout the metropolitan area.
- **Electronic notification**: An electronic notification system will let center staff notify primary care physicians, insurance companies, and behavioral health service providers when patients arrive. This will trigger provider "reach in" and allow for a more intentional, effective hand-off to community-based services when the patient leaves the center.
- **Collaboration and consolidation**: Development of the Unity Center is the result of collaboration among four area hospitals, county and city staff, the police bureau, and the local ambulance services. The center's inpatient psychiatric beds represent a consolidation of current psychiatric beds from several local hospitals.

- **Outcomes:** Outcomes data on this program are not yet available. Based on research of similar programs, the Unity Center expects to discharge 70 to 75 percent of its patients back to the community.

Court Programs

Connecticut Community Forensic Services Program

- **Comprehensive program:** This community forensic services program provides clinical alternatives to arrest and incarceration, ensures continuity of care for those who are incarcerated, and facilitates reintegration for those who are sentenced. It coordinates with the jail to provide a variety of services for people with mental illness who are not diverted from jail.
- **Court Liaison Program:** Mental health clinicians are located in court during arraignment of people with mental health disorders; in Connecticut, arraignment takes place before booking. The clinicians obtain the client's consent and permission from the court to work on the client's behalf. They then assess the client, develop a treatment plan that could involve inpatient or outpatient care, and recommend the plan to the judge, who can either accept or reject it. If the treatment plan is accepted, the participant is granted a conditional release and typically is required to reappear for another pretrial hearing in several weeks.
- **Clinical role:** Because the mental health clinicians are employed by a mental health agency instead of the court, they adhere to industry standards and rules regarding the goals of their work (to assist the client), treatment consent, and confidentiality and they perform a clinical, rather than court, role. This means that they do not coerce the client, offer promises of a lighter sentence in return for participation in treatment, or share information about the client's mental health condition (e.g., their diagnosis) with people in the criminal justice system. Instead, they present the treatment plan and describe how the mental health system can meet the client's needs.
- **Multiple possible outcomes:** Diversion from jail or dismissal of the case are not guaranteed and remain the decision of the judge, based on seriousness of the charges and the potential value of the treatment proposed by the mental health clinicians. The treatment plan simply offers the judge an additional option. If the court accepts the plan, the clinician communicates with the court on the client's compliance. If the client does not participate in treatment, the case proceeds as if there had been no mental health assessment and treatment planning.
- **Alternative to competency evaluations:** The Community Forensic Services program serves as an alternative to competency evaluations and hospitalizations, which formerly were the only way that the court could access mental health treatment for defendants.
- **Outcomes**: The program has reduced the number of days that people with mental illness spend in jail and increased the continuity of their care once they are released.

Bridgeport (Connecticut) Treatment Pathway Program

- **Court-based psycho-social assessment and referral to outside treatment**: In Bridgeport Superior Court, licensed clinical social workers (LCSWs) conduct a full psycho-social assessment of detainees with substance use disorders. The LCSWs determine the detainee's treatment needs, and—if appropriate and if the detainee, defense attorney, and prosecutor agree—present a recommendation to the court at arraignment for outside treatment, instead of booking and incarceration. (Note: In Connecticut, arraignment occurs before booking.)

Treatment options include detoxification, medication-assisted treatment (MAT), outpatient services, and residential treatment.

- **Licensed satellite mental health clinic**: The assessments and case management are conducted at the courthouse lock-up in an attorney-client conference room that has been converted into a licensed satellite mental health clinic. Using a licensed clinician and space is intended to pave the way for Medicaid fee-for-service reimbursement because (1) the services are the same as those provided in a clinician's office, and (2) the client is not considered incarcerated because, at this point, he or she has not been charged and is not in the custody of the Department of Corrections.
- **Outcomes**. Outcomes data on this program are not yet available, although data collection and analysis are underway. (Recovery Network of Programs)

Jail Programs

Kentucky Jail Mental Health Crisis Network

- **Telephonic behavioral health triage in jail:** Inmates are screened for suicide and mental health risk using a research-based triage instrument designed specifically for the jail environment. Positive responses trigger an immediate phone call, 24/7, to a mental health professional who determines the inmate's risk for suicide and need for behavioral health care services. Based on the identified risk level, the jail initiates specific protocols related to housing, supervision, clothing, property, and food.
- **Follow-up mental health services**: Depending on need, mental health professionals from the local community mental health clinic provide follow-up services at the jail or via video conferencing. Response times for follow-up services are dictated by the level of risk. Services include brief counseling, crisis consultation to mitigate risk, consultation with jail staff on crisis management and treatment, and recommendations regarding in-custody care, medication, and post-discharge care.
- **State funding**: There was bipartisan support for legislation to use state general funds and provide this service statewide.
- **Outcomes**: An evaluation at five pilot test sites showed consistent assessments, easy connection with community mental health provides, more consistent implementation of jail protocols, and reduced jail liability. For some inmates, charges were dropped or amended in favor of appropriate mental health treatment.

Colorado Jail-based Behavioral Health Services (JBBS)

- **Screening, assessment, and treatment in jail**: State-funded staff (both state employees and contracted providers) screen, assess, and treat jail inmates for mental health and substance use disorders (including co-occurring disorders) while they are in jail, using evidence-based practices.
- **Continuity of care:** The same behavioral health organizations provide case management, transition planning, and treatment in the community once inmates are released.
- **Statewide expansion:** JBBS began five years ago but in 2015 expanded to every county in the state.
- **Outcomes**: During Fiscal Year 2015, 29 percent of clients were still engaged in the recommended treatment services one month after release. One year after release, 27 percent were still engaged in community-based treatment.

Eau Claire County (Wisconsin) Evidence-based Decision-Making

- **Evidence-based decision-making (EBDM):** Eau Claire County adopted EBDM as its top strategy for improving the administration of justice and promoting public safety through planning, research, education, and system-wide coordination of criminal justice initiatives. The county began implementing research-based criminal justice practices and the use of actuarial tools to inform decisions.
- **Multiple assessment tools:** The county uses the Proxy Pre-Screen Assessment Tool for decisions related to felony custodial arrests, diversion, and charges and the COMPAS Risk and Need Assessment System for decisions related to cash bail, sentencing recommendations, and probation supervision.
- **Risk-based custodial arrest and pretrial release:** Low-risk felony defendants are not held on cash bail unless it is statutorily required (for domestic violence, for example). Cash bail review can be expedited, based on results of the pretrial COMPAS assessment.
- **Evidence-based probation supervision:** Probation supervision is reserved for medium- and high-risk individuals, unless there is a compelling public interest for low-risk individuals. Jail is imposed as a condition of probation only when necessary.
- **Pretrial and probation case management:** A community transition center provides a variety of services for pre-sentence bond clients and probationers, including assessment, case management, randomized alcohol and drug testing, and educational programming.
- **Multiple drivers:** The change to evidence-based decision-making was driven by funding limitations, the need for a new jail, public support for a "smart on crime" rather than "tough on crime" approach, and the commitment of justice system leaders and the county board of commissioners to maintaining public safety while moderating jail population increases.
- **Outcomes:** Participants in Eau Claire's pre-charge diversion program had a two-year recidivism rate of 18.6 percent, while the control group's rate was 33.6 percent. The majority of cases referred to the program involved disorderly conduct, possession of THC, and theft charges. The county's Community Transitions Center, which supervises defendants released on bond and electronic monitoring, saved the county 17,538 jail bed days in 2015 while maintaining a 4.9 percent rate of positive drug tests.

Miami-Dade County Criminal Mental Health Project (CMHP), in Florida's 11th Judicial Circuit

- **Post-booking crisis stabilization:** Defendants in jail undergo evidence-based screening for mental illness (using the Brief Jail Mental Health Screen), medical assessment that includes psychiatric functioning, and, if necessary, evaluation by the correction health services' psychiatric staff. Defendants arrested for misdemeanors and third-degree felonies who are identified as seriously mentally ill and in need of acute-care services are transferred to a community-based crisis stabilization center within 48 hours of arrest.
- **Post-booking diversion to voluntary mental health treatment:** If prosecutors and the victim(s) agree, the stabilized defendant is offered the option of participating in mental health treatment and services as an alternative to jail, with legal charges dismissed or modified upon completion of the program.
- **Transition planning and peer support:** Comprehensive transition planning using the nationally recognized APIC model (a best practice) links participants with community-based treatment, support, and housing services, including a peer support specialist.

- **Entitlement enrollment:** Transition planning includes screening program participants for eligibility for federal entitlement benefits, such as SSI or SSDI, and helping them enroll.
- **Outcomes:** The one-year recidivism rate (i.e., return to jail) for misdemeanants who completed the program was 20 percent, compared to 72 percent for misdemeanants who did not participate in diversion. For felons, the one-year recidivism rate was 6 percent.

Connecticut Pretrial Jail Re-Interview

- **Re-interview for bond modifications and pretrial release**: Under the auspices of the Court Support Services Division (i.e., the judicial branch), Jail Re-Interview (JRI) staff re-evaluate defendants held on bond to assess treatment needs or circumstantial changes in the condition of the person, and develop a supervision plan to present to the court in the form of a bond modification. JRI staff work with the defendant and their family and/or references, to develop a pretrial release plan and placement in an incarceration alternative program. (State of Connecticut Judicial Branch)
- **Outside treatment under supervised released:** If an appropriate pretrial release and treatment plan can be developed, with the support of the defendant's family and/or references, a pretrial release recommendation is presented to the court and ruled on during a bond modification hearing. During treatment, the defendant may be under supervision by probation officers. If the defendant completes the treatment program satisfactorily, charges are dismissed. (State of Connecticut Judicial Branch; Dr. Kathleen Maurer, personal communication)
- **Outcomes**. In fiscal year 2006, JRI staff screened more than 6,000 pretrial defendants and judges agreed to release 64 percent of them to the community. In fiscal year 2007, the number of people screened increased to 10,885, with judges approving 69 percent of the release recommendations. (Immarigeon and Greene 2008)

Nevada Forensic Diversion Efforts

- **State investment.** Nevada has invested state dollars to resolve medication and formulary issues in jails, provide transition services in jail, and supply housing staffed by psychiatric case workers and mental health professionals for justice-involved individuals with mental illness. The state also raised Medicaid reimbursement rates for hospital psychiatric beds. The higher reimbursement rates have encouraged private hospitals to establish psychiatric units; this in turn has reduced demand on the state hospitals, including civil beds, and freed up beds for forensic clients.
- **Medicaid TCM reimbursement for parole and probation services**. Parole and probation departments in Nevada are just beginning to leverage Medicaid funds through targeted case management (TCM) for parole and probation services.
- **Outcomes**. Outcomes data were not available for this report.

Competency-related Programs

Nevada Competency Court

- **Competency court**. In response to a consent decree, Clark County (Las Vegas) established a competency specialty court in 2007 that serves as a single point of contact for services related to competency and restoration.[1]

- **Outcomes**: The court significantly shortened the wait time for evaluations and treatment access and received a 2007 Achievement Award from the National Association of Counties (Skolnik 2007).

Arapahoe County (Colorado) Jail-based Competency Restoration

- **Independent contractor:** An independent contractor runs the 52-bed RISE ("Restoring Individuals Safely and Effectively") program, which provides competency restoration services in a portion of an existing jail, for the Colorado Department of Human Services. The contractor selected the jail, contracted with the sheriff's office, and made extensive modifications for suicide mitigation and softening. The facility is staffed by corrections officers who provide security and logistics and mental health professionals (employed by the contractor) who provide all treatment and program-related services.

- **State screening of participants**: The court refers potential RISE program participants to the Colorado Department of Human Services (DHS), which reviews all referrals and identifies people who are likely to be successful in the program (i.e., they take medications voluntarily and probably can be restored relatively easily). The RISE program must accept into the program everyone DHS refers.

- **Robust programming**. Restoration programming is based on programming at the state hospital but is both more robust and more flexible.

- **Per-bed savings:** Per-bed costs for the RISE program are approximately $300 per day, compared to more than $600 per day at the state hospital. Savings are attributable in part to avoided indirect costs associated with accreditation of hospitals, plus the fact that psychiatrists work in house only part time (although they are available on call).

San Bernardino (California) In-Jail Competency Restoration

- **Short-term, in-jail treatment program:** Since 2011, Liberty Healthcare of California has run an in-jail competency restoration program at West Valley jail for people it believes can be restored to competency in 90 days or less. A forensic psychiatrist, forensic psychologist, forensic social worker, rehabilitation therapist, and nurse work with defendants in the jail, providing group treatment and individualized targeted competency education. One custody deputy is assigned to the program. There is no forced medication, and 85 percent of patients fully comply with voluntary medication.

- **Expansion:** The program began as a 20-bed pilot but expanded to 76 beds in 2015 and now accepts people from outside the county.

- **Outcomes:** As of 2013, approximately 58 percent of program patients had been restored to competency, in an average of 56 days. A 2012 the California Legislative Analyst Office

[1] http://www.clarkcountycourts.us/clerk/rules/Admin07-07.pdf.

(LAO) study showed that the program restored competency more quickly than the state hospitals do.

Miami-Dade Forensic Alternative Center

- **Alternative to state hospital placement:** The program opened in 2009 with a goal of providing safe, effective, and cost-efficient alternative placement options for defendants ruled incompetent to stand trial who are charged with non-violent second- and third-degree felonies. The program offers a continuum of care during the commitment period and after reentry into the community, including monitoring of individuals who have returned to the community to ensure that treatment and support services are maintained.
- **The center:** The unit has 16 beds, with a staff that includes nurses, case managers, a psychiatrist, and competency instructors. Patients spend an average of 97 days at the center. Following restoration, defendants return to court, where they may receive probation, charges may be dropped, or they may choose to have a trial.
- **Outcomes:** Individuals at the center are less likely than those returned to jail to decompensate and be declared incompetent to proceed. Outcomes data indicate that competency is restored more quickly in the program than at state hospital facilities (103 days versus 146 days) and that the program costs less per bed day ($229, versus $333 at state hospital facilities) (The Florida Senate Interim Report 2012-108).

Multnomah County Mental Health and Addiction Services Division Forensic Diversion Program

- **Program goal:** This community-based competency restoration program is designed to identify individuals involved in the criminal justice system who have severe, acute, chronic mental health issues and to develop appropriate community competency restoration and jail diversion plans that will decrease jail and hospital stays, ensure progress toward recovery, and decrease recidivism.
- **Participation:** Participants are evaluated on a case-by-case basis to assess criminogenic risk and behavioral health needs. The only excluded charges are murder and predatory sex offenses. Participants must be currently involved or at risk of being involved in the criminal justice system; have an acute, chronic mental health illness; reside in Multnomah County; and voluntarily agree to participate.
- **Services:** The average length of program participation is 6 to 12 months. Program services include behavioral health screening and assessment, development of individualized restoration/diversion plans, services to address basic needs (e.g., housing, food, and clothing), treatment to address behavioral health needs and barriers to recovery, legal skills education, referral and linkage to community-based care, systems navigation and forensic case coordination to ensure that participants attend treatment appointments and court hearings, follow through on court orders, etc.
- **Staffing and funding:** The program is funded through a mix of county general fund, state general funds, and federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant funds. The program is staffed with five qualified mental health associates (QMHA) who carry caseloads of 25 each, two qualified mental health professionals who carry flexible caseloads and conduct screenings and assessments, one housing coordinator, and 1.5 FTE forensic peer support specialists. One of the QMHAs is focused on culturally responsive services for the African-American population.
- **Data and outcomes:** In fiscal year 2016, 43 percent of program referrals were made by public defenders and 23 percent came from community partners, including community

supervision (i.e., probation). The program served 405 unduplicated clients, saved 5,513 state hospital days for a cost savings of $4,961,700, and saved 6,577 jail bed days for a savings of $1,313,756.[2]

Transition and Residential Treatment Programs

Maricopa County (Phoenix) Criminal Justice Engagement Team (CJET)

- **Connection within 24 hours:** Within 24 hours of receiving a referral, peer engagement specialists meet with low-risk jail detainees who have a mental illness or other behavioral health condition, have been arrested, and are being released from jail. The peer specialists provide clients with support and encouragement and connect them with services. Most clients have been diagnosed with a serious mental illness and were arrested for misdemeanor offenses such as public intoxication or petty theft.
- **Release without charges:** Given the quick referral process, judges sometimes release low-risk offenders after just one night in jail, before charges are filed—as long as the detainee agrees to meet with the peer engagement specialists.
- **Rich array of services**: Peer engagement specialists motivate and support clients in accessing a variety of services, including emergency shelter and housing assistance, coordinated case management, assessments and treatment planning, assistance meeting basic needs (clothing, food, transportation, hygiene), health care appointments, individual counseling, medication stabilization and education, legal/court system navigation, substance abuse counseling, and vocational training. Services are directed toward reducing activities that result in arrests.
- **Collaborative effort**: The program is the result of collaboration among Maricopa County's pretrial and correctional health services groups and the jail diversion team for Mercy Maricopa Integrated Care, the regional behavioral health authority.
- **Outcomes**: CJET began in February of 2016, so no outcome data are yet available. During the first eight months of program operation, 178 individuals were referred to the program and 58 percent of them (103 people) were released from jail to CJET peer engagement specialists. Of those individuals released to CJET, 85 percent (88 people) participated in services.

Cascadia Secure Residential Treatment, in Portland, Oregon

- **Structured treatment and support:** Secure residential treatment facilities for people with severe symptoms of mental illness focus on prevention, skill building that promotes health and safety, and a holistic approach to treatment. The goal is to stabilize both psychiatric and medical issues so that patients can continue their recovery and eventually live as independently as possible.
- **24/7 staffing:** Facilities are staffed 24 hours a day, seven days a week, with 24-hour access to nursing staff and regular visits from a licensed medical provider.

---

[2] Multnomah County Health Department Mental Health & Addiction Services Division Forensic Diversion Program Presentation. August 4, 2016.

References

Aidala, A.A., W. McAllister, M. Yomogida, and V. Shubert. 2013. Frequent Users Service Enhancement 'Fuse' Initiative: New York City Fuse Ii Evaluation Report. Columbia University, Mailman School of Public Health.

Alakeson, V., N. Pande, and M. Ludwig. 2010. "A Plan To Reduce Emergency Room 'Boarding' Of Psychiatric Patients." Health Affairs. September 2010, Vol. 29, No. 9, 1637-1642. Available at http://content.healthaffairs.org/content/29/9/1637.full.

Almquist, L., and E. Dodd. 2009. Mental Health Courts: A Guide to Research-Informed Policy and Practice. Council of State Governments Justice Center. Supported by the MacArthur Foundation. Available at https://www.bja.gov/Publications/CSG_MHC_Research.pdf.

Bazelon Center for Mental Health Law. 2010. Supported Employment Fact Sheet. Available at http://www.bazelon.org/LinkClick.aspx?fileticket=IVd2OXBERnI%3D&tabid=350.

Brodsky, M. 2012. Residential Treatment — When to Consider It, What to Look For. Social Work Today. March/April 2012 Issue. Vol. 12, No. 2, P. 8. Available at http://www.socialworktoday.com/archive/031912p8.shtml.

