NCSL

The Legislative Primer Series for Front End Justice:

Mental Health

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This report is the first in a series that will explore policies that impact the front end of the criminal justice system. Each brief will look at who is entering the "front door" of the criminal justice system and give examples of legislation, national initiatives, best practices, promising programs and key research on timely issues. The series will give legislatures the tools they need to consider cost effective policies that protect public safety.

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The Legislative Primer Series for Front End Justice: Mental Health

BY AMBER WIDGERY

For people in the midst of a mental health crisis, the criminal justice system and jail are all too often the first or only available response—but not necessarily the best. Legislators play a critical role in changing the way we think about and use jails in America. State law can dictate both the policy and the resources necessary to effect change, and legislators are community leaders who can convene necessary stakeholders to advance new approaches for handling individuals with mental illness on both the state and local levels.

Statewide support for system-level changes can alter how we respond to mental illness in our communities, reduce the number of people who come into contact with the criminal justice system, and maintain public safety. For those with mental illness who are appropriate for entry into the justice system, access to appropriate treatment can be provided or increased.

This report examines ways in which states can support diverting appropriate individuals with mental illness away from the criminal justice system entirely. Most experts and policymakers agree that the justice system is generally not the best intervention for those accused of low-level offenses, and that community-based services may be better suited to breaking the cycle of justice system involvement. This report also identifies correctional interventions for those for whom community-based services are not appropriate. These interventions can hold offenders accountable while also connecting them to treatment and services that are designed to reduce recidivism.

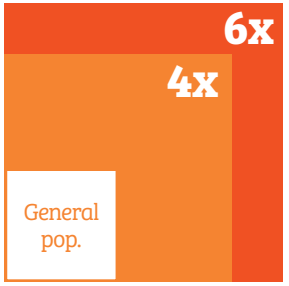
Jails: De Facto Mental Health Institutions and Burgeoning Populations

A movement in the 1950s to "deinstitutionalize" mental illness drastically decreased the availability of state hospital beds for people with mental illness.[1] The intent was to treat individuals instead in a community-based setting, a policy change that was appealing for both fiscal and civil rights purposes.[2] Unfortunately, community-based treatment capacity was not developed as planned, and now local jails largely serve as de facto mental health institutions.

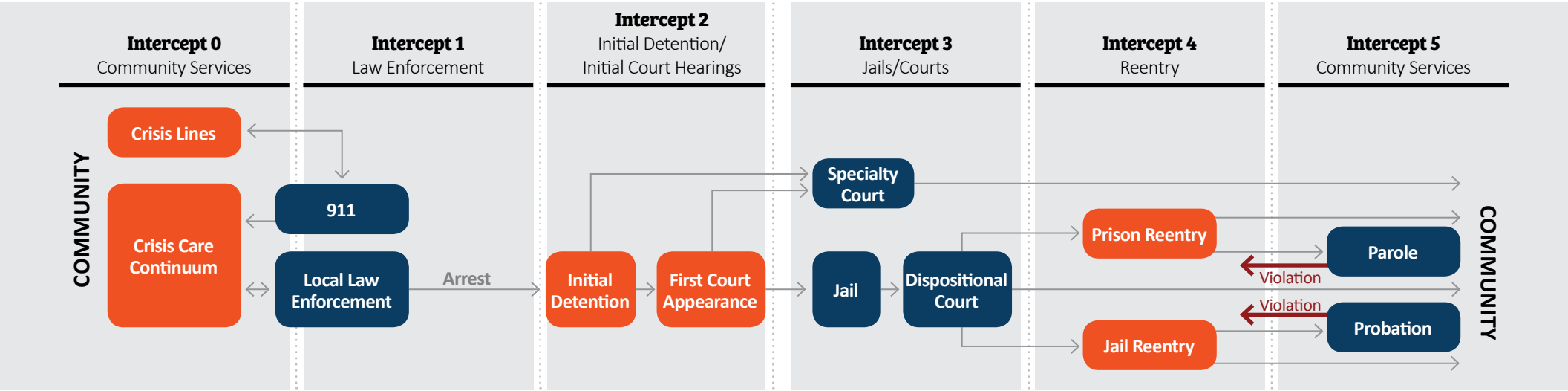
Today, a person who is experiencing a mental health crisis is more likely to encounter law enforcement than receive the medical assistance they need.[3] Jail populations currently reflect this reality. Rates of serious men-

Serious Mental Illness in Jails

Rates are four to six times higher than in the general population.