Broner, N., D.W. Mayrl, and G. Landsberg. 2005. "Outcomes of Mandated and Non-Mandated New York City Jail Diversion for Offenders with Alcohol, Drug, and Mental Disorders." The Prison Journal 85(1):18-49.

Buntin, J. 2015. "Miami's Model for Decriminalizing Mental Illness in America." Governing the States and Localities. August 2015. Available at http://www.governing.com/topics/public-justice-safety/gov-miami-mental-health-jail.html.

Burt, M., and J. Anderson. 2005. AB.2034 Program Experiences in Housing Homeless People with Serious Mental Illness. Oakland, CA: Corporation for Supportive Housing. http://documents.csh.org/documents/ca/csh_ab2034.pdf. (Accessed January 25, 2006.)

Camilletti, C. 2010. Pretrial Diversion Programs: Research Summary. Bureau of Justice Assistance, U.S. Department of Justice. Available at https://www.bja.gov/Publications/PretrialDiversionResearchSummary.pdf.

Carabello, K. 2013. Jail-Based Restoration of Competency Program Fact Sheet. Testimony provided March 28, 2013, by Ken Carabello, Vice President of Operations, Liberty Healthcare Corporation. Available at http://www.leg.state.nv.us/Session/77th2013/Exhibits/Senate/JUD/SJUD623F.pdf.

Center for Problem-Oriented Policing. 2005. Psychiatric Emergency Response Team and Homeless Outreach Team: San Diego Police Department. Available at http://www.popcenter.org/library/awards/goldstein/2005/05-12.pdf.

Clifasefi, S.L., H.S. Lonczak, and S.E. Collins. 2016. LEAD Program Evaluation: The Impact of LEAD on Housing, Employment and Income/Benefits. Harm Reduction Research and Treatment Center University of Washington – Harborview Medical Center. March 31, 2016. Available at http://static1.1.sqspcdn.com/static/f/1185392/27047605/1464389327667/housing_employment_evaluation_final.PDF?token=%2BGd%2BQD%2Fc0lpefHydWkfxkJklt60%3.

Collins, S.E., H.S. Lonczak, and S.L. Clifasefi. 2015. LEAD Program Evaluation: Criminal Justice and Legal System Utilization and Associated Costs. Harm Reduction Research and Treatment Lab University of Washington – Harborview Medical Center. June 24, 2015. Available at http://static1.1.sqspcdn.com/static/f/1185392/26401889/1437170937787/June+2015+LEAD-Program-Evaluation-Criminal-Justice-and-Legal-System-Utilization-and-Associated-Costs.pdf?token=2kAXwtFY99Ctvp2ho5LCwhiTk2Y%3D.

Colorado Department of Human Services. Jail Based Behavioral Health Services (JBBS). Available at https://sites.google.com/a/state.co.us/cdhs-behavioral-health/home/community-behavioral-health/programs-and-services/services-for-people-involved-in-criminal-justice/jail-based-behavioral-health-services-jbbs. Viewed November 4, 2016.

Cook, J.A., et. al. 2005. Results of a Multisite Randomized trial of Supported Employment Interventions for Individuals With Severe Mental Illness, Archives of General Psychiatry, May 2005.

Council of State Governments. 2002. Criminal Justice/Mental Health Consensus Project. Document No. 197103. June 2002.

Cowell, A.J., A. Aldridge, N. Broner, and J.M. Hinde. 2008. A Cost Analysis of the Bexar County, Texas, Jail Diversion Program. Report 2: An Analysis of Cost-Shifting between the Treatment and Criminal Justice Systems. Prepared for Leon Evans, President/Executive Officer, The Center for Health Care Services. RTI Project Number 0209991.000. May 2008.

Cox, S.M., D. Mitchell, and R. Tirnady. 2010. The Final Report of the Evaluation of the Court Support Services Division's Mental Health Case Management Pilot Project. Department of Criminology and Criminal Justice, Central Connecticut State University. June 2010. Available at http://www.jud.ct.gov/cssd/research/Ev_CSSD_MentalHealth_CMPP.pdf.

Culhane, D.P., S. Metraux, and T. P. Hadley. 2002. "Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing." Housing Policy Debate 13: 107–162.

Culhane, D.P., W. Parker, B. Poppe, K. Gross, and E. Sykes. 2007. "Accountability, cost-effectiveness, and program performance: Progress since 1998." In Toward Understanding Homelessness: The 2007 National Symposium of Homelessness Research, edited by D. Dennis, G. Locke, and J. Khadduri. Washington, DC: U.S. Department of Health and Human Services and U.S. Housing and Urban Development.

De Hert, M., C.U. Correll, J. Bobes, M. Cetkovich-Bakmas, D. Cohen, I. Asai, J. Detraux, S. Gauman, H. Möller, D.M. Ndetei, J.W. Newcomer, R. Uwakwe, and S. Leucht. 2011. Physical Illness in Patients with Severe Mental Disorders. I. Prevalence, Impact of Medications and Disparities in Health Care. Educational module in World Psychiatry. Feb 2011; 10(1): 52–77.

Disability Rights California. Placement of Individuals Found Incompetent to Stand Trial: A Review of Competency Programs and Recommendations. Publication #CM52.01. Available at http://www.disabilityrightsca.org/pubs/CM5201.pdf.

Eau Claire County. 2016. Criminal Justice Report – 2015 CJCC Review. Available at http://co.eau-claire.wi.us/home/showdocument?id=11102.

Fan, Z.J., B.A. Lucenko, S. Estee, B.E.M. Felver, C. Black, D. Mancuso. Improving Employment Outcomes for People with Mental Health Disorders in Washington State. Prepared in collaboration

with Melodie Pazolt, Behavioral Health Program Administrator, Division of Behavioral Health and Recovery, Behavioral Health Administration.

Fazel, S., G. Gulati, L. Linsell, J.R. Geddes, and M. Grann. 2009. "Schizophrenia and Violence: Systemic Review and Meta-analysis." PLoS Medicine, 6, e1000120.

Ferguson, J. Research analyst, Maricopa County Adult Probation. Personal communication. November 1, 2016.

Fontaine, J., D. Gilchrist-Scott, J. Roman, S. Taxy, and C. Roman. 2012. Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home—Ohio Pilot Project. The Urban Institute Justice Policy Center. August 2012.

Fox, Patrick. Chief medical officer, Colorado Department of Human Services. Personal communication. October 24, 2016.

Gilger, Lauren. 2016. 24 Hours From Arrest To Release To Services For Seriously Mentally Ill In New Program. Available at http://kjzz.org/content/368554/24-hours-arrest-release-services-seriously-mentally-ill-new-program. September 22, 2016.

Griller, G.M. 2011. The Quiet Battle for Problem-Solving Courts. National Center for State Courts. Available at http://www.ncsc.org/sitecore/content/microsites/future-trends-2011/home/Specialized-Courts-Services/3-1-The-Quiet-Battle-for-Problem-Solving-Courts.aspx.

Henzel, P.D., J. Mayfield, A. Soriano, and B.E.M. Felver. 2016. Behavioral Health Needs of Jail Inmates in Washington State. Report to the Washington State Office of Financial Management's Statistical Analysis Center, Thea Mounts, Director, and Keri-Anne Jetzer, Forecast Analyst. DSHS Research and Data Analysis Division, Olympia, Washington. RDA Report 11.226. January 2016.

Highland Community News. 2015. San Bernardino County to Expand its Jail-Based Restoration of Competency Program. August 20, 2015. Available at http://www.highlandnews.net/news/public_safety/san-bernardino-county-to-expand-its-jail-based-restoration-of/article_6754c8ca-4755-11e5-97ae-e7c4bc4dade2.html.

Huckelberry, C.H. 2013. Memorandum to the Honorable Chairman and Members, Pima County Board of Supervisors, re: Crisis Center Annual Report. February 26, 2013. Available at http://webcms.pima.gov/UserFiles/Servers/Server_6/File/Government/Administration/CHHmemosFor%20Web/February%20Memos/February%2026,%202013%20-%20Crisis%20Response%20Center%20Annual%20Report.pdf

Immarigeon, R., and J. Greene. 2008. Diversion Works: How Connecticut Can Downsize Prisons, Improve Public Safety and Save Money with a Comprehensive Mental Health and Substance Abuse Approach. A Better Way Foundation Report. Commissioned by the Drug Policy Alliance. April 2008. Available at http://www.drugpolicy.org/sites/default/files/DiversionWorks.pdf.

Kentucky Cabinet for Health and Family Services. Kentucky Jail Mental Health Crisis Network. Available at http://dbhdid.ky.gov/dbh/jail-triage.aspx. Viewed November 1, 2016.

Kessler, R.C. et al. (1999) as cited in Council of State Governments, 2002, Criminal Justice/Mental Health Consensus Project. Document No. 197103. June 2002.

Kessler, R.C. et al. 1999. "A Methodology for Estimating the 12- Month Prevalence of Serious Mental Illness." In Mental Health United States 1999. Edited by R.W. Manderscheid and M. J. Henderson. Rockville, MD: Center for Mental Health Services, 1999.

King, R.S., and J. Pasquarella. Drug Courts: A Review of the Evidence. 2009. The Sentencing Project. April 2009. Available at http://www.sentencingproject.org/wp-content/uploads/2016/01/Drug-Courts-A-Review-of-the-Evidence.pdf.

Leifman, S. 2009. "Eleventh Judicial Circuit Criminal Mental Health Project." Future Trends in State Courts 2009. National Center for State Courts. Available at http://cdm16501.contentdm.oclc.org/cdm/ref/collection/spcts/id/201.

Maurer, K., Health Services Director, Connecticut Department of Corrections. Personal communication. September 27, 2016.

Monahan, J., and H. Steadman. 2012. "Extending Violence Reduction Principles to Justice-involved Persons with Mental Illness." In J.Dvoskin, J. Skeem, R. Novaco, and K. Douglas (Eds). Applying Social Science to Reduce Violent Offending (pp. 245-261). New York: Oxford University Press.

Monhan, J. 2011. "Mandated Psychiatric Treatment in the Community—Forms, Prevalence, Outcomes and Controversies." In Coercive Treatment in Psychiatry: Clinical, Legal and Ethical Aspects. First Edition. Edited by T. Kallert, J. Mezzich, and J. Monahan. John Wiley & Sons, Ltd.

Morrisey, J., and P. Meyer. 2008. Extending Assertive Community Treatment to Criminal Justice Settings. CMHS National GAINS Center. May 2006, updated August 2008.

Morrissey, J.P. 2013. Forensic Assertive Community Treatment: Updating the Evidence. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. October 2013.

Multnomah County Health Department. 2014. 2014 Report Card on Racial and Ethnic Disparities. December 12, 2014. Available at https://multco.us/file/37530/download.

Munetz M.R., and P.A. Griffin. 2006. "Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness." Psychiatric Services, 57:544-549. doi:10.1176/appi.ps.57.4.544).

Neighbors, Elizabeth. Director, Nevada Statewide Forensic Program. Personal communication. October 25, 2016.

New York State Office of Mental Health. 2005. Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment. March 2005. Available at https://www.omh.ny.gov/omhweb/kendra_web/finalreport/.

Noreus, B. 2006. Connecticut's Criminal Justice Diversion Program. Maine Criminal Justice/Mental Health Brief #3. Prepared by the Diversion Re-Entry Steering Committee. January 2006. Available at the Maine Statistical Analysis Center website: http://muskie.usm.maine.edu/justiceresearch.

Pasadena Villa. "What Is the Difference Between Inpatient and Residential Mental Health Treatment?" Posted April 14, 2015. Available at http://www.pasadenavilla.com/2015/04/14/what-is-the-difference-between-inpatient-and-residential-mental-health-treatment/. Viewed November 17, 2016.

Peterson, J.K., J. Skeem, P. Kennealy, B. Bray, and A. Zvonkovic. 2014. "How Often and How Consistently Do Symptoms Directly Precede Criminal Behavior among Offenders with Mental Illness?" Law and Human Behavior. Vol. 38, No. 5, 439-449.

Peterson, M., and P. Repard. 2015. "Are Cops Prepared to Deal with Mentally Ill?" The San Diego Union-Tribune. September 6, 2015. Available at http://www.sandiegouniontribune.com/news/crime-courts-fire/sdut-police-mentally-ill-training-pert-2015sep06-story.html.

Prins, S.J., and L. Draper. 2009. Improving Outcomes for People with Mental Illnesses under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice. Council of State Governments Justice Center. Supported by the MacArthur Foundation. Available at https://csgjusticecenter.org/wp-content/uploads/2012/12/Community-Corrections-Research-Guide.pdf.

Promoting Independence and Recovery through Work: Employment for People with Psychiatric Disabilities, Briefing Document for the National Governors Association, Center For Best Practice (NGA) Webcast Transforming State Mental Health Systems: Promoting Independence and Recovery through Work: Employment for People with Psychiatric Disabilities, July 31, 2007.

Recovery Network of Programs. Treatment Pathway Program. Viewed November 14, 2016. Available at http://www.recovery-programs.org/services/addiction-treatment/outpatient-treatment/treatment-pathway-program/.

Reuland, M., M. Schwarzfeld, and L. Draper. 2009. Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice. Council of State Governments Justice Center. Supported by the MacArthur Foundation. Available at http://www.nccpsafety.org/assets/files/library/LE_Responses_to_Mental_Illnesses_-_Policy_and_Practice.pdf.

SAMHSA's Gains Center for Behavioral Health and Justice Transformation. "What Is Jail Diversion?" and "Types of Jail Diversion." http://gainscenter.samhsa.gov/topical_resources/jail.asp. Viewed Nov. 19, 2014.

SAMSHA's GAINS Center for Behavioral Health and Justice Transformation and the Council of State Governments Justice Center. 2012. A Checklist for Implementing Evidence-based Practices and Programs for Justice-Involved Individuals with Behavioral Health Disorders. August 2012.

San Diego County Grand Jury. 2016. PERT Psychiatric Emergency Response Team. Available at http://www.sandiegocounty.gov/content/dam/sdc/grandjury/reports/2015-2016/PERTReport.pdf.

Shah, J. Jail Based Behavioral Health Services Program (JBBS) Annual Report: FY 2015. Colorado Department of Human Services, Office of Behavioral Health. Available at https://drive.google.com/file/d/0B1-_ZOVijYoDUnBiU0dFUU5tSHJULTZ6RlUya2lXV2dRTWlv/view.

Sirotich, F. 2009. "The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of the Evidence." Journal of the American Academy of Psychiatry and the Law, 37:461-72, 2009.

Skolnik, S. 2007. "Reforms streamline competency court, save money." Las Vegas Sun. July 16, 2007. Available at http://lasvegassun.com/news/2007/jul/16/reforms-streamline-competency-court-save-money/.

Southwest Behavioral & Health Services. Criminal Justice Engagement Team. Brochure.

State of Connecticut Judicial Branch. Court Support Services Division, Adult Bail/IAR (Intake, Assessment, Referral). Available at http://www.jud.ct.gov/cssd/bail.htm. Viewed November 14, 2016).

State of Connecticut Judicial Branch. Court Support Services Division: Adult Bail/IAR (Intake, Assessment, Referral). Available at https://www.jud.ct.gov/cssd/bail.htm. Viewed September 27, 2016.

Steadman, H.J. 2014. When Political Will Is Not Enough Jails, Communities, and Persons with Mental Health Disorders. White Paper 1, prepared for John D. & Catherine T. MacArthur Criminal Justice Reform Initiative: Reducing the Overuse and Misuse of Jails in America Initiative. Policy Research Associates, Inc. July 2014.

Steadman, H.J., E. Mulvey, J. Monahan, P. Robbins, T. Grisso, L. Roth, and E. Silver. 1998. "Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods." Archives of General Psychiatry, 55, 393-401.

Stewart, G., L. Gerritsen, E. Covelli, and K. Henning. 2012. Report on Police Interactions with Person in Mental Health Crisis. March 21, 2012.

The Florida Senate Interim Report 2012-108. Budget Subcommittee on Health and Human Services Appropriations. The Forensic Mental Health System. September 2011. Available at http://www.flsenate.gov/publishedcontent/session/2012/interimreports/2012-108bha.pdf.

Thomas, K.A., D.J. Rickwood, and G. Bussenschutt. 2015. Adult Step-up Step-down: A Sub-acute Short-term Residential Mental Health Service." International Journal of Psychosocial Rehabilitation. Vol 19(1) 13- 21. Available at http://www.psychosocial.com/IJPR_19/Adult_Step-up_Thomas.html.

Torrey, E.F. 2006. Surviving Schizophrenia : A Manual for Families, Patients, and Providers. Quill; 5th edition. April 1, 2006. ISBN: 0060842598.

Trueblood Diversion Plan. 2016. Submitted by the parties in Trueblood as Next Friend of A.B. et al v. Washington State Department of Social and Health Services (DSHS), Case No. C14-1178 MJP. Submitted to the Honorable Marsha J. Pechman, Chief United States District Judge United States District Court for the Western District of Washington at Seattle. August 19, 2016

Ventura, LA., C.A. Cassel, J.E. Jacoby, and B. Huang. "Case Management and Recidivism of Mentally Ill Persons Released from Jail." Psychiatric Services 49:10, Oct. 1998, 1330-37.

Zeller, S., N. Calma, and A. Stone. 2014. "Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments." Western Journal of Emergency Medicine. 2014 Feb; 15(1): 1-6. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935777/. Viewed November 17, 2016.

Appendix B:
Using Medicaid Funding to Support Jail Diversion

This document presents results from work that Joplin Consulting completed for Task 5 of Contract No. K1911 with the Washington State Office of Financial Management (OFM). Under the contract, Joplin Consulting reviewed best practices to safely and appropriately divert people with mental illness from the criminal justice system to community-based treatment and made recommendations to Washington state on how to increase jail diversion opportunities for people with mental illness.

Under Task 5, Joplin Consulting conducted and summarized a brief literature review and phone interviews with national experts to identify promising practices in the use of Medicaid funding to support jail diversion for individuals with mental illness.

Medicaid Enrollment as an Opportunity

- The Affordable Care Act (ACA) expands Medicaid eligibility to adults without children who have income of up to 133 percent of the federal poverty level (FPL). This category of people who are newly eligible for Medicaid includes many individuals who are involved in the criminal justice system, such as young, lower income men who do not have children and are not disabled.

- Historically, the jail-involved population was among the largest groups without health insurance, yet many of them have high health care needs. They are more likely than the general public to suffer from mental illness, substance use disorders, and/or chronic disease, and often their health needs have been unaddressed because of their social conditions (e.g., poverty, unemployment, low educational achievement, low literacy rates, and homelessness). (Hanig 2015)

- Enrolling people in Medicaid who move into and out of incarceration has multiple potential benefits, including increasing their access to care, improving their health, and reducing expenses by the state. (Bazelon Center for Mental Health Law 2009). This is particularly true for people with mental illness, who have a relatively high rate of recidivism (Morrissey et al. 2007 as cited in Bazelon 2009, Community Oriented Corrections Health Services 2013).

- Many people with mental illness cycle in and out of jail, in part because, upon release, they lack access to case management, treatment, and rehabilitation services in the community. However, if they are enrolled in Medicaid at release and thus can access community-based services immediately, they tend to receive more services and stay in the community longer than people with mental illness who are not on Medicaid (Bazelon Center for Mental Health Law 2009, Morrissey et al. 2007 as cited in McKee et al. 2015, and Hanig 2015).

- Washington State found that justice-involved individuals who enrolled in Medicaid at release from jail were more likely to access community mental health and substance abuse services than were justice-involved individuals not enrolled in Medicaid (Community Oriented Corrections Health Services [COCHS] 2015b).

Suspension vs. Termination of Medicaid Benefits

- Medicaid law requires that federal payments for services be discontinued once someone is in a jail or prison (unless they are in an inpatient hospital for more than 24 hours). However, Medicaid eligibility rules differ from those concerning federal payment for services. The law does not require that individuals in jail or prison lose their Medicaid eligibility, but it does not allow for payments for services furnished to them while in jail. This means that states can temporarily suspend an incarcerated person's payments without the individual being totally terminated from the Medicaid program (letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives, April 6, 2000 as cited in Bazelon Center for Mental Health Law 2009).

- Both the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services have urged states to suspend, rather than terminate, Medicaid enrollment when people enter jail or prison. CMS encouraged this as early as 2004 (McKee et al. 2015).

- In the case of individuals who are covered by Medicaid managed care entities, states can stop capitated payments to plans when these individuals are in jail or prison, without terminating their enrollment in Medicaid (McKee et al. 2015).

- A few states require corrections staff to facilitate the application process for individuals nearing release. Sometimes this task is done by dedicated eligibility workers who are hired specifically to process Medicaid applications (Cohen 2013 as cited in McKee et al. 2015). In Washington, the Department of Corrections (DOC) and many jails are incorporating enrollment for Apple Health (i.e., Medicaid) into their release planning (Washington Health Care Authority 2014 as cited in McKee 2015).

- Suspending rather than terminating Medicaid eligibility when someone is incarcerated may also make it easier for the state to receive Medicaid reimbursement for care when an inmate is cared for in a hospital, nursing facility, psychiatric facility, or intermediate care facility for more than 24 hours (McKee 2015).

- In Washington State, the governor signed SSB 6430 into law on March 31, 2016. The law became effective on June 9, 2016, and requires the Washington State Health Care Authority (HCA) to "suspend, rather than terminate, medical assistance benefits by July 1, 2017, for persons who are incarcerated or committed to a state hospital." A progress report is due to the Governor and legislature by December 1, 2016. Currently there are multiple workgroups and stakeholders engaged in meeting the requirements of this legislation. HCA is developing an interface with DOC and the Jail Booking and Reporting System (JBRS) that will allow inmates' benefits to be suspended instead of terminated. The work is on track to meet the July 1, 2017 deadline.

Using Medicaid to Fund Crisis Services

- Studies show that crisis services such as 23-hour crisis stabilization centers, short-term crisis residential services, mobile crisis services, hotlines, warm lines, and peer crisis services can result in significant cost savings because they reduce inpatient utilization, divert people from

hospital emergency rooms, and make more appropriate use of community-based services (Substance Abuse and Mental Health Services Administration [SAMHSA] 2014).

- In 2012, all states were using Medicaid funds to finance some of their crisis services, including mobile crisis services (this was common) and peer crisis services (15 states, including Washington). Typically, states use a variety of funding sources to provide a continuum of crisis services. "States with Medicaid managed care tend to combine state and Medicaid funds to operate their crisis services programs." (Substance Abuse and Mental Health Services Administration [SAMHSA] 2014).

- Massachusetts, Tennessee, and Michigan are using Medicaid managed care waivers to expand their crisis services continuum, sometimes braiding together Medicaid funds and state general funds. "States with Medicaid managed care behavioral health carve-outs were better able to create a full continuum of crisis services" than were states that operated under the Medicaid fee-for-service model (Substance Abuse and Mental Health Services Administration [SAMHSA] 2014).

Medicaid Administrative Claiming (MAC)

- Most Medicaid dollars (96 percent) are used to pay for traditional direct services. However, through Medicaid Administrative Claiming (MAC), some funds are available for non-service-activities expenses related to the administration of mental health, social service, and public health programs. (Community Oriented Corrections Health Services [COCHS] 2015b)

- The federal match is available only for activities that use local, county, or state dollars (Community Oriented Corrections Health Services [COCHS] 2015b).

- All public safety entities—probation and parole, sheriffs, specialty courts, regular courts, public defenders, and prosecutors—are eligible to participate in MAC, although few of them are doing so currently. (Community Oriented Corrections Health Services [COCHS] 2015b). Mental health agencies, social services, and schools also can claim MAC (Community Oriented Corrections Health Services [COCHS] 2015a).

- Through MAC, public safety entities can be reimbursed for activities such as enrolling justice-involved individuals in Medicaid and connecting them with community-based health care services. (Community Oriented Corrections Health Services [COCHS] 2015b). Reimbursable activities fall into four categories:

    - **Medicaid eligibility intake**, such as helping a client fill out a Medicaid application. Helping someone gather documentation needed to complete a Medicaid application is reimbursable, as is time spent filling out the application or responding to questions from local and state agencies (including courts) regarding the application. (Community Oriented Corrections Health Services [COCHS] 2015 and 2015c)

    - **Medicaid outreach,** such as informing a client where he or she can receive mental health treatment and helping schedule an appointment. Educating and informing people about Medicaid and how and where they can enroll are reimbursable, as is time spent linking someone with a health care service such as mental health

treatment. (Community Oriented Corrections Health Services [COCHS] 2015a and 2015c)

- **Arranging transportation to a Medicaid-covered service,** such as driving or arranging transportation for a client to a detox center for services. Coordinating a person's transportation to a doctor's office or other health care provider is reimbursable, along with the actual cost of providing that transportation. (Community Oriented Corrections Health Services [COCHS] 2015a and 2015c)

- **Referral, coordination, and monitoring,** such as a probation officer monitoring his or her client's progress in a substance abuse treatment program. Reimbursable activities include following up to determine whether a person sought the health care treatment they were referred to and discussing the individual's health care status and needs with clinicians, therapists, case managers, and others. (Community Oriented Corrections Health Services [COCHS] 2015a and 2015c)

Medicaid Targeted Case Management (TCM)

- An additional federal Medicaid program—TCM, or targeted case management—also reimburses state and county agencies, local public entities, and contracted community-based organizations for the costs that they incur while providing TCM services. Many of these entities already are performing reimbursable activities. Covered case management activities fall into four categories:

  - Assessment
  - Development of a care plan
  - Referral and related services
  - Follow-up and monitoring (Community Oriented Corrections Health Services [COCHS] 2015a)

– Probation, parole, and other public safety entities typically qualify for participation in TCM (Community Oriented Corrections Health Services [COCHS] 2015a). In Nevada, Parole and probation officers are just beginning to provide TCM that is reimbursable through Medicaid, mostly for people with serious mental illness who are in the community on electronic monitoring (Neighbors, personal communication, 2016).

- For states that have not yet designated public safety agencies as eligible claiming units to receive TCM, a sample plan is available at http://cochs.org/files/medicaid/TCM-SPA.pdf (Community Oriented Corrections Health Services [COCHS] 2015b).

State Examples: Arizona, Massachusetts, and Connecticut

Suggested Practices

- **Suspending rather than terminating Medicaid eligibility.** As of January 2016, more than 30 states were suspending rather than terminating Medicaid coverage for incarcerated individuals. (Unpublished data from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.) In Arizona, this is done using an automated, electronic process in which jails and prisons send a daily file of bookings and releases to the state Medicaid agency. The agency then places people on suspension status or lifts their suspension when they are released, so that their coverage is reactivated. (Ryan et al. 2016)

- **Enrolling inmates in Medicaid when they receive inpatient hospital care that qualifies for Medicaid coverage.** In Massachusetts, the state's Corrections Department medical care vendor assists in enrolling people in Medicaid before they receive inpatient care or, if necessary, while they are in the hospital. (Ryan et al. 2016)

- **Enrolling inmates before they are released from incarceration.** In Arizona, jails and prisons focus on enrolling people with serious mental illness and complex health needs in Medicaid about 30 days before they are released. Applications are submitted to the Medicaid agency online, by fax, or by email, and the agency has a dedicated unit to process them. In Connecticut, the state Department of Social Services facilitates the processing of Medicaid applications. (Ryan et al. 2016)

- **Enrolling people on probation and parole.** In Connecticut, every person sentenced to probation from court is screened for Medicaid; if they are not enrolled, the probation officer initiates the application process. In Massachusetts, police officers trained as Certified Application Counselors (CACs) help people complete and submit applications for Medicaid. (Ryan et al. 2016)

Accessing Care

- Once justice-involved individuals with mental illness are enrolled in Medicaid, they need to be connected to health care in the community. This can involve release planning, connecting the individual with a behavioral health agency or managed care plan, providing prescription drug vouchers, enlisting probation officers in educating the individual about Medicaid and how to access care, and more. (Ryan et al. 2016)

Outcomes

- **Use of outpatient care.** In Connecticut, individuals who were enrolled in Medicaid before they were released connected to outpatient care more quickly than those that were not pre-enrolled. They also used more outpatient care and less inpatient care. However, there were no significant differences in their number of visits to the emergency room, and they were more likely to use the emergency room than those that were not pre-enrolled. (Lin et al. 2013 as cited in Ryan et al. 2016)

- **Cost savings**

    - **In Arizona:** Implementation of suspension policies reduced state costs ($30 million in fiscal year 2015) by avoiding in capitation payments to managed care plans while individuals were incarcerated. (Ryan et al. 2016)

    - **In Massachusetts:** The jails and prisons have saved money by receiving federal Medicaid funds for inpatient care provided to inmates. The state Department of Corrections (DOC) estimates that, since July 2015, it has offset more than $4.2 million in costs for inpatient care provided to prisoners at private hospitals. Massachusetts soon will begin to claim reimbursement for inpatient care provided in the state hospital. (Ryan et al. 2016)

Obstacles

- In spite of the successes described above, a number of barriers remain to enrolling justice-involved individuals in Medicaid in states. Obstacles identified in Arizona, Connecticut, and Massachusetts include:

    - Coding or other system limitations

    - Challenges in sharing information between jails and community providers

    - Difficulty enrolling people who move in and out of custody quickly, or whose release dates are unpredictable (Ryan et al. 2016)

- People also can have difficulty accessing care even if they are enrolled and have support, because of competing priorities, lack of health literacy, the complexity of their needs, the lack of culturally appropriate service providers, and discrimination among providers against people with a criminal history. (Ryan et al. 2016)

References

Bazelon Center for Mental Health Law. 2009. The Effect of Incarceration on Medicaid Benefits for People with Mental Illness. Developed under a grant from the Department of Education, NIDRR grant number H133B080029. Available at http://www.bazelon.org/Where-We-Stand/Access-to-Services/Medicaid/Medicaid-Policy-Documents.aspx.

Cohen, R. 2013. OLR Research Report: The Affordable Care Act and Prisoners, August 13, 2013. Available at: http://www.cga.ct.gov/2013/rpt/2013-R-0288.htm.

Community Oriented Corrections Health Services (COCHS). 2013. Frequently Asked Questions (FAQs): The Affordable Care Act (ACA) and Justice-Involved Populations. May 2013. Available at http://cochs.org/files/ACA/COCHS_FAQ_ACA.pdf.

Community Oriented Corrections Health Services (COCHS). 2015. Frequently Asked Questions (FAQs): The Medicaid Administrative Claiming (MAC) Program. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_MAC.pdf.

Community Oriented Corrections Health Services (COCHS). 2015. Frequently Asked Questions: Medicaid Administrative Claiming FAQs For District Attorneys. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_FAQ4_DAs.pdf.

Community Oriented Corrections Health Services (COCHS). 2015. Issue Paper: Medicaid Claiming and Public Safety Agencies. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_Public_Safety.pdf.

Community Oriented Corrections Health Services (COCHS). 2015a. Frequently Asked Questions (FAQs): The Medicaid Administrative Claiming (MAC) Program. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_MAC.pdf.

Community Oriented Corrections Health Services (COCHS). 2015b. Issue Paper: Medicaid Claiming and Public Safety Agencies. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_Public_Safety.pdf.

Community Oriented Corrections Health Services (COCHS). 2015c. Frequently Asked Questions: Medicaid Administrative Claiming FAQs For District Attorneys. May 2015. Available at http://cochs.org/files/medicaid/cochs_medicaid_FAQ4_DAs.pdf.

Hanig, D. 2015. New Tools to Improve Health of Jail-involved Population. October 1, 2015. Available at https://www.optum.com/resources/library/justice-involved.html.

Hanig, D. 2015. New Tools to Improve Health of Jail-involved Population. October 1, 2015. Available at https://www.optum.com/resources/library/justice-involved.html.

Health Care Finance Agency Program Issuance Transmittal Notice Region IV (Mar. 6, 1998) (transmitting policies set forth in the December 1997 policy letter to Medicaid agencies in AL, FL, GA, KY, MS, NC, SC, and TN.

Joseph P. Morrissey, Gary S. Cuddeback, Alison Evans Cuellar & Henry J. Steadman, The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons With Severe Mental Illness, 58 Psychiatric Services 794, 799-800 (2007).

Letter from Associate Regional Administrator, Division of Medicaid and State Operations, Region II, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State (September 14, 2000), confirmed in a Letter from Secretary of Health and Human Services to Congressman Charles Rangel, (October 1, 2001).

Letter from Associate Regional Administrator, Division of Medicaid and State Operations, Region II, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State (September 14, 2000), confirmed in a Letter from Secretary of Health and Human Services to Congressman Charles Rangel, (October 1, 2001).

Letter from Robert A. Streimer, Dir., Disabled and Elderly Health Programs Grp., Ctr. for Medicaid and State Operations, Dep't of Health & Human Servs., to All Associate Regional Adm'rs., Div. for Medicaid and State Operations 1 (Dec. 12, 1997)

Letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives (April 6, 2000). See also Letter from Associate Regional Administrator, Division of Medicaid and State Operations, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State (September 14, 2000).

Letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives (October 1, 2001).

Letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives (April 6, 2000). See also Letter from Associate Regional Administrator, Division of Medicaid and State Operations, to Kathryn Kuhmerker, Director, Office of Medicaid Management, New York State (September 14, 2000).

Letter from Secretary of Health and Human Services to Charles Rangel, U.S. House of Representatives (October 1, 2001).

Lin, H., L. Frisman, and C. Gallagher. 2013. Expedited Medicaid Restoration in Connecticut, American Public Health Association Annual Meeting, Boston, MA. November 2013.

McKee, C., S. Somers, S. Artiga, and A. Gates. 2015. State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration. Issue brief. August 2015. Available at http://cochs.org/files/medicaid/issue-brief-state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration.pdf.

McKee, C., S. Somers, S. Artiga, and A. Gates. 2015. State Medicaid Eligibility Policies for Individuals Moving Into and Out of Incarceration. Issue brief. August 2015. Available at http://cochs.org/files/medicaid/issue-brief-state-medicaid-eligibility-policies-for-individuals-moving-into-and-out-of-incarceration.pdf.

Morrissey, J.P., G.S. Cuddeback, A.E. Cuellar, H. J. Steadman. 2007. The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons With Severe Mental Illness, 58 Psychiatric Services 794, 799-800 (2007).

Neighbors, Elizabeth. Director, Nevada Statewide Forensic Program. Personal communication. October 25, 2016.

Ryan, J., L. Pagel, K. Smali, S. Artiga, R. Rudowitz, and A. Gates. 2016. Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States. Issue Brief. The Kaiser Family Foundation. Available at http://files.kff.org/attachment/Issue-Brief-Connecting-the-Justice-Involved-Population-to-Medicaid-Coverage-and-Care.

Ryan, J., L. Pagel, K. Smali, S. Artiga, R. Rudowitz, and A. Gates. 2016. Connecting the Justice-Involved Population to Medicaid Coverage and Care: Findings from Three States. Issue Brief. The Kaiser Family Foundation. Available at http://files.kff.org/attachment/Issue-Brief-Connecting-the-Justice-Involved-Population-to-Medicaid-Coverage-and-Care.

Substance Abuse and Mental Health Services Administration (SAMHSA). 2014. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at

http://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848.

Washington Health Care Authority. 2014. Apple Health (Medicaid) Manual Incarceration Overview (updated November 10, 2014). Available at http://www.hca.wa.gov/medicaid/manual/Pages/90-110.aspx).

Appendix C:
Washington Mental Health Jail Diversion Programs

This document presents results from work that Joplin Consulting completed for Task 2 of Contract No. K1911 with the Washington State Office of Financial Management (OFM). Under the contract, Joplin Consulting reviewed best practices to safely and appropriately divert people with mental illness from the criminal justice system to community-based treatment and made recommendations to Washington state on how to increase jail diversion opportunities for people with mental illness.

Under Task 2, Joplin Consulting (1) used phone interviews to survey Washington county, city, and regional jails about their current jail diversion practices, and (2) conducted site visits at King, Pierce, Yakima, Snohomish, and Pacific counties to learn more about their diversion practices. Findings are summarized below.

Survey of Diversion Programs (Phone Interviews)

The information presented below is a summary. For more detailed description, see Appendix A.

Protocol

Joplin Consulting invited representatives of all 39 Washington counties and a selection of city, regional, and tribal jails to be interviewed by phone about their local mental health jail diversion practices. In total, we conducted 46 phone interviews with 54 people who, together, represented 20 counties, four city jails, and the SCORE regional jail (see Table 1). We also conducted in-person site visits in five counties—King, Pacific, Pierce, Snohomish, and Yakima—where we interviewed an additional 48 people. Questions focused on the type of diversion, the target population, funding, management and outcome data, the lead agency, and key partners. We did not independently verify the content of responses.

Table 1

Data Sources: Counties or Jails Surveyed or Visited

Counties Surveyed		Counties Visited	City/Regional Jails Surveyed
Clark	Lewis	King	Enumclaw
Columbia	Lincoln	Pacific	Kirkland
Cowlitz	Pend Oreille	Pierce	Puyallup
Franklin	Skagit	Snohomish	Yakima
Grays Harbor	Spokane	Yakima	SCORE
Island	Stevens		
Jefferson	Thurston		
Kitsap	Wahkiakum		
Kittitas	Walla Walla		
Klickitat	Whatcom		

Although we interviewed jail chiefs and knowledgeable individuals, not everyone we initially talked with had the information or perspective to provide complete, accurate answers. As needed, we contacted additional sources to get a clearer picture of a particular jurisdiction's jail diversion efforts.

Survey Results

Table 2 summarizes survey results from the phone interviews and site visits. Numerical results in the table represent responses about facilities located in 25 different Washington counties. In the table, "counties" refers to geographical areas, rather than jurisdictions. Thus, if one or more jails (county or city) in the same geographic county indicated that they are using a particular diversion practice, that was tallied as one county where the practice is being used. Additionally, the table reports positive responses only; because some interviewees did not know the answer to a survey question or did not respond, it is possible that a given diversion component is being used in more counties than indicated in the table.

For a narrative summary of results, see Appendix A. Additional detail is available upon request.

Table 2

Prevalence of Diversion Components and Related Activities in 25 Washington Counties

Diversion Component	Minimum # of Counties Where Component Is Used	Notes
Mobile crisis team	14	In three of the 14 counties that have mobile crisis teams, the team is either not available 24/7 or is used infrequently.
DMHPs available to law enforcement officers (typically at the jail or hospital)	25	In a few counties DMPHs reportedly do not show when called, have a response time of up to two hours, or require that the person in question be medically cleared before being assessed.
Crisis/triage center	10	Six of the 10 crisis/triage centers exclude people who have an open warrant, are facing a misdemeanor charge, have been arrested on any charge at all, are displaying assaultive behavior, are charged with crimes against persons or some sex offenses, or are using methamphetamine. Four additional counties are building or planning to build crisis beds.
Mental health staff available for jail detainees	20	Mental health staff are employed as follows: – Contracted provider—nine counties – Employed by the county—six counties – Mix of contract and county employees—two counties – Access provided an on-call basis—three counties
Mental health screening of individuals at booking using observation, officer reports, and standard intake questions.	22	
Mental health screening of individuals at booking using a formal screening tool	2	
Initial mental health screening done by corrections officer	16	Initial screening sometimes is done by: – R.N.—five counties – Mental health professional—three counties

Diversion Component	Minimum # of Counties Where Component Is Used	Notes
Formal pretrial risk assessment tool	5	Pretrial risk assessment tools used are: – ASRA – SWASRA – COMPAS – PSA – Virginia Pretrial Risk Assessment Spokane County plans to start using a tailored version of STRONG-R by November 2016.
Supervised pretrial release	22	Pretrial release includes the use of electronic monitoring and supervision in the community.
Pretrial release—for people with mental illness	5	Includes programs specifically for people with mental illness that are currently operating and programs that are in development.
New jail diversion programs	4	Four counties have recently started new jail diversion programs or will do so soon. These programs are not necessarily limited to people with mental illness.
Mental health court	11	One additional county (Kitsap) expects to launch a mental health court in mid-2017.
Medicaid enrollment before release from jail	14	Half the counties that enroll inmates in Medicaid have a contracted staffer to do this. In others, the work is done by discharge/reentry planners, medical staff, and pretrial staff.
Mental health sales tax	17	Funds from mental health taxes are most commonly used to pay for therapeutic courts, mental health or medical staff in the jail, and/or prevention and early intervention programs for adults and youth. Less commonly, mental health tax funds are used for low-income individuals who are not eligible for Medicaid, medication for people in custody, crisis services, and/or housing.

NOTE: This table reports positive responses only; because some interviewees did not know the answer to a survey question or did not respond, it is possible that a given diversion component is being used in more counties than indicated in the table.

Additional County-specific Results

Island County Ride-alongs. Island County Human Services will soon be able to dispatch mental health workers to do ride-alongs with patrol officers.

Pend Oreille County Mental Health Diversion. Pend Oreille County does not have an official mental health court but allows some people with mental illness to be diverted for three to six months with charges pending. If the participants establish a treatment program and show progress, charges are dismissed.

Spokane County Social Workers. Spokane County is hiring social workers to work in its public defenders' offices to help address mental health, alcohol, drug, or housing issues with voluntary participants while their cases are pending. The goal is to reduce the jail population by driving down the number of failures to appear (FTAs).

Spokane County Community Court and "Hotspotters." The Spokane County Community Court provides alternatives to jail for low-level, nonviolent offenders in a particular area of downtown Spokane who do not have an Axis 1 diagnosis. Most are homeless, and many have unaddressed mental illness or have not stayed engaged in treatment. Some exclusions are handled on a case-by-case basis, but generally the program excludes people with assault, DUI, DV, or recent sex offense charges. (However, even people who are not accepted can meet with program service providers.)

Court is held every week at the downtown library, with 15 to 30 service providers available in an adjacent room. Providers connect people with treatment, housing in two new housing facilities (for a total of 200 beds), and DCHS and ACA navigators. Participants do not plead guilty. Instead the court uses a stipulated order of continuance. The court has jurisdiction for up to a year on simple misdemeanors, and two years on misdemeanors and gross misdemeanors. Individuals have to complete 8 hours of community service and show that they have contacted and are participating in needed services.

Community court collaborates with Hotspotters, which focuses on people who lack insurance, have many mental health needs and co-occurring disorders, and call the Fire Department or go to the emergency room repeatedly (up to 37 times in a few months). Working together, Community Court and Hotspotters coordinate communication and provide wraparound services for these individuals, such as enrolling them in AppleCare and getting them a primary care physician.

Whatcom County Task Force. Whatcom County has an incarceration reduction and prevention task force that has prioritized pre-arrest diversion of individuals with mental health issues; the county is in the process of finalizing its model to implement. To avoid service gaps, the county is combining elements of the sequential intercept model (developed by Mark R. Munetz, M.D., and Patricia A. Griffin, Ph.D.) and the Institute of Medicine's substance abuse prevention, intervention, treatment, aftercare (PITA) model.

Whatcom County Mental Health Probation Caseload. Whatcom County also has developed a specialized mental health caseload, supported by a forensic psychologist, that has dramatically improved the rate at which individuals with mental illness complete probation. Before the specialized caseload was implemented, about 25 percent of people with mental illness completed their probation; one year later, about 78 percent of them were completing probation.

Interviewee Voices

- "The system's broken. The sad ones are the people who are mentally ill and developmentally delayed. We see them again and again. The way that mandatory arrest laws work for domestic violence, the officer *has* to arrest them. I've seen people in my jail functioning at the level of 3-year-old. It's ridiculous that a police officer had to arrest them even though the victim, the officer, and the jail don't want them arrested. Same thing with mentally ill people. If you have someone who's naked and screaming obscenities in public, jail is absolutely the last place they should be. And they end up there because there are no community resources. There are not enough intensive services for people who need them. The jails become the provider of last resort for everything. Because the state is obligated to fund community mental health but not jails, the problem won't ever be fixed."

- "Police and courts have the option to divert; jails should too."

- "Mental health housing is always a problem. Usually, the only housing available is clean and sober, and if they don't have a chemical dependency diagnosis, then they can't get admitted. Or if they're paranoid schizophrenic, it's not a good idea to put them in with strangers."

- "Our reentry specialist works on housing, which is the biggest issue. When people are released from jail, it may take a couple of months to see someone in treatment. The ACA means more people have coverage to get mental health care, so treatment slots are jammed. And the housing market is tight: landlords will check people's names against jail rosters, which are a matter of public record, and deny housing, even though a local organization has money to pay for housing them."

- "We need more resources to house people. We had a client here who was 74 with dementia and a traumatic brain injury. She was in jail because she violated the restraining order of her ex-husband, who she kept calling in order to report that she was safe. She assaulted his girlfriend. It took two weeks to get an evaluation from the regional state hospital, but once they found her incompetent to stand trial, it took another two weeks to get her placed at Eastern Washington State Hospital in their geriatric ward. No other place would take her because she was in jail on an assault charge. She spent a month here in jail. We couldn't house her in with the general population, for her own safety."

- "The biggest problem right now is offenders and the type of mental illness they have. So many are co-occurring, and most mentally ill offenders, especially repeat misdemeanants, are not classified as seriously mentally ill, but they have flaming personality disorders and nobody wants them. There's a very vocal group in the community that says folks with mental health issues shouldn't be in jail. I agree, but no treatment facility in the community wants them. They tend to be transient, homeless, and hooked on meth. A huge percentage would fit under anti-social diagnoses. The hospital won't take them (there's no treatment that will work if antisocial and criminogenic factors are their top issues), treatment won't take them, and we can't ITA them because they have a history of getting violent when psychotic…. The situation is worse now than at any time in the 35 years I've been involved in the jail."

Site Visits

Overview

A team of associates from Joplin Consulting conducted site visits to five counties to collect more in-depth information about the state of deflection and diversion programs available to people with mental illness in those counties, as well as ideas local stakeholders had about state-level changes that might support increased diversion opportunities. The five counties visited included King, Pacific, Pierce, Snohomish and Yakima. Site visits were conducted between September 6, 2016 and September 22, 2016 and ranged from one to three days per site. While on site, the team toured programs and conducted interviews with individuals and groups of stakeholders representing law enforcement, jail management, prosecution, diversion, defense, courts, executive leadership, human services, behavioral health organizations, and providers. The information provide here summarizes the observations and input from stakeholders who participated in the site visits. It does not represent recommendations from Joplin Consulting.

General Themes

Front-end diversion. Interviewees were very interested in front-end (i.e., pre-booking) diversion. Once people with mental illness are in jail it is hard to treat them or move them out to a more appropriate setting. Specialty courts are too late in the process and tend to have low participation rates.

Housing. There is a pervasive need for housing, which is crucial for this population's success in treatment. Supportive, case-managed, service-rich housing in particular is needed. Common challenges include a lack of housing stock (some communities are seriously undersupplied) and a lack of low- and no-barrier housing (i.e., accepts people with a criminal record and/or who are not alcohol and drug free).

Co-occurring disorders. Interviewees describe high rate of co-occurring disorders (i.e., mental illness substance use disorders) in the potential diversion population, along with some cases of mental illness caused by chronic drug use. Co-occurring disorders can present challenges in diagnosis, treatment, record-keeping, information sharing, and funding.

Subacute Residential and Step-Down Outpatient Treatment Services. Increased access to subacute residential and structured, step-down care could decrease the flow of patients to the state hospital by stabilizing patients in the community and avoiding destabilization that leads to more intensive hospitalization. Subacute and step-down services generally are in short supply.

Obstacles. Many existing diversion options have conditions that limit referrals or participation. Crisis stabilization centers, for example, sometimes (1) exclude people who have outstanding warrants or need detox services, (2) are located at inconvenient locations for law enforcement drop-off, or (3) do not conduct adequate outreach and education to law enforcement about inclusion and exclusion criteria. Mental health courts often require participants to be drug and alcohol free, pay restitution and/or program fees, and undergo treatment for significantly longer than the length of their sentence if they had simply pled guilty. In addition, many mental health courts do not support medication-assisted treatment (MAT), despite the evidence supporting its use, and treatment requirements ordered by the courts sometimes conflict with treatment that mental health professionals deem medically necessary.

Cross education. There generally is limited ongoing cross-education among law enforcement, the criminal justice system, and mental health professionals. Possibilities include law enforcement officers touring crisis triage centers, mental health professionals regularly attending law enforcement agency roll calls to share information about available services, mental health professionals participating in ride-alongs, and cross hiring, such as Comprehensive Healthcare hiring the former Yakima County sheriff as a liaison between the company and law enforcement agencies.

Information sharing. The different sites are using varied and sometimes somewhat informal methods of sharing booking information with their BHOs and providers. They would benefit from more consistent and structured mechanisms for sharing this information.

Medicaid suspension: Local jurisdictions, especially criminal justice partners, have not been updated on the work occurring regarding suspension versus termination of benefits. We have since learned that Washington's governor signed SSB 6430 into law on March 31, 2016. The law became effective

on June 9, 2016, and requires the Washington State Health Care Authority (HCA) to "suspend, rather than terminate, medical assistance benefits by July 1, 2017, for persons who are incarcerated or committed to a state hospital." A progress report is due to the Governor and legislature by December 1, 2016. Currently there are multiple workgroups and stakeholders engaged in meeting the requirements of this legislation. HCA is developing an interface with DOC and the Jail Booking and Reporting System (JBRS) that will allow inmates' benefits to be suspended instead of terminated. The work is on track to meet the July 1, 2017 deadline.

Community resources. Resources to treat people in the community are not adequate to meet demand. Without accompanying services, jail diversion does not address underlying problems and reduce the likelihood of future bookings of former inmates with mental illness, many of whom have chronic physical and behavioral health needs.

Reentry Services. Reentry services are not being consistently delivered or funded across the state. The research is clear that case planning for transition from jail to the community, "warm hand-offs," and supportive case management after release reduce recidivism and rebooking.

"Frequent fliers." Four out of five sites are identifying "frequent fliers," meaning people who have been booked in jail many times, and are considering ways to assess and address these individuals' needs (mental health treatment, chemical dependency treatment, housing, etc.). These counties are examining the level of jail resources that frequent fliers use and seeing potential value in addressing tough cases, not just the "low-hanging fruit."

Diversion pilots: Barriers to implementing the pilot diversion programs funded through the Office of Financial Management include short implementation and funding time frames, which led to challenges in recruiting and hiring program staff, and funding uncertainty beyond June 30, 2017. In addition, the programs focused

Jail/BHO coordination. From site to site, there is considerable variation in the arrangements that jails and behavioral health organizations (BHOs) have for providers to serve members who are in jail. In some regions, jails and the BHO have established methods to identify members who have been detained and providers have easy access to inmates in order to coordinate medication, do case planning, and provide other services. At other sites, the level of coordination between the jail and the BHO is much less.

Site Visit Summary: King County

Conducted on September 6-8, 2016

Interviewees

Jail	Mike West, Project/Program Manager, King County DAJD
Jail Mental Health	Mike Stanfill, Psychiatric Services Manager, King County Jail
Prosecution	Dan Satterberg, Prosecuting Attorney Manka Dhingra, Deputy Prosecuting Attorney, Therapeutic Alternative Unit Rebecca Vasquez, Senior Deputy Prosecuting Attorney, Criminal Division
Community & Human Services	Jim Vollendroff, Diversion Director Jesse Benet, Diversion and Reentry Coordinator, King County Behavioral Health and Recovery Division Jeanne Camelio, Hospital and Forensic Services Division, King County
Defense	Anita Khandelwal, Policy Director, King County Defense
Municipal Court	Betty McNeely, Seattle Municipal Court Resources Center Rich Cook, Data Management
LEAD	Kris Nyrop, Public Defenders Association Chloe Gale, Reach Co-Director Susan Collins, LEAD Evaluation Najja Morris, LEAD Administration and Case Management Natalie Walton-Anderson, Prosecutor and LEAD Liaison LEAD Operation Work Group (case staffing)
City of Seattle	Scott Lindsay, Public Safety Advisor, Office of the Mayor Peter Holmes, City Attorney
Community Corrections	Randy Vanzandt, Special Needs Unit, Department of Corrections
Crisis Solutions Center (DESC)	Daniel Malone, ED, Crisis Solutions Center Maggie Hostnick, Program Manager, Crisis Solutions Manager

Background and General Thoughts from the County

- With a total population of 2.1 million, King County is home to Seattle and has the highest population density of Washington's 39 counties. The county is growing faster than the state

as a whole and has a higher percentage of working-age adults, college-educated people, and people of color.[1]

- African-Americans are disproportionately represented in the jail for most crime categories.

- Seattle has a large number of people experiencing homelessness and reportedly has been hit hard by the national heroin epidemic.

- At any given time, there are an estimated 2,000 people in King County who meet the county's criteria for being a "Familiar Face," i.e., they have been booked in the county jail at least four times in a single year and have been identified as having a mental health and/or substance use disorder (this is true of 94 percent of the Familiar Faces). Of the 2,000 people who meet Familiar Faces criteria, 40 percent also had municipal jail bookings.

- Few people have been booked in King County Jail four or more times without having a behavioral health issue.

- In 2014, 22 percent of the Familiar Faces had some type of involvement with the City of Seattle Municipal Health Court, King County Regional Mental Health Court, or King County Drug Diversion Court (such as being screened), but only 8.5 percent of them opted in to one of these specialty courts.

- Approximately 60 of people entering jail in the county already are enrolled Medicaid, but many of them have not attempted or do not understand how to access services.

- Some community-based agencies do not provide culturally informed and response treatment or treatment in multiple languages.

Opportunities Identified by the County

- Examine whether forensic patients at the state hospital who are "flipped" to civil beds under the involuntary treatment act (ITA) could be treated instead in the community, if there were appropriate discharge planning from the hospital and if subacute treatment options were available. ("Flips" are people who have been in the hospital for restoration but whose competency cannot be restored in a reasonable length of time. Typically their charges are dismissed, yet because of their mental illness, they remain likely to continue committing similar crimes if released.)

- Establish programs to restore competency in the community, instead of just at the state hospital. This is being done successfully in other states, with results that are comparable to inpatient restoration, and would help to free up beds in Washington's state hospitals.

- Create more subacute or "step-down" treatment options, so that people currently occupying local hospital and E&T beds could be treated in less intensive residential or outpatient settings in the community and connected with housing and other services.

[1] Vance-Sherman, A. 2015. King County Profile. Washington State Employment Security Department. Updated September 2015. Available at https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/county-profiles/king-county-profile.

- Expand the number of police CIT units and/or implement a co-response model, in which law enforcement officers are paired with mental health professionals and the two respond as a team to crisis calls. (Shoreline Police Department has implemented a "CIT Plus" program in which co-responder teams conduct proactive outreach in the community, rather than only responding to crisis calls).

- Establish crisis intervention teams in all law enforcement offices and coordinate CIT responses countywide.

- Ensure strong connections and cross training between mobile crisis teams and police departments, to build trust and understanding among law enforcement officers and clinicians.

- Eliminate the outstanding warrant exclusion for intakes at the Crisis Solutions Center. This exclusion requirement was apparently included in the original RFP for crisis services.

- Implement a validated pretrial risk assessment tool to increase effective release decision-making making, potentially increasing own recognizance releases.

- Make use of paralegals to conduct "legal health" checks for defendants. These checks can help clear outstanding warrants and connect defendants with services that can assist them in resolving outstanding debts, getting proper identification, and enrolling in benefits.

- Establish interlocal agreements that allow outstanding warrants from multiple jurisdictions to be quashed, to streamline this process. (Existing agreements allow quashing only of warrants of $2,500 or less on non-domestic violence cases.)

- Housing:

    - Develop more structured housing with medication distribution and onsite case managers (i.e., combining Housing First and ACT-type activities) that is open to people with ongoing substance use disorders.

    - Create incentive programs for landlords to rent to people with a criminal history and mental illness.

    - Consider incarceration and hospitalization time as part of prioritization for housing under the coordinated entry system for housing.

    - Increase overall efforts to site housing and treatment facilities.

- Ramp up jail discharge planning and associated community-based services, so that inmates leaving jail have a "warm handoff" to community-based services, including transportation, immediate housing, appointments with health care and other treatment providers, etc. in a timely manner. These services help people stabilize and reduce the likelihood of future contact with law enforcement.

- Reimburse community-based mental health treatment providers at higher rates, so that they have the financial incentive to treat justice-involved clients.

- Increase incentives for colleges and state universities to graduate more clinicians, especially those from dual certification (mental health and chemical dependency) programs.

- Facilitate movement of BHO members across counties. BHOs are resistant to transferring members.

Current Programs and Practices—Highlights

Crisis Intervention Training (CIT)

King County's MIDD tax funds crisis intervention training (CIT) for sheriff's deputies, police, jail staff, and other first responders. CIT training provides first responders with a better understanding of the dynamics of mental illness and skills to de-escalate situations that might otherwise result in the arrest of people with mental illness. Although many Seattle Police officers have had CIT training, the department currently has only one crisis intervention team, with multiple sergeants and staff, and only one social worker for the entire department.

Crisis Solutions Center, with Mobile Crisis Team

King County currently has one crisis stabilization center, the Crisis Solutions Center (CSC), which is funded by the MIDD tax. The program is exploring the possibility of accessing Medicaid funding as well. A second facility is being considered in south King County. The CSC has three components:

- Mobile crisis teams that respond to calls (including from law enforcement). Only 15 percent of mobile crisis team calls result in transport to the CSC; the rest are resolved in some other way.

- A 16-bed 72-hour crisis diversion facility. Many of the clients in this facility transfer directly to the interim services facility after their initial 72-hour stay.

- A 30-bed 14-day crisis diversion interim services (CDIS) facility with an average stay of 7 days.

All participation in the CSC is voluntary, although the facility is secure. Law enforcement officers seldom drop people off at the CSC, but there is some indirect use via officer calls to the center's mobile crisis unit. Most referrals come from local hospitals. A likely obstacle to direct law enforcement use is an outstanding warrant exclusion that was written into King County's RFP for the facility. However, CSC does not actively screen people for outstanding warrants at intake and occasionally works with clients to quash their warrants. The CSC does not appear to be well known or understood in King County, and law enforcement officers may view the outstanding warrant exclusion as a reason not take someone there. The facility provides an option for people displaying behavior that is annoying or frightening but not necessarily criminal. Eliminating or in some other way addressing the exclusion on outstanding warrants, such as quashing them via a phone call, could increase use by law enforcement, as would education and culture change among police.

Law Enforcement-Assisted Diversion (LEAD)

Law Enforcement-Assisted Diversion (LEAD) is a program through which people who allegedly have committed nonviolent drug, property, or prostitution-related crimes can be referred to intensive, client-focused social services rather than be arrested. Eighty percent of the target population is experiencing homelessness, and many have co-occurring mental illness. Most are people who have been on the streets for a long time and have long-standing behavioral problems. The program provides intensive outreach and case management. Case managers meet the client "where they're at," provide social services, use trauma-informed motivational interviewing approaches to help clients identify their personal goals, and support clients as they work toward their goals. In addition, the program is characterized by a harm reduction approach in which clients are provided emotional, practical, and financial support without being required to abstain from drugs and alcohol. Services and benefits are not time limited, and there are no punitive sanctions for non-compliance.

About half of LEAD cases are true diversion, in that the person is arrested but their case is never filed if they complete the LEAD program's intake process within 30 days of their arrest. In the remaining cases, called "social contact diversions," there is no arrest; the person is simply referred for services. Services include connecting clients with housing (when possible) and assisting with other immediate needs, as well as providing long-term engagement, counseling, and case management, with the possibility of eventual substance abuse treatment.

Currently in its fourth year, LEAD has approximately 350 participants. Because participants never "graduate" from the program (although their needs may ebb and flow), for long-term success, the volume of community-based services must keep up with demand. LEAD relies on a high degree of coordination and communication between law enforcement and program staff (about client whereabouts, appointments, possible relapses, social networks, etc.); this includes twice-monthly operational coordination meetings.

Although LEAD is focused on people with substance use disorders rather than mental illness, the two populations overlap, and elements of the LEAD model could be adapted to programs tailored to people with mental illness.

Community Assessment and Referral for Diversion Program (CARD)

This is a new, voluntary program by the Prosecuting Attorney's office to identify people with mental illness who have been booked into jail on nonviolent offenses and could be diverted to mental health treatment before their case is filed. People in the target population may have encountered the criminal justice system multiple times, committing low level and/or "nuisance" crimes, cycling through the local jails, and interfacing intermittently with several other publicly funded systems, such as behavioral health, social services, housing, and primary care in a fragmentary and uncoordinated manner.

Services include assertive outreach, comprehensive assessments and plans of care, and integrated and inclusive services, with a goal of the diverted individual being stable and engaged with treatment and housing. If the person remains successfully engaged in their individualized CARD treatment plan for a period of time, the case is dismissed without prejudice. Otherwise, the case is filed and prosecuted in Regional Mental Health Court, King County Drug Diversion Court, or regular criminal court. To be eligible, participants must have a mental illness or be flagged for a competency

evaluation, be enrolled with the BHO for mental health services, or currently be on an LRO (i.e., less restrictive order).

People with some nonviolent offenses, such as stalking, are excluded from the program. Victims are informed about the program, and, if appropriate, a restitution plan is developed. Participants sign a release form to facilitate access to services and information sharing. CARD is just beginning, with first clients expected in October 2016. The program expects to have a capacity of 50 people. Funding for this program is currently scheduled to end in July 2017, which allows for only 8 months of operation.

Regional Mental Health Court

Regional mental health (RMHC) court is a post-plea, voluntary opt-in program for felony cases referred from King County Superior Court, misdemeanor cases by the King County Prosecuting Attorney's Office, and cases referred from cities in King County. Participants include people with "drop-down" felony charges, in which case the felony against someone with a mental illness is dismissed and a misdemeanor is filed, so that the individual can be under supervision and receive services in the community. More than 70 percent of people who opt into the King County Regional Mental Health Court have had their charges reduced from a felony to a misdemeanor specifically so that they can come into the court. The program is funded through King County's Mental Illness and Drug Dependency (MIDD) sales tax.

Participants in mental health court agree to up to 2 years of mental health treatment and abstinence from alcohol and drugs; most have Axis 1 diagnoses. In order to opt in to RMHC, the defendant must enter a case disposition. Depending upon the nature and severity of the charge(s), this may be a stipulated order of continuance or other diversion agreement, or, most commonly, a guilty plea.

Participants begin treatment after an assessment and review by the court to determine whether they are a good fit.

Capacity in mental health court is 300 cases, but the average caseload is approximately 280.

Municipal Mental Health Court

The Municipal Mental Health Court (MHC) is a post-plea, opt-in program for people with misdemeanor charges filed by the City of Seattle. Referrals come from judges, defense attorneys, prosecutors, jail staff, and others. The criminal activity of participants must be related to or caused by mental illness. MHC defendants may have a variety of charges. They may have any type of serious mental illness, be developmentally disabled, have a brain injury, or suffer from dementia. The defendant may be a first-time offender or have a lengthy record.

Individuals in MHC voluntarily opt for two years of probation, coupled with housing and treatment provided by community partners. Clients begin receiving services as soon as their case is heard in court. A clinical mental health expert works with clients initially to assess needs and provide connections to treatment. Probation counselors then meet with clients individually on a regular basis for up to two years. Regular reviews in court are opportunities for the Mental Health Court Judge to monitor progress and provide praise, guidance, and direction. Mental health court participants have access to 30 reserved beds in treatment facilities, along with additional services (as do many people who are eligible for mental health court but do not opt in). During the first half of 2016, just 25 people out of the 415 who were referred to mental health court actually opted in.

During the last year, the court has seen a significant jump in the number of competency-related hearings, from 25 percent to 45 percent.

Familiar Faces Intensive Care Management Team

The Familiar Faces Initiative's Intensive Care Management Team (ICMT) is a new, evidence-based program initiated by King County Diversion and Reentry Services (DRS), within the county's Behavioral Health and Recovery Division (BHRD).

ICMT began in July of 2016. The program provides comprehensive, integrated services to adults who are being released from jail pretrial or post-sentence and who, twice within the last 3 years, have had four or more bookings in the King County Jail over a 12-month period. These are people who have behavioral health conditions (i.e., mental illness and/or co-occurring substance abuse issues), have high needs, may be experiencing homelessness, and have repeatedly come into contact with the criminal justice system. A guilty plea is not required to participate in the program.

ICMT is much like ACT or FACT (assertive community treatment or forensic ACT), in which an interdisciplinary, community-based team is available to provide intensive mental health and substance use disorder treatment services to clients 24 hours a day, seven days a week. However, the ICMT approach allows for more flexibility in the size of the care team (as the client's needs change), maintains a more consistent "key contact person" with the client, and has team members who are familiar with the criminal justice system and who can coordinate with criminal justice system partners, to support reentry and reduce incarceration and crisis system utilization.

For the King County ICMT, direct services are provided by behavioral health and housing organizations, including the local housing authority, and a deputy prosecuting attorney meets with the team once a week. The current caseload is 28 people, with a target of 60. Initial services have related to health care enrollment, social security, transportation, housing, identification, and clothing. The initial demonstration team, which is operated by Evergreen Treatment Services' REACH program in coalition (i.e., joint contract) with Harborview Behavioral Health, has been named the Vital Program.

Community Center for Alternative Programs (CCAP)—Day Reporting

Operated by King County's Department of Adult and Juvenile Detention, the Community Center for Alternative Program (CCAP) is an alternative to jail for people who do not have the money to post bail or who have had a poor history of court compliance. Under CCAP, judges allow pretrial defendants to report to the day reporting program until their court date or until they have completed their court-ordered obligation. While on day reporting, clients can be referred to services such as the state Department of Social and Health Services (DSHS) for food, medical care, and chemical dependency treatment. Clients also are referred to the court's resource center for housing referrals, GED program resume preparation, and court-ordered classes. The program also is used for post-conviction clients and as a sanction for probationers.

Roughly 115 people per day are served at the CCAP, but actual reporting rates for pretrial clients are reportedly are low (less than 50 percent), with "graduation" rates even lower. Under pretrial programs such as CCAP it can be difficult to provide effective, structured treatment and services without an individual assessment, which defense attorneys may resist because the results (e.g., substance use) could be used as part of criminal prosecution.

Dedicated Prosecutor

LEAD, the Crisis Solutions Center, and the Familiar Faces ICMT work with a dedicated prosecuting attorney who is familiar with the characteristics and issues of their clients and can work with them to quash warrants, etc.

New Ideas

Single Diversion Portal

King County and other stakeholders are in the planning phase of developing a Single Diversion Portal that will enable law enforcement officers, fire fighters, and other first responders to quickly access resources to help individuals with mental health or substance use disorders avoid jail and the use of emergency room departments. The portal is intended to coordinate diversion opportunities and activities associated with LEAD, law enforcement crisis intervention training, and the Crisis Solutions Center, to clarify options for first responders.

Assisted Outpatient Treatment (AOT)

The Washington Legislature recently authorized the use of assisted outpatient treatment (AOT), which is similar to New York's Kendra's Law. King County received a federal grant in September of 2016, which supplemented state funding and allowed the county to begin AOT. With AOT, someone evaluated for potential commitment can be court-ordered to engage in community-based mental health treatment (including taking medication if appropriate). The program is intended to provide support and services to people whose mental illness is not acute enough to meet criteria for detention but who would benefit from additional structure. Typically, AOT is directed toward people with serious mental illness who have a history of not complying with treatment. If the person does not comply with AOT, they cannot be detained.

Outpatient Competency Restoration/Stabilization

The King County Department of Community and Human Services (DCHS) submitted a proposal to pilot-test a formal outpatient competency restoration program for a small number of defendants from the regional mental health court who are facing non-serious misdemeanor or non-violent felony charges. Alternatives to inpatient restoration are allowed under Washington State statutes and being implemented in 16 other states. Outcomes in other states are "fairly uniform and positive" and restore people to competency at about the same rates as corresponding state hospitals (about 77 percent), while being less restrictive and much less expensive than inpatient restoration.

Under DCHS's proposal, individuals would be assessed for clinical need, risk of violence and recidivism, and restorability; be monitored individually; receive behavioral health services; and be assisted in meeting their court obligations, with oversight coordinated between the restoration and clinical program staff and the specialty court prosecutor. Services would be provided under both a facility-based model and a care management/day support model.

This proposal was rejected for "New Concept" financing from King County's Mental Illness and Drug Dependency (MIDD) sales tax.

Pilot Program: Familiar Faces Release Planning Coordination

As a Familiar Faces initiative, one of King County's managed care organizations and King County Jail's Health Services are developing a pilot program that will pilot-test allowing managed care caseworkers to come into county jails to do release planning and provide transitional services for

members of the managed care company. The research is clear that this type of "reach in" transition planning and reentry support services decrease recidivism and repeat bookings.

References

Camelio, J. MIDD Briefing Paper: Competency Stabilization Services Program Pilot.

King County Health and Human Services. 2016. The Familiar Faces Initiative. June 2016.

King County. 2016. Familiar Faces Data Packet: Current State—Analysis of Population. Updated May 2016.

Office of Forensic Mental Health. 2016. 5177 Diversion Program Summaries.

U.S. Department of Housing and Urban Development, Office of Community Planning and Development. 2014. The 2014 Annual Homeless Assessment Report (AHAR) to Congress. October 2014. Available at https://www.hudexchange.info/resources/documents/2014-AHAR-Part1.pdf.

Vance-Sherman, A. 2015. King County Profile. Washington State Employment Security Department. Updated September 2015. Available at https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/county-profiles/king-county-profile.

Site Visit Summary: Pacific County

Conducted on September 22, 2016

Interviewees

Health & Human Services	Katie Oien Lindstrom, Deputy Director Rosanne McPhail, project manager for diversion/sequential intercept mapping
Prosecution	Hon. Mark D. McClain
Sheriff's Office	Pat Matlock, Chief Deputy. Jail
Courts	Tessa Clements – Pacific County Health Dept., Therapeutic Courts Lisa Farvour
Providers	Marc Bollinger – Great Rivers Behavioral Health Organization Geri Marcus – Willapa Behavioral Health (pilot provider) Jennifer Magnuson— DMHP

Background and General Thoughts from the County

- Pacific County has a population of approximately 20,000. Community services are limited and residents are widely distributed, which makes it difficult to provide timely services. It can take two hours for a DMHP to respond to a law enforcement call, for example, and the closest crisis stabilization centers are up to two hours away, in Hoquiam and Longview.

- Mental health service providers, jail, law enforcement, and the hospital are understaffed. All have difficulty attracting professional staff for multiple reasons, including a lack of housing.

- The county jail operates at higher occupancy rates than it was designed for (it was rated for a capacity of 29, has 58 beds in place, and houses an average daily population of 40 to 45). It has increasing numbers of female inmates, inmates with mental illness, and incidents of assaults.

- The availability of inpatient mental health treatment is in issue. With the construction of new E&T facilities in McCleary in Grays Harbor County and Centralia in Lewis County there soon will be 54 treatment beds in the region. However, travel to and from these locations can take up to two hours, and many of those beds are expected to be occupied by people from other parts of the state. There is also concern that those facilities will be reluctant to serve people from Pacific County because of the challenges of arranging return transportation.

- Pacific County is one of four counties that has received a year of funding through the Washington State Office of Forensic Mental Health Services to implement a demonstration

prosecutorial mental health diversion project. In this case the project is a diversion program using court-mandated assisted outpatient treatment (AOT). The program was officially funded on July 1, 2016, but as of the date of our site visit, had only served one person. The program workgroup is considering expanding the program inclusion criteria, which originally only included nonviolent misdemeanants eligible for AOT.

- Pacific County Sheriff's Office received a 2015 Justice and Mental Health Collaborative Program grant of $150,000 from the Bureau of Justice Assistance for planning and implementation, including sequential intercept mapping and gap analysis.

- Pacific County's Mental Health and Justice Collaboration was one of the 50 teams chosen nationally to attend the National Stepping Up Summit hosted by the Council of State Governments Justice Center, the National Association of Counties, and the American Psychiatric Association Foundation to help policymakers and other local stakeholders create and/or refine plans to reduce the prevalence of people with mental illnesses in their jails.

Strengths Identified by the County

- A history of relationship-based information sharing and collaborative problem solving, a small number of providers who know each other and their clients, and buy-in from criminal justice system partners on diverting people with mental illness from the jail.

- Grants that fund collaboration and monthly meetings of the Prosecutor's Office, Pacific County Public Health and Human Services, behavioral health organization leadership and mental health provider, courts, Sheriff's Office jail management, and law enforcement.

- Availability of the DMHP to provide screening in the jail and knowledge about individual inmates.

- .5 FTE funding through the pilot prosecutorial diversion program for a mental health professional in the jail (to help identify and divert people with mental illness and provide behavioral health services), although recruitment and hiring of this position has proved challenging.

Opportunities Identified by the County

- Provide cross-county information sharing opportunities for criminal justice and forensic mental health partners to support peer-to-peer networking, enable replication of innovative policies and practices, and provide a mechanism for the state to provide guidance and education on legal and best practice issues.

- Increase mental health staffing (including community-based treatment and support) in rural areas. Staffing limitations in Pacific County, for example, create challenges, such as limiting the independence of DMHPs (i.e., DMHPs are called on to evaluate their own clients or other people they know).

- Provide regular training for DMHPs (i.e., annual weeklong "boot camps") to update people on state requirements, ensure consistency in practices, and train new DMHPs.

- Allow rural counties to waive certain professional requirements in order to increase the pool of otherwise qualified MHP applicants (e.g., accept other states' standards for mental health professionals).

- Develop a universal release form for justice involved behavioral health clients, so that service entities can better share information with each other.

- Lengthen the time period for the pilot prosecutorial diversion project, which ends in June 2017. One year is too short.

- Within existing funding, BHOs should require jail reentry services, including "reach-in" case management focused on housing, employment, behavioral health treatment access and engagement, and Medicaid enrollment.

- Develop more acute and subacute behavioral health treatment facilities and site them within more reasonable travel distances.

- Expand the diversion pilot by using the "non-emergent LRA" process that requires documentation of gradually escalating behavior; include lower level felony charges.

- Provide more specialized training for jail corrections officers through the Washington State Criminal Justice Training Commission.

Current Programs and Practices—Highlights

Crisis Intervention Training (CIT)

Sheriff deputies and other law enforcement officers completed 8-hour crisis intervention training (CIT), as have more than 100 community members. Pacific County corrections officers will be participating in a 40-hour specialized jail CIT training offered in Clark County.

Mental Health Crisis Line

Willapa Behavioral Health runs a 24-hour mental health crisis line staffed by master's level mental health therapists who counsel people over the phone and refer them to services. Law enforcement officers distribute crisis line business cards at social service agencies and to people they encounter in the field. Officers often refer to the hotline to identify appropriate social services or connect someone immediately with a counselor.

Mental Health Diversion Program Pilot

Pacific County began planning for its Mental Health Diversion Program (MHDP) in April of 2016 and began implementation on July 1, 2016. The MHDP is a pilot program in which individuals who are arrested for misdemeanor crimes and have had previous hospitalizations for mental illness are court-ordered to assisted outpatient treatment (AOT); the charges of AOT participants are dismissed without prejudice. During the first 2 ½ months of the new diversion program, only one person met the criteria for AOT. (Most other potential participants were excluded because they did not meet the charge or AOT criteria.) In September of 2016 Pacific County decided to broaden its criteria for participation in the diversion program and make the program voluntary, rather than using the AOT mechanism. The county and its partners are in the process of determining standards for eligibility in the program, which may include expanding to non-violent felony charges.

Procedurally, participants enter the diversion program in two ways: (1) by being assessed at the jail or hospital by a DMHP, or (2) by being assessed in the field by a DMHP who law enforcement has called to the scene.

Ideas in Development

Universal Mental Health Screening Questionnaire

Local law enforcement agencies are in the process of finalizing a brief questionnaire to use in screening people for mental health issues. All agencies will use the same questionnaire and enter the results into the local law enforcement database. All officers in each agency will have access to the database and thus will know whether someone they encounter has previously been flagged as having a mental health issue.

Co-Responder Model

Pacific County is considering developing a co-response model, in which mental health professionals team with law enforcement officers in responding to crisis-related calls. Staffing limitations (there is only 1 FTE DMHP) and travel time (up to 2 hours) have been obstacles to implementing this type of program.

Tele-psychiatry

The jail is considering using tele-psychiatry as an option for prescribing medications for jail inmates.

Site Visit Summary: Pierce County

Conducted on September 19-20, 2016

Interviewees

Defense	Michael Kawamura, Director, Pierce County Assigned Counsel
Jail and Mental Health	Janet Rhoton MA, LMHC, CCHP, PCDCC Mental Health Manager Patti Jackson-Kidder, Jail Chief
County Exec	Al Rose, Executive Director, Justice Services, Office of the County Executive
BHO	Bea Dixon, PhD, ED, Optum Pierce BHO Allie Franklin, VP of Clinical Services, Optum Pierce BHO Tracy Card, Greater Lakes Mental Healthcare Deanna Carron, Director of Forensic Services, Greater Lakes Mental Healthcare

Background and General Thoughts from the County

- The population of Pierce County numbers roughly 800,000 people, about 250,000 of whom qualify for Medicaid. Large expanses of the county consist of unincorporated rural area. In both the urban and rural areas, the county is challenged by a relatively large population of people who are homeless and suffer from mental illness. In the more rural areas, these people may live relatively inconspicuously, whereas in the more urban core, their behavior is often more visible and disruptive.

- There is a general perception among interviewees that the number of people with acute mental health problems in the county continues to grow, as does the homeless population, which is perceived as large. The county reportedly has high rates of suicide and attempted suicide.

- Pierce County is the site of Western State Hospital, located in Lakewood, Washington.

- The jail population increasingly consists of the elderly, people with dementia, and people with traumatic brain injuries (TBI) who may have injured themselves through risky behavior related to substance use or mental illness.

- People with mental illness represent 15 to 20 percent of the county public defenders' case load.

- Although Pierce County did not authorize the mental health sales tax (.01%), the City of Tacoma did, so the city has additional dedicated resources for mental health treatment and services.

- Pierce County was the first county to contract with independent providers to perform competency evaluations, rather than rely solely on DSHS employees. This has sped up the competency evaluation process but has not shortened delays in getting restoration beds. If the restoration period is long (i.e., 45 to 90 days), jail inmates are especially likely to languish in jail waiting for a restoration bed at the state hospital.

- Requests for competency evaluations are twice as high in district court as they are in municipal court.

- The county lacks a secure detox facility.

- There is a notable lack of short-term, interim support facilities to help stabilize people. Housing, medication management, and treatment resources in general are lacking.

- People released from the civil side of the state hospital often choose to stay in Pierce County because they are transient, have few resources, and have no particular incentive to leave. Unlike with forensic patients, the state is not required to return civil patients to their county of origin.

- There is a perception that Western State Hospital is not consistent in its competency decisions and makes some decisions based on a lack of beds at the hospital, or the institution's hesitancy to accept violent males, who may pose a danger to staff and other patients.

- There is some fear in the county about risk to public safety as a result of jail diversion. This may be due in part because of the murder of four police officers in Lakewood in 2009 by Maurice Clemmons, who had recently been released from jail (although he was not diagnosed as mentally ill), as well as other incidents involving people with mental illness. Pierce County is not unique in this concern. Other Washington communities also have experienced high-profile violent crimes that lead to reactive policy making and aversion to jail diversion strategies.

Strengths Identified by the County

- Additional resources available through the City of Tacoma as a result of the local mental health sales tax (.01%).

- Local consensus by law enforcement, the courts, and community service agencies that enforcement is not the way to solve mental health issues. Strong law enforcement buy-in, influenced by leadership.

- Strong connection between the BHO and the jail, as evidenced by the BHO funding the mental health court, the jail transition services, and community reentry program.

Opportunities Identified by the County

- Consider eliminating the restoration process for misdemeanors. Formerly, charges against a non-competent person could be dismissed but the person could be detained for a short

period to determine whether they were a danger to self or others, during which time they would be held in a more appropriate setting than jail.

- Expand housing options, medication management, and treatment resources in the community. Create alternative therapeutic sites to jail.
- Have no "wrong door" for services - destigmatize mental illness.
- Integrate mental health and substance use disorder services into family practice medicine.
- Implement in-jail mental health treatment.
- Expand placement options (housing, medication management, etc.) beyond just shelters for people being released from involuntary treatment.
- Decrease the criteria and barriers to involuntary treatment (danger to self or others). For these individuals, provide appropriate treatment, housing, case management, and monitoring outside of the competency evaluation process. Involuntary treatment is faster and more flexible than the forensic commitment process.
- Move geriatric patients out of Western State Hospital to adult care facilities. This would free up beds at the hospital.
- Allow video hearings for the ITA process, rather than requiring in-person hearings.
- Provide integrated dual-diagnosis (mental health and substance use disorders) treatment to people while they are in jail.
- Stabilize funding for the crisis line, jail transition services, and similar activities, many of which are not eligible for Medicaid reimbursement. State funding for these activities has been declining while the need increases.
- Create integrated WACs to guide billing and treatment provision for co-occurring mental health and substance use disorder treatment.
- Create more no- and low-barrier housing for people who are not yet clean and sober and/or have criminal records.
- Create value-based payments from the state that incentivize high performance by counties in achieving performance measures (e.g., reduced recidivism, emergency room visits, and 30-day readmits).
- Reduce barriers to employment for people with criminal backgrounds; provide supportive employment in the community for people with mental illness.

Current Programs and Practices—Highlights

Law Enforcement CIT Training — Informal Diversion via Referral

City police officers have had CIT training and refer people in the field to social services.

Co-Response Teams

Mental health professionals employed by Multicare (a BHO) are embedded with the Tacoma Police and go out into the community on calls.

Greater Lakes (a provider) has obtained private funding that pays for a mental health professional to co-respond to calls with the Lakewood Police. Between direct responses and follow-ups on referrals from other law enforcement officers, the mental health professional has served 343 people since January 2015, only 14 of whom have been arrested during that time.

24-hour Crisis Line and Mobile Outreach Team

This is funded by Optum, a BHO.

Mobile Outreach Van

Pierce County has a mobile outreach van that goes out to unhoused people who are not living in a shelter or apartment. The van provides a variety of services, such as addressing medical issues.

Recovery Response Center (in Fife, WA)

Operated by Recovery Innovations (under contract with Optum), the Recovery Response Center is a 16-bed triage center that can take people in crisis on a voluntary basis, for 72 hours or up to 14 days; most people leave within 72 hours. The center usually is between 90 and 95 percent full. Criteria for acceptance to the Recovery Response Center are not fixed, but the facility would like to avoid receiving people who have been recently assaultive and could be a danger to staff; people who with drugs on them also are not eagerly welcomed. The drop-off process is quick, but the Center is not conveniently located for law enforcement (i.e., it takes a while to drive there), so it gets most of its referrals from the hospital, rather than law enforcement. Because of turnover and leadership changes, law enforcement officers need constant reminders to use the facility. They also tend not to return if they have experienced (or heard about) someone being turned away because the facility is full.

"Felony Flips"

The prosecutor can choose to not charge someone who has been arrested for a felony and instead refer them for civil commitment at the state hospital, if they are a danger to themselves or others. In this case the individual is booked but the charge is never filed, and the individual is represented by a public defender through the ITA process. When someone is referred for civil commitment, a law enforcement or corrections officer may need to wait at the hospital to supervise the person until a bed is available at Western State Hospital.

Dismissals

If the judge dismisses someone's case, they either are released outright or evaluated for potential civil commitment, if they are a danger to self or others. If the individual is declared not competent, they can wait for months to get a bed in Western, even past the maximum sentence for their crime.

Dismiss and Refer

In the City of Tacoma, in lieu of RCW 1077 competency restoration, the case against an individual who appears to have a mental illness can be dismissed and the person referred to social services. In this case the individual is assessed by a mental health professional. Police officers have access to dedicated mental health professionals to do these assessments.

Mental Health Court—Superior Court and Municipal Court

The Superior Court program has been in place for about a year and is funded by Optum, a BHO; the program has a target population of about 50 participants, who must be approved by the prosecutor, after they are charged. It does not provide housing or medication management. There also is a weekly municipal mental health court, in which DMHPs do same-day evaluations of individuals at the request of the judge if there is a potential dismiss and detain situation. The evaluation sometimes is done at initial arraignment but may be done later in the process. People with mental illness are assigned to mental health court at arraignment.

Pretrial Services

Pretrial Services, which is operated by the Superior Court Clerk's office, uses a screening tool to make recommendations to the court regarding supervised release (electronic monitoring, etc.). Services do not appear to be specific to the needs of the mentally ill. Pierce County is one of the few counties in Washington that is doing pretrial releases.

Jail Transition Services

People reentering the community from jail receive transition services from Greater Lakes Mental, which screens them for eligibility, identifies their needs, and, once they have been released, helps them connect them with mental health services, Medicaid and social security, health care, and placement at a shelter or clean and sober housing. Greater Lakes has not been billing Medicaid for any of its in-jail services.

Community Reentry Program

Initiated by Optum (a BHO) in 2012, the Community Reentry Program enrolls up to 50 people who have had multiple arrests in a single year. The program provides its clients with intensive, 24/7 case management from an interdisciplinary team, on an outreach basis, much like an ACT or FACT team. The program focuses on its clients' mental health needs, but it also assists with basic services such as housing, which is critical for this population. A grant from the Tacoma mental health tax subsidizes housing for clients. Greater Lakes Mental Health works closely with landlords to build relationships and address problems, such as property damage or difficult behavior. (Landlords value being able to call Greater Lakes case managers, for example.) As a result, landlords have housed clients with bad credit, criminal records, or a history of being kicked out of shelters, and many clients have maintained their housing for years. Greater Lakes claims a 75 to 80 percent reduction in recidivism within this group, measured in terms of new arrests and new charges. Greater Lakes is very aware of the social determinants of health and states that lack of housing and substance abuse are greater risk factors for re-arrest than mental illness per se is.

Site Visit Summary: Snohomish County

September 19-20, 2016

Interviewees

Mental Health	Cammy Hart-Anderson, Snohomish Human Services—Behavioral Health and Veterans' Services
Prosecution	Shelly Yale, Therapeutic Alternative to Prosecution (TAP) Program Supervisor
Specialty Courts	Janelle Sgrignoli, Programs Administrator—Specialized Courts, Superior Court
Jail	Chief Tony Aston, Jail Administrator Nikki Behner, Health Services Administrator

Background and General Thoughts from the County

- With an estimated 757,660 residents, Snohomish is the third most populous county in Washington. It is growing at a faster rate than the state average and has a higher proportion of people younger than 18.[1]

- As are many areas of Washington, Snohomish County is seeing high levels of heroin addiction and a noticeable increase in the number of elderly people in jail.

- Lack of housing is a significant issue in Snohomish County, where the vacancy rate is less than 5 percent. Both the County and the City of Everett are developing new low-barrier or supportive temporary housing, such as the Carnegie Building, which will provide social services as well as housing. Those facilities are expected to fill quickly and not meet demand.

- The 120-bed Denney Juvenile Justice Center in Everett is significantly underutilized. (Currently it houses fewer than 30 juveniles). There is discussion of repurposing a portion of the facility for inpatient behavioral health treatment for adults.

- Two facilities that serve the county are scheduled for closure in the next two years: (1) the 145-bed Pioneer Center North secured chemical dependency treatment facility, and (2) an E&T facility on the same campus that provides adult inpatient mental health treatment.[2]

[1] Vance-Sherman, A. 2015. Snohomish County Profile. Washington State Employment Security Department. Available at https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/county-profiles/snohomish-county-profile. Updated September 2015.

[2] Evergreen Recovery Centers will be opening a second 16-bed medical detox in the first quarter of 2017 in Lynnwood.

Although Pioneer Center North is a statewide facility, it treats participants in the Snohomish County drug court. The 200-acre state-owned site is expected to be transferred to the Port of Skagit and City of Sedro Wooley.

- Snohomish County's analysis of high jail utilizers indicates that those individuals have high rates of chemical dependency and mental illness and are not accessing community resources. During a 10-month period in 2012, the analysis focused on 23 people who had been booked into the county jail nine times or more. These 23 people had a total of 399 non-jail health or emergency services encounters during the study period (DeBlieck et al. 2013).

Strengths Identified by the County

- Strong informal collaborative relationships and information sharing among the Sheriff's Department and jail, County Human Services, and community-based treatment providers—willing partners who recognize the value of relationships, and a history of success with small collaborations.

- Human Services being embedded in the jail and assisting with both large and small system improvements, such as allowing inmates to keep their jail wristband when they leave jail. (The jail wristband can be used as proof of identify when applying for state identification, which is required to access services outside of jail.)

- Co-funding of desired services, such as a 16-bed triage center that is co-funded by Snohomish County Human Services and the BHO, and Human Services-funded social workers who are embedded with Sheriff Office patrols.

- Local county funds being used to fund Human Services staffing in the jail, including 1 FTE focused on ACA enrollment and 1 FTE focused on reentry success coordination.

- Strong relationships between the BHO and Snohomish County Human Services (e.g., monthly coordination meetings, County Executive and Council members serving on the BHO board, and regular local crisis response committee meetings).

- Strong partnership between Snohomish County Human Services, Snohomish County Jail, and the Apple Health managed care organizations (MCOs), resulting in the MCOs' community care coordinators working with their members in custody and before their release from the jail.

- Jail leadership that is proactive in making changes to jail policies, programs, and practices, such as implementing booking limitations, to build a safer and more evidence-based system.

- An electronic medical record system (CorEMR) at the jail that provides longitudinal information on health and psychiatric history (especially diagnoses and medication use) from previous jail stays. CorEMR is also a valuable tool in coordinating care and services for inmates who are involved in release planning.

Opportunities Identified by the County

- Develop the infrastructure for an electronic information exchange that can alert the BHO when its enrollees are booked in jail (so that the BHO can require the provider to come into the jail and work with their client) and inform the jail of types of services and medications the person has accessed in the past.

- Expand the number of community-based treatment options, possibly by repurposing, remodeling, or replacing existing structures, such as the juvenile detention center, old nursing homes, and vacant hotels.

- Automate suspension and reactivation of Medicaid benefits as people are booked into and released from jail; ensure that there is the capacity to educate inmates about the value of having health insurance and how to access both physical and behavioral health care.

- Expand the number and accessibility of community prescribers, so that people with mental illness who are involved in the criminal justice system can be evaluated for and supplied with appropriate medications more quickly, and their medication adjusted as needed shortly after their release from jail.

- Expand access to medication-assisted treatment options (i.e., methadone, Suboxone, and Vivitrol). Cover the cost of providing Suboxone and Vivitrol to inmates before their release when continuing treatment is coordinated in the community at release.

- Establish a state fund to purchase buildings that can be retrofitted for use as case managed housing (apartments, vacant hotels and nursing homes, shipping container housing, etc.)

- Create low-barrier, service-rich housing for people with a criminal history, chemical dependency, and mental health issues. Without stable housing and wrap-around services, people struggling with homelessness, mental illness, and substance use disorders who have been diverted from jail will not be successful in the community.

- Improve the public transportation system, so that people (especially youth) can get to treatment and appointments safely.

- Lower the standard for civil commitment, as an alternative to people waiting for competency evaluations and restorations.

- Hold forced medication hearings in jail before a forensic client is admitted to Western State Hospital, to reduce the number of forensic clients awaiting hospitalization for medication stabilization.

Current Programs and Practices—Highlights

Mobile Crisis Team

A 24-hour community-based mobile crisis team (the Crisis Prevention and Intervention Team, or CPIT) operated by Compass Health provides short-term behavioral health services to people at

home or in homes or hospitals, such as in the case of a community emergency. Services are available to anyone by calling the CPIT directly or a Volunteers of American hotline.

Crisis Triage Center

County Human Services and the BHO jointly fund a voluntary, 16-bed crisis triage center located near the jail that is set up for direct law enforcement drop-off. All sheriff's deputies have taken a tour of the facility. People are turned away from the triage center if they do not have a true mental health crisis (if they are simply homeless, for example), need detox, or have significant medical issues, and they are discharged if they engage in threatening behavior. The center tends to be about three-quarters full. A new pilot program will begin in January 2017 in which emergency medical services will transport and drop people off at the triage center and get reimbursed by Medicaid.

In 2015, law enforcement referrals to the center represented 18.5 percent of all referrals (compared to 43 percent from hospital emergency rooms and 23 percent from the community mental health agency); this represents a drop from 24.5 percent in 2012. It took an average of 13.46 minutes for a law enforcement officer to drop someone off at the center. (Snohomish County Department of Human Services 2015)

In 2016, the Everett Police Department expanded its Crisis Intervention Training (CIT) program to include trainers from multiple community providers, Human Services and the jail to explore alternatives to incarceration, including referrals to the Crisis Triage Center.

Homeless Outreach Team with Embedded Social Workers

As part of a jointly funded project, Snohomish Human Services and the Sheriff Department's Office of Neighborhoods, a homeless outreach team consisting of sheriff's deputies and embedded social workers responds to crisis calls and also goes to local homeless encampments, connects with people there (many of whom have mental illness), and attempts to engage them in social services and reconnect them with family. Snohomish Human Services employs the social workers, who provide clinical oversight and linkages to community resources.

Jail Booking Restrictions

For two years, Snohomish County Jail has declined to book misdemeanants who have serious mental health, detox, or medical needs and are brought in on nuisance crimes such as public urination, food theft, or illegal camping. Instead, officers cite and release these misdemeanants or transport them elsewhere. The jail booking restrictions originally were a response to high occupancy rates in the jail's specialty housing units (Medical, Observation, and Psychiatric); however, those rates have not declined and the booking restrictions remain in force.

Mental Health Services, Screenings, and Evaluations In Jail

Snohomish County Jail collaborates with staff from Snohomish County Human Services and the managed care organizations (MCOs), communicating with them about the status and needs of inmates with mental health, substance use, and/or physical health conditions and allowing them access to inmates for discharge planning and case management. The jail also employs licensed mental health professionals who assess and help stabilize people with mental illness and pre-screens inmates referred for competency evaluations; about one-third of these referrals do not end up undergoing a competency evaluation. Additionally, the jail has worked with the state to coordinate

an onsite forensic psychologist from Western State Hospital who performs competency evaluations in the jail and for other regional facilities.

Therapeutic Alternatives to Prosecution (TAP)

Therapeutic Alternatives to Prosecution (TAP) is a voluntary alternative to prosecution for adult offenders whose felony arrest is attributable in part to a mental health and/or substance abuse problem. The program has a capacity of 120 offenders and a current caseload of 98, plus 12 being considered for the program. Participants are referred to the program by the deputy prosecuting attorney, who sometimes is alerted of a mental health or substance abuse problem by defense council. Excluded crimes are misdemeanors, extremely violent charges, and most sex offenses. Participants undergo a lengthy evaluation and assessment process before being admitted to the program, to clarify their mental health and chemical dependency status and ensure that they are a good fit. The program lasts up to three years. Instead of entering a plea, participants sign a contract, confession, and stipulation agreement, and the case is stayed as long as the person is active in the program. If they do not complete the program, the case continues and their confession is used against them in a bench trial.

Program participants pay restitution, program fees (which are waived if necessary), and co-pays for any required mental health or chemical dependency treatment. Once they are stable, they do community service and the pursue education or employment.

A total of 65 people have completed the program since it began in 2013. The percentage of referred cases that were not accepted has dropped from 50.8 percent to 21.2 percent. About 25 percent of those who start the program do not finish. The eleven people who have completed the program so far did not have any criminal convictions or violations in the year after they finished.

TAP does not work with high-risk clients and uses an assessment tool (the Ohio Pretrial Risk Assessment, or ORAS) to confirm that they are not accepting high-risk clients.

Mental Health Alternatives Program (MAP)

Since 2013, the City of Everett has run a mental health court whose participants typically have been charged with theft, criminal trespass, assault, criminal mischief, and unlawful camping. Participants commit to at least 12 months of judicially supervised treatment and services. For those who complete the program, charges are dismissed. As of November of 2015, there were 19 active participants in MAP (City of Everett, Washington).

A total of 10 people have graduated from MAP, and two were terminated for non-compliance. Among the graduates, only one has had a criminal charge since graduating from the program (City of Everett, Washington).

Snohomish County District Court Mental Health Court (Judge Tam Bui)

Snohomish County District Court runs a mental health court for people with an Axis 1 diagnosis who have been charged with misdemeanor or gross misdemeanor crimes. Participants are voluntarily diverted to judicially supervised, community-based treatment for between 12 and 24 months. A full-time licensed mental health professional acts as the court liaison, assessing participants' mental health and chemical dependency needs, linking participants with treatment, monitoring their progress, and assisting them in finding employment and housing (Snohomish County Department of Human Services, undated).

Between October 2012 and April 2016, 62 defendants were accepted into the mental health court and 18 were being considered at the time of analysis, out of 236 who had been referred (Snohomish County Department of Human Services 2015). Among the six defendants who had completed the program at least 12 months before the analysis was conducted, there were significant reductions in bookings into Snohomish County jail, days spent in jail, and criminal charges (85 percent, 98 percent, and 68 percent, respectively) (Snohomish County Department of Human Services 2015).

High Utilizer Discharge Planning

Shared funding from Snohomish County Human Services and the BHO pays for two FTEs to assist with release planning in jail, with a focus on Medicaid enrollment (if necessary) and health insurance literacy, so that inmates understand what it means to have insurance and how to access care once they are released. A third position recently was funded to assist with release planning for high utilizers of the jail who have chemical dependency or mental health issues. (High utilizers are identified as the 200 people who have been booked into the jail most often: at least seven times within the past 18 months.) This coordinator conducts needs assessments, identifies relevant county and other services (including housing), jumpstarts enrollment with a provider, and connects the high utilizer with a community health worker (if they have managed care insurance) or mental health case manager (if they have Medicaid). Jail medical staff calls in a full month's supply of medications to the inmate's pharmacy to ensure continuity of care until the released inmate attends follow-up appointments in the community .

MCO Supported Jail Transition Services

Case managers from certain managed care organizations (MCOs) have access to the jail to provide transition services. These services may include assistance with getting access to behavioral health and/or medical care, state identification, housing, transportation and other transition support services.

References

City of Everett, Washington. Mental Health Alternatives Program (MAP). Viewed September 23, 2016. Available at https://www.everettwa.gov/1375/Mental-Health-Alternatives-Program-MAP.

DeBlieck, S., R. Fenn, and R. McCarty. 2013. People with Numerous Jail Bookings Utilize Many Health and Emergency Services, and May Have Unmet Mental Health and Substance Abuse Need. Snohomish County Department of Human Services, Research Division. Policy Brief No. 1. Available at http://wa-snohomishcounty.civicplus.com/DocumentCenter/View/14101.

Snohomish County Department of Human Services. (Undated.) Snohomish County Mental Health Court Evaluation of Program to Date: October 2012 through April 2016. Available at https://snohomishcountywa.gov/DocumentCenter/View/36923.

Snohomish County Department of Human Services. 2015. 1/10th of 1% Sales Tax Annual Report. Available at https://snohomishcountywa.gov/documentcenter/view/36924.

Vance-Sherman, A. 2015. Snohomish County Profile. Washington State Employment Security Department. Available at https://fortress.wa.gov/esd/employmentdata/reports-publications/regional-reports/county-profiles/snohomish-county-profile. Updated September 2015.

Site Visit Summary: Yakima County

Conducted on September 13, 2016

Interviewees

Defense	Paul Kelley, Yakima Co. Department of Assigned Counsel Director
Mental Health	Rick Weaver, Comprehensive Healthcare CEO Courtney Hesla, Comprehensive Healthcare Division Director Ed Thornbrugh, Comprehensive Healthcare VP
Jail	Ed Campbell, Department of Corrections Director

Background and General Thoughts from the County

- Yakima is a large, mostly rural county in eastern Washington. Approximately 35 percent of the county's population lives in the city of Yakima; another 38 percent live in unincorporated areas of the county.

- The city of Yakima is home to a recently opened state competency restoration facility. Known as the Fairgrounds Annex, the facility is housed at the Pacific Avenue jail, a minimum-security facility. A portion of the facility was remodeled and repurposed in 2016 for competency restoration.

- The county has a comparatively low rate of referrals to the state hospital for competency evaluations and restoration. Comprehensive Healthcare attributes this in part to informal diversion by law enforcement officers, as well as formal diversion programs.

- Interviewees repeated points made in other counties that, to be used by law enforcement, crisis triage/stabilization centers must be (1) conveniently located (for speedy access), and (2) repeatedly publicized and promoted to law enforcement personnel, to compensate for police officer turnover, varying levels of awareness and commitment by leadership, etc.: "You have to reboot every few months." Crisis intervention training provides an opportunity to promote utilizaton of triage and other diversion programs.

- Yakima County has not elected to access the .01% tax, which funds behavioral health and diversion services in many counties that do collect the tax. However, the county did authorize the 3/10th sales tax for public safety, which it splits with city and uses for law enforcement purposes.

Strengths Identified by the County

- Grant funding from the Bureau of Justice Assistance to participate in the Smart Pretrial Demonstration Initiative, a three-year initiative to test the cost savings and public safety

enhancements that can be achieved by improving pretrial policies and practices. Yakima's initiative includes technical assistance from the Pretrial Justice Institute (PJI) to establish the Pretrial Services Program, including the implementation of the Laura and John Arnold Foundation's Public Safety Assessment Tool. Concurrently, changes have included assignment of a seasoned prosecutor to filing decisions, addition of a .5 FTE assigned counsel, and commitment of the county commissioners through general fund financing. In addition, Comprehensive Healthcare has committed a fulltime mental health professional co-located with the Pretrial Services Program. The average length of stay in the jail has decreased from 14 to 2 days.

- Good working relationships among the assigned counsel's office, Yakima Police Department, Sheriff's Office, and court; includes Comprehensive Healthcare's hiring of a former Yakima County Sheriff to serve as a liaison with local law enforcement (facilitating crisis intervention training, etc.).

- Program for new City of Yakima police hires to shadow DMHPs, so that they better understand the behavioral health system.

- Law enforcement buy-in (particularly by leadership) for diversion programs.

- High emphasis on developing personal relationships across organizations and disciplines (law enforcement and mental health provider staff, for example) as a basis for further collaboration.

- Community leadership and commitment—people who are willing to stay at the table, find a way to say "yes," and get things done

- Prearrest diversion for nonviolent misdemeanants, consisting of (1) law enforcement officer drop-off at Commprehensive Healthcare's crisis triage center, and (2) a cite-and-release policy in some jurisdictions.

- Rich array of behavioral health services, including mobile crisis outreach, crisis triage center, evaluation and treatment facilities for adults and juveniles, and a detox facility.

- Attendance of assigned council at first appearance (began in February 2016).

- Jail reach-in—i.e., easy access of behavioral health providers to mentally ill people in jail, for assessment and case planning, etc.

- Newly hired jail staff to pursue Medicaid reimbursement when an inmate is in the hospital for more than 24 hours.

Opportunities Identified by the County

- Implement the use of peer counselors to strengthen the intensity of the misdemeanor diversion program.

- Fund the pretrial services program after BJA funding expires in 2018. The program has the potential to divert large numbers of people who do not need to be in jail.

- Eliminate repeated competency evaluations for people who are charged multiple times (i.e., fast-track people who are already known to have competency issues for placement at the state hospital).

- Include recidivism rates as a performance metric for the BHOs.

- Revise WACs to eliminate unnecessary security and licensing requirements for crisis stabilization centers. The current criteria are excessive.

- Stabilize funding for corrections, diversion activities, and community-based treatment, without relying so heavily on fluctuating state funding, which has consistently dropped.

- Add additional adult E&T facilities. The single 16-bed facility currently available (operated by Comprehensive) is not enough.

- Modify/remodel jail facilities to create spaces appropriate for group mental health treatment activities. (The current jail architecture precludes this.)

- Dedicate a corrections officer to escort mental health professionals, to facilitate and expand treatment options in jail.

- Get uniform, vetted, and practical guidance from the state regarding treatment programming for inmates with mental illness. Without clearly defined treatment standards and protocols, county jails are vulnerable to lawsuits, especially with older facilities that do not have spaces suitable for treatment.

- Fund and implement reentry/transition services, with an in-house reentry specialist and/or DSHS liaison, for everyone in jail. Housing is especially needed. Without such services people are likely to reoffend.

Current Programs and Practices—Highlights

Informal Diversion

Police officers in Yakima County have wide discretion and, as of the last few years, the authority to cite and release for misdemeanors (with the exception of domestic violence, in which case an arrest is required). In the case of felonies, police officers arrest as a matter of course. Police sometimes drop charges knowing that Comprehensive Healthcare will work with the person. Officers sometimes do not charge people with mental illness who they see frequently and believe prosecutors are unlikely to charge.

Behavioral Health Diversion to the Crisis Triage Center

Officers who encounter an individual with a mental illness and/or substance use disorder can transfer that person to the Crisis Triage Center for stabilization. Operated by Comprehensive Healthcare, the center also serves as a doorway to individualized intensive case management and

support services. People who law enforcement transfers to the crisis triage center are non-violent misdemeanants (as defined by a prosecutor agreement). Common charges include disrupting the peace, drug use, possession of drug paraphernalia, harassment, petty larceny, and trespassing. No charges are filed initially; however, if the person fails to stay engaged in treatment for several weeks, charges may be filed.

Mobile Crisis Team

This 24-hour unit conducts outreach to crisis calls and delivers people to the crisis triage center. Each county served by Comprehensive Healthcare maintains a mobile crisis team(s).

Misdemenaor Diversion to Crisis Triage Center (Mental Health and Substance Use Disorders)

A SAMSHA grant was used to start a diversion program in 2008 that, after some reworking, ended up taking the form of pre-arrest diversion by police officers, with drop-off at the first crisis triage center in Washington. If clients stay engaged in treatment for several weeks, the prosecutor drops the charges. The program accepts people charged with misdemeanors and people who have been picked up by city or county law enforcement for probation technical violations. Excluded are people charged with DUI, domestic violence, violent offenses, or sex offenses. The center has a detox program, apartment housing, and a flexible enough program that people can participate from their own home.

For some time the diversion program had hundreds of intakes per month. However, once police officers began citing and releasing people, law enforcement referrals to the program decreased substantially.

Pretrial Services

Pretrial Services is a new, voluntary program for felonies in district court. The program began in February 2016 as part of the Smart Pretrial Demonstration Initiative, a three-year initiative funded by the Bureau of Justice Assistance and managed by the Pretrial Justice Institute that involves the use of risk assessment to inform pretrial release decision-making, to improve pretrial outcomes. As part of the program, the Yakima County jail uses the validated Arnold Foundation Public Safety Assessment (PSA) tool to assess every arrestee's risk of committing a new crime, violence, and failure to appear if released pretrial.

Additionally, a dedicated public defender is present at first appearance hearings. This is a constitutionally mandated right but until recently has not often happened.

Comprehensive Healthcare has assigned a mental health professional to the Pretrial Services unit. This person does assessments, determines care needs, and makes referrals to voluntary mental health treatment and other services. Engaging with the Comprehensive Healthcare staff person is an integral part of the pretrial assessment process.

Mental Health Court

Yakima County has a small mental health court that started as a pilot project. The program is structured to take high-acuity people, with schizophrenia and bipolar disorder, and, uncharacteristically, initially focused on felonies, although it has since expanded to include misdemeanors. Completion of the two-year program, which involves stabilization, counseling, and

treatment, results in dismissal of charges. However, few people who have a mental illness participate in the program, in part because their history of involvement with the criminal justice system and the challenge of meeting the participation requirements. Deputy prosecutors, too, can veto their participation. As a result, the court currently has only 12 participants. Funding—for county, prosecution, and BHO staff time—has been an issue, as has educating local lawyers about the program.

Jail Mental Health Services

The Yakima County jail has a prescriber, two case managers, two mental health professionals, and a support person located in the jail. The jail coordinates with the Comprehensive Healthcare to identify members who have been arrested and detained, so that case managers can "reach in" to the jail to coordinate medication, case planning, and other services. Individuals also can be flagged for a mental health evaluation by the arresting officer or during jail medical screening at booking, or they can self-refer once they are in jail.

People in jail who are acutely psychotic are transferred to a Comprehensive Healthcare inpatient facility, using a court-ordered furlough process or, if charges are dismissed, the civil ITA process. A furlough can take place at any time—pretrial, while waiting for competency evaluation or a restoration bed, or while serving a sentence. In most cases the patient is treated and returned to jail, rather than sent to Eastern State Hospital.

Transition Planning

Comprehensive Healthcare develops transition plans for its clients who are being released from jail, with a focus on people who have a mental illness. Most other inmates do not receive transition planning. The exceptions are veterans and the developmentally disabled, who are served by special interest groups.

References

Yakima County Development Association. Yakima County Profile. Available at http://www.yakimacounty.us/DocumentCenter/View/1579.

Appendix D:
Key Messages from State-level Information Gathering

This document presents results from work that Joplin Consulting completed for Task 4 of Contract No. K1911 with the Washington State Office of Financial Management (OFM). Under the contract, Joplin Consulting reviewed best practices to safely and appropriately divert people with mental illness from the criminal justice system to community-based treatment and made recommendations to Washington state on how to increase jail diversion opportunities for people with mental illness.

Under Task 4, Joplin Consulting conducted phone or in-person interviews to identify legal, financial, or other barriers that limit the ability of local government agencies and mental health systems to divert individuals with mental illness from jails and possible solutions to these challenges. Interviewees included representatives of state agencies, state associations, and legislative staff, among others in Washington.

Interviewees

Office of Governor Jay Inslee	Bob Crittenden, Special Assistant for Health Reform
Health Care Authority	MaryAnne Lindeblad, Medicaid Director Nathan Johnson, Chief Policy Officer
Department of Social & Health Services (DSHS)	Carla Reyes, Asst. Secretary Behavioral Health
DSHS Behavioral Health Administration (BHA) – Office of Forensic Mental Health	Thomas Kinlen, Director Ingrid Lewis, Program Manager Simone Vijoen, Forensic Evaluator Barry Ward, Psychology Services Supervisor
BHA – Division of Behavioral Health & Recovery	Jessica Shook, Mental Health Program Admin.
BHA - Behavioral Health & Managed Care	David Reed, Office Chief
BHA – Division of State Hospitals	Al Bouvier, Management Analyst, Washington State Hospital Randall Strandquist, Dir. Of Psychology, Eastern State Hospital
DSHS Research & Data Analysis Division	Jim Mayfield, Senior Research Manager
Department of Corrections	Annmarie Aylward, Assistant Secretary, Community Corrections Division Jody Becker-Green, Deputy Secretary, Operations

	Kevin Bovenkamp, Assistant Secretary, Health Services
Legislature	Sandy Stith, Senate Ways and Means, Fiscal Analyst Andy Toulon, House Ways and Means, Fiscal Analyst
Washington State Criminal Justice Training Commission	Sue Rahr, Executive Director
Washington Association of Prosecuting Attorneys	Tom McBride, Executive Secretary
Washington Council for Behavioral Health	Ann Christian, Chief Executive Officer
Washington State Association of Counties	Juliana Roe, Policy Director
Washington Association of Sheriffs and Police Chiefs	Ned Newlin, Jail Services Liaison
Disability Rights Washington	David Lord, Public Policy Director
Better Health Together	Alison Carl White, Executive Director
Clark County Department of Community Services	DeDe Sieler, Program Manager II

The findings summarized below represent thoughts and ideas expressed by the interviewees. They do not necessarily reflect the views of Joplin Consulting. Joplin Consulting will present its recommendations, based on the entirety of the work completed under this contract, to the Office of Financial Management in a final report in November 2016.

Quotes have been edited for clarity and conciseness. In some cases they have been paraphrased or synthesized to reflect more than one person's comment.

Key Messages Expressed by Interviewees

Availability of treatment. There is great interest in jail diversion for people with mental illness but concern about the limited treatment options, including outpatient and residential treatment. There need to be options for people with serious mental illness who commit minor crimes. Often these individuals do not need to be in held in a secure setting, but simply need access to a residential or intensive outpatient program that encourages and supports participation in treatment. The lack of residential treatment is particularly acute in rural counties, which may have no other option than to send people to the state hospital, leaving patients far from their families and support system. It is unclear whether the treatment adequacy issue is related to insufficient investment, poor management, or lack of accountability.

"Not everyone needs to be at the state hospital, but everybody needs something. It's not necessarily a requirement that the beds be secure; most staff can talk people into staying. We want to do more diversion, but there aren't the resources."

State funding. Much of the state's investment in the mental health system has focused on resolving issues related to acute care, competency, and restoration. Meanwhile, state funding for community-based residential and outpatient mental health treatment has dropped, and Medicaid reimbursement rates are perceived as too low. This has affected staff recruitment, hiring, and retention at community mental health agencies and resulted in reduced capacity to provide residential and outpatient services. State funds[1] that used to pay for transition planning for inmates prior to their release from jail were helpful in connecting people with services as they left the jail, yet funding for these activities, too, has dropped. Stakeholders are skeptical about approaches such as restoration in the community that, over the long term, could result in fewer state hospital beds and thus be seen as the state trying to shift its responsibility for competency restoration to the counties.

"We need to broaden the focus of mental health investments to beyond just the deep-end challenges. We're lacking the flexibility and quick response we need."

The state notes that its investments in the state hospitals and community-based behavioral health systems have increased beyond the rate of inflation. From FY 2013 to 2017, for example, state funding for mental health and chemical dependency programs increased by 62 and 116 percent, respectively. Specific investments have included programs of assertive community treatment (PACT) teams, assisted outpatient treatment (AOT), and mobile crisis teams, as well as 150 additional inpatient beds in the community. Part of the increase in funding was related to Medicaid expansion, while state funding for non-Medicaid programs was reduced, assuming that some of the people formerly served by those programs would obtain services through the expanded Medicaid funding. Whether this is actually happening, and to what degree, would need to be determined through additional data collection and analysis.

"How have caseloads changed since this shift? How has the population changed? Are Medicaid-eligible people getting signed up and accessing services? Why or why not? We could use administrative data to identify themes and patterns and better understand the effectiveness of these investments that Washington has made."

CIT training. The value of crisis intervention training (CIT) extends beyond teaching law enforcement officers to recognize and understand mental illness. (Many officers already have learned this on the job, through experience.) The training should be delivered regionally and involve both behavioral health and criminal justice professionals, so as to provide valuable cross-training and relationship-building opportunities. CIT training serves as a venue for officers and behavioral health professionals to connect, exchange information, and share and understand available resources, including how to contact and work with each other. Community corrections officers and jail and prison staff currently receive very little, if any, CIT training.

---

[1] Jail Services Proviso, HB 1087 (2011). FY16 $2,291,000 and FY 17 $2,291,000. https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Fact%20Sheets/Jail%20Services.pdf

"Community providers love it when law enforcement officers are CIT trained, especially when the mental health providers do the training and they all meet each other personally. Expansion of CIT across the state is a good investment."

Crisis Intervention. Stakeholders support the use of mobile crisis teams and crisis stabilization/triage centers as a way to deescalate situations in the community and engage people who have mental illness in treatment. Mobile crisis teams are seen as costly[2] but very effective at cutting the number of arrests for low-level offenses. The state needs more low- and no-barrier crisis stabilization centers and to continually educate law enforcement about how to use them.

"Mobile crisis teams cost money, but they engage people and get them back into their treatment setting."

DMHP issues. There are not enough designated mental health professionals (DMHPs). DMHPs are the only people authorized to make decisions about involuntary commitment. Their work is quite specialized. It focuses on risk to self or others (rather than competency, which is a legal issue), and it requires particular qualifications. Contracts require that DMHP services be available round the clock. Although the Washington Association of Designated Mental Health Professional provides regular training, DMHPs in small counties often have difficulty attending trainings because there is no one to cover for them: crisis workers, other mental health professionals, and even the DMHP's supervisor may not have the required skills and qualifications to provide backup coverage.

"Contracts for crisis services require someone to be available 24/7. If there are only three DMHPs, you can't send two of them off to training for a week."

In addition, there is a perceived need for greater consistency in how DMHPs follow the Involuntary Treatment Act (ITA) (RCW 71.05), and the state needs to take corrective action when warranted to increase accountability.

Placement in E&Ts. DMHPs sometimes have difficulty placing someone at an evaluation and treatment facility (E&T) on a short-term involuntary hold (i.e., a 72-hour hold or a court-ordered 14-day hold), for several reasons. E&Ts often reject potential patients—based on a patient's high acuity or the current mix of patients' acuity, for example. Additionally, E&Ts tend to fill up with people on 90-day holds who are waiting to get into the state hospital, leaving few beds for people on shorter holds who may not need the high-level services of the state hospital.

People who are not accepted at an E&T typically are placed in a hospital psychiatric unit or on a single-bed psychiatric certification,[3] or they are released, without receiving adequate stabilization support or treatment. In some counties, responders do not initiate the DMHP process because they know that no E&T beds are available, or that the E&T will not accept the individual in question. Reportedly, DMHPs sometimes also do not come into the jail to conduct assessments because they know that the inmate cannot be placed at an E&T.

---

2 http://www.wsipp.wa.gov/ReportFile/1557/Wsipp_Inventory-of-Evidence-based-Research-based-and-Promising-Practices-Prevention-and-Intervention-Services-for-Adult-Behavioral-Health_Benefit-Cost-Results.pdf

3 http://apps.leg.wa.gov/wac/default.aspx?cite=388-865-0526.

E&Ts must accept people on 90-day holds who have been referred by a judge through a dismiss and refer process.

> *"There's a lot of competition for E&T beds. When someone is released from a single-bed cert at the hospital because there wasn't room at the E&T, what happens to them? Do they come back? We don't know. Sometimes people get pushed into more in restrictive settings than they need, like the state hospital, because other options aren't available."*

Communication and follow-through with law enforcement and prosecutors. Before directing people into diversion programs, law enforcement officers and prosecutors want to be assured that the person with mental illness actually will engage in treatment, that the program will deliver, and that the person will not simply end up back out on the street with no plan for treatment. For example, prosecutors often would welcome jail diversion if they could be informed about what agency will provide the treatment, and whether the offender completes treatment. Prosecutors understand that people with mental illness often need support and guidance in order to make it to their first treatment appointment and to engage.

> *"Law enforcement officers and prosecutors want to know where they'll go, so that the problem is addressed and the person doesn't come back repeatedly."*

Data access. The jails and the behavioral health system have varying access to electronic records and use inconsistent definitions. Currently most Washington jails do not have access to the medical and treatment records for inmates with mental illness, including records related to medication. Likewise, it is hard for BHOs and providers to get data from the jails, such that most of the time providers do not know that their clients are in custody. Although there have been data sharing agreements between DSHS and the jails for specific research projects, there is no ongoing agreement. Having a clinical data repository and ongoing data sharing agreements between DSHS and the jails would (1) increase care coordination, and (2) provide aggregate data that could be used to analyze the jail population for the purposes of targeting future initiatives and investments.

By July of 2017 is it expected that jail booking data will be transmitted electronically to the state. However, there is still no timeline for when or how that data will then be communicated to providers. The Washington Health Care Authority is working to develop a clinical data repository. The clinical data repository could serve as the mechanism to ensure that providers know when their clients are incarcerated. In the interim, Island County is participating in a North Sound clinical data repository for use by hospitals, providers, payers, and jail medical staff.

> *"Without access to medical and treatment records, it's hard to understand who these people are and what they need while they are in jail. Most jails don't know anything about an inmate's care in the community. It's important to have jail data so we understand who's in jail, and what led them there. It's more than just data—it's a tool for knowing where to direct resources. There's a lot of data out there, but jails don't all have electronic medical records, or define terms similarly. How consistent the data is and how readily available it is depends on where it's coming from."*

Peer support specialists. Most providers use peer support specialists to accomplish portions of their work, especially for hospital discharge planning, increasingly for transition planning in jails. Providers have experienced challenges getting peers through the background checks required to

enter jails to provide transitional support, particularly because peers of inmates with mental illness may have a criminal background.

> *"Is the screening at the appropriate level of stringency? Some facilities are pretty restrictive. I care about the criminal history of peer counselors or mentors if there are legitimate issues, like introducing contraband or recent assault or drug charges. But not a DUI from 10 years ago. You have to find a reasonable balance."*

Service gaps related to "access to care" standards. Many justice-involved individuals who have a serious mental illness (SMI) will meet the Medicaid "access to care" standards that BHOs use in determining what treatment services to provide to a person; however, people whose mental illness is not as severe may not qualify for services. Additionally, specialty court judges sometimes order different or longer courses of treatment (for chemical dependency, for example) than is considered medically necessary.

> *"Just because inmates are on Medicaid doesn't mean that they meet the 'access to care' standards that BHOs typically use. Psychotic people do, but what can we do with people who don't have a diagnosis of serious mental illness?"*

Wrap-around services. Justice-involved individuals with mental illness are unlikely to be successful in the community unless they receive comprehensive services, such as supportive housing, case management, medication, and physical and behavioral health treatment. Many also need supportive employment and other wrap-around services. The use of peer support specialists is increasingly recognized as a key part of these services. Appropriate services need to be provided across the continuum of care, and included in transition plans as inmates are released from jail.

> *"You need wrap-around services from beginning to end. They can't fall through any holes. If people are being served in the community, most of them will not become involved in the criminal justice system because they've got active case management and services."*

Community resistance. Communities are resistant to the siting of community-based treatment facilities. As a result, facilities such as crisis stabilization centers end up being inconveniently located or have unreasonable rules (e.g., no smoking allowed on the grounds). One method of avoiding some of the siting challenges is to repurpose existing facilities; this was done with Maple Lane (a former juvenile detention center) and Yakima Annex (a vacant jail), both of which are now being used as state psychiatric hospitals. Some counties are also considering repurposing juvenile justice centers as residential treatment centers.

> *"Even when a program is successful and has low recidivism rates for people with mental illness, the response from community varies in different parts of the state. Especially when it comes to siting facilities."*

Uneven resources for offenders on community supervision. The amount and availability of community-based services varies throughout the state, with some areas having very little. Even if a service (MH treatment, supportive housing, etc.) is required under the conditions of someone's supervision, that service is not necessarily readily available in their community, or available at all. Although some community corrections officers (CCOs) are good at making connections and finding placements and resources for their clients on supervision, this is inconsistent throughout the state. Supervision is not a substitute for mental health treatment.

"Resources available in the community are quite uneven. If there are no services in the community, what can you do? And what about people who don't make the cut for participation in the program?"

Delays in access to services for offenders on community supervision, and forensic clients generally. Offenders with mental illness who are on supervision in the community have difficulty accessing services and can experience long delays in accessing mental health treatment. This probably reflects the shortage of services and gaps in the system; however, multiple interviewees expressed concern that providers may be reluctant to serve forensic clients—out of fear, concerns about liability, and because of the additional paperwork and documentation involved. Community corrections officers found it easier to find treatment slots for their clients when services were funded through the Department of Corrections (DOC) and were co-located at criminal justice centers, which is no longer the case.

"There are big delays in getting people into services. This reflects gaps in service. There are not enough services to go around, plus forensic clients are often excluded by providers."

Sanctions for technical violations. "Swift and certain" confinement in jail as a sanction for violating conditions of supervision may not be appropriate for people who have mental illness because it may not have the desired deterrent effect. People with mental illness may need alternative sanctions for technical violations.

"Offenders with serious mental illness should be excluded from swift and certain criteria. They aren't going to learn from it, which is its whole purpose."

Unique needs of rural counties. Many rural counties have unique needs related to low population density, geographic isolation, transportation challenges, and general lack of resources. For example, it is challenging for many rural counties to provide effective 24-hour crisis care. Law enforcement officers and designated mental health professionals (DMHPs) may not be able to attend professional trainings because they do not have enough staff to provide back-up services. Many small counties do not have crisis stabilization centers or E&T facilities. In some counties even telepsychiatry is not practical because the county lacks the necessary technology infrastructure. Washington's urban and most populous counties tend to drive public policy decisions and solutions that do not necessarily work well for rural counties. King County, in particular, has programs, services, and ideas that are on a much different scale than is practical for other counties in the state.

"The needs of small counties are different from those of large counties. It's not that one size fits all. We make decisions based on the eight largest counties, and that doesn't work for every county."

Variability across counties. There is considerable variability across counties not just in available resources for mental health treatment (some counties use the .01% tax), but also in practices and procedures related to jail deflection and diversion. This includes practices and procedures related to charging decisions, exclusionary criteria at crisis stabilization centers, involuntary commitment, data sharing between jails and providers, provider access to clients who are in jail, and transition planning. Often the variability is a function of relationships, rather than established policy. Given the differences in county sizes and resources, it is not necessary that all practices and procedures be consistent across the state. However, variability affects whether, when, and how justice-involved people with mental illness are able to access the services they need and therefore how successful they are in the community.

"There's a mix of services. I hear complaints about lack of consistency, and practices are quite variable. But probably it's not so much practices as relationships—with the jail and with parts of the mental health community. How do we bridge that when people are crossing different systems? We need to build this into our planning."

Implications of health care integration on counties. In many parts of Washington, counties and behavioral health care providers have histories of strong, collaborative partnerships. Multiple interviewees expressed concern about the potential loss of these important collaborations and the distancing of counties from policy making for behavioral health systems once the Washington health care system is fully integrated. It is unclear how county policy-makers will influence the delivery of behavioral health care (and other aspects of health care) if they do not have a role in administering the behavioral health benefit.

"With integration, there's a risk of new kinds of silos and fragmentation. We want counties to have an ongoing role, to impact the whole healthcare delivery system."

Opportunities Identified by Interviewees

Crisis Response

- Create opportunities for people with behavioral health issues to be identified, assessed, and referred to services before they become involved in the criminal justice system.

- Divert people from jails before arrest, such as through more crisis intervention and referrals to services.

- Strengthen the relationship and understanding between law enforcement and the crisis response system.

- Provide law enforcement officers with direct, immediate access to mental health professionals for information and consultation regarding people with mental illness they encounter in the field.

- Encourage local-level partnerships between community mental health agencies and law enforcement, so that agencies can participate in problem-solving on the ground and quickly connect people to available resources (about which they are well-informed), before charges are filed. Similarly, strengthen the relationship between community mental health agencies and criminal justice professionals, so that issues can be resolved at the lowest level possible.

- Employ DMHPs through community mental health agencies, instead of counties, to encourage decisions that lead to stabilization and treatment, rather than commitment and incarceration.

- Expand the availability and use of crisis stabilization centers. Ensure that crisis centers have a true open-door policy (i.e., that they will accept anyone, regardless of charge, criminal history, or level of agitation) and that they have step-down options for people as they stabilize. Use seclusion and restraint at crisis centers if necessary, to maintain the open-door policy.

- Expand crisis intervention training beyond law enforcement officers to include behavioral health and criminal justice professionals (e.g., community corrections officers and jail and prison staff). This provides cross-training and relationship building opportunities.

- Increase the number of E&T beds to accommodate and prioritize people on short-term holds who do not need the higher level, longer term services of the state hospital.

Booking and Intake

- In large counties, designate a wing of the jail as a 23-hour crisis observation facility. Use this facility before arraignment to assess people's mental health condition and needs.

- In jails that do not have mental health professionals onsite, establish the use of a standardized mental health triage tool for use during booking and intake. Results of the triage process could trigger a phone consultation with a mental health professional. This could aid small jails in understanding their inmates' mental health status and risks and in providing helpful information to the court, prosecutor, and defense.

In Jail

- Provide state funding to create electronic medical record systems in jails that lack them.

- Establish statewide or regional clinical data repositories to increase care coordination across corrections and community-based health care.

- When people with mental illness who are housed in a jail are very sick and are decompensating, use mechanisms such as court orders for temporary transfers or furloughs to transfer them to E&Ts for short-term treatment and stabilization, and subsequently return them to jail.

Transition/Reentry

- Expand state funding for and/or use contract provisions with managed care and behavioral health organizations to incentivize the provision of jail transition services (i.e., release planning, Medicaid enrollment, and "warm hand-offs" to providers) for people with mental illness), as a targeted investment.

- Establish state standards for the provision of medication to inmates being released from jail. (Current practices vary greatly from jail to jail.)

- Identify jail "frequent fliers" and provide them with robust transition planning and wrap-around services upon release.

- Make use of peer support specialists for transition planning in jail and upon release, to connect people who have mental illness with services.

- In large jurisdictions that release many people from jail, consider using Medicaid administrative claiming (MAC, also known as MAM, or Medicaid administrative match) to

leverage Medicaid funds for the cost of Medicaid enrollment services and Medicaid targeted case management to fund transition services.

Community-based Services

- Expand outpatient treatment capacity, for both front-end diversion and for flexible, responsive services for people on community supervision and those reentering the community from prison and jails.

- In areas with multiple providers, encourage/incentivize a provider to specialize in working with justice-involved individuals who have mental illness.

- Managed care plans are required to meet standards for access to care. If the data indicates they are not meeting those standards, the legislature should require performance improvement plans on specific populations.

- Ensure that people with mental illness have supportive housing when they are released from jail. Housing is essential to success.

- Currently in Washington, supportive housing has been authorized in the state Medicaid plan but not funded. Existing programs are paid for through block grants and HUD funding, but often exclude justice-involved individuals. Funds from Washington's recently approved Medicaid waiver are expected to provide supportive housing to several thousand people over several years, but it is unclear whether forensic clients will receive any prioritization.

- Identify and support/fund treatment options for forensic clients who have a mental illness that does not rise to the level of an SMI. Such facilities are likely to be community health centers.

- When possible, co-locate mental health treatment facilities and criminal justice centers, to facilitate communication and coordination, reduce stigma, and remove attitudinal barriers to treatment of forensic clients.

Pre-trial and Community Supervision

- Revise DOC Swift and Certain (SAC) policy to exclude offenders with serious mental illness from SAC sanctions, such as automatic jail time, and instead allow sanctions that are more likely to have an impact on this population, such as additional program or treatment requirements.

Data Collection/Analysis

- Analyze Medicaid, jail, and DSHS data to better understand the impacts of state funding changes and Medicaid expansion on the population of people with mental illness who are being jailed. How has the population changed? What percentage of people with mental illness who are being jailed are eligible for Medicaid? Are they enrolled? Have they been referred to services? Have they accessed services? Why or why not? What does this say about

the availability and effectiveness of mental health treatment for the justice-involved population?

- Conduct a gap analysis on the needs of offenders with mental illness who are on community supervision and those who are returning to the community from prison.

- Establish an ongoing data sharing agreement between the jails and DSHS to allow for ongoing data access and cross-system analysis.

- As Washington's integration of the health care system progresses, analyze system data to determine whether justice-involved individuals who have a mental illness are receiving timely and effective care (i.e., who has a mental health diagnosis, how many people with mental illness are being incarcerated, and are they connecting with services upon release?). It is likely that existing data can be analyzed to determine the treatment penetration rate for people with particular behavioral health conditions.

Other

- Support communities that have chosen to implement the mental health tax by providing information on evidence-based and cost-effective methods of investing those revenues.

- Expand the charges handled by therapeutic courts to include lower level person crimes, including Assault 3 felonies.

- Create a review board with more medically based than legally based members, to help with release decisions. Such boards can withstand scrutiny about release decisions better than the state hospitals can.

- Expand the Seattle Family Intervention and Restorative Services (FIRS) program beyond juveniles to young adults. Under the FIRS program, juveniles detained because of alleged domestic violence (typically toward family members, rather than intimate partners) are not charged with a crime but instead enter into an agreement to engage in services specifically catered to the needs of the youth and family. Often, the family agrees to engage in Step-Up, a court-based domestic violence intervention program designed to address youth violence and acting out toward family members; Step-Up uses a 20-session curriculum in a group setting with youth and parents. Other times, youth need evidence-based treatment such as drug and alcohol treatment or mental health treatment. Under the FIRS program, families are rapidly enrolled in services specifically tailored to their needs.