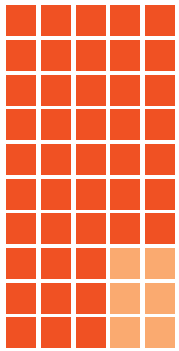
The Sequential Intercept Model



Policy Research Associates Inc.

tal illness in jails are four to six times higher than in the general population.[4] The most recent studies estimate that about 2 million people with serious mental illness are admitted to local jails annually.[5] A recent survey showed that in 44 of the 50 states, a prison or jail holds more individuals with mental illness than the largest remaining state psychiatric hospital.[6]

The use of the justice system to address the mentally ill has contributed to significant growth in overall jail populations. At least 700,000 people were held in local jails each day in 2015.[7] By contrast, that number in 1970 was just 157,000.[8] Our jails have grown significantly over the past several decades and according to the Vera Institute of Justice, nearly 11 million people are admitted to the country's more than 3,000 jails each year.[9]



Mentally Ill Stretch Jails

In 44 of the 50 states, a prison or jail holds more individuals with mental illness than the largest remaining state psychiatric hospital.

Opportunities to Reduce Mental Illness in Jails Using the Sequential Intercept Model

The Sequential Intercept Model (SIM)[10] is a framework communities can use to evaluate various systems and existing resources to organize targeted strategies that assist justice-involved individuals with behavioral health disorders. The tool helps to methodically evaluate a system and determine how those with mental and substance use disorders flow from the community into the criminal justice system and eventually return to the community. The SIM tool identifies opportunities–or intercept points (0 through 5)–where justice-involved individuals can be linked to services, rerouted from the justice system, or prevented from entering the justice system altogether. The model can help policymakers determine available resources, identify gaps in services, and develop policy and service changes.

Intercept 0: Community Services

While community and crisis services have traditionally been part of the SIM mapping process, Intercept 0 was formally integrated into the model in 2017. Intercept 0 includes both crisis response and law enforcement strategies that can reroute individuals prior to entry into the justice system. There are many types of crisis care services[11] that can assist individuals who have mental health needs; however, it is critical that communities are aware of these resources. This includes law enforcement officers, who are often the first point of contact for people experiencing a mental health crisis even when no criminal act has occurred.

Legislation and state funding have supported community mental health services to various extents over the years. Most recently, states are starting to look at how those community-based services can be better used by improving coordination with the criminal justice system and ensuring that individuals avoid the criminal justice system, if appropriate.

In 2017, the Colorado legislature acted to ensure that people in mental health crisis avoid the justice system if appropriate. Senate Bill 207[12] removed language from statute that allowed, at any time for any reason, an individual confined on an emergency 72-hour mental health hold to be detained in a jail, lockup or other facility used to confine persons charged with or convicted of a crime.

The goal of the legislation is to end the use of jails and correctional facilities as a placement option for people under emergency mental health holds who are not charged with a crime. To ensure these changes would take place, the bill appropriated funds to enhance Colorado's existing coordinated behavioral health crisis response system. The enhanced statewide framework strengthens community partnerships and provides first responders with a variety of options to address behavioral health crises in a way that meets the needs of an individual in a clinically appropriate setting.

INTERCEPT 0 IN PRACTICE: AN EXAMPLE OF COLLABORATION

In Charleston County, South Carolina, the Tri-County Crisis Stabilization Center opened its doors in 2017, providing the community and law enforcement with an alternative to arrest and jail for individuals who need mental health services. The facility is part of the South Carolina Department of Mental Health and receives funding from local hospitals, which expect to recoup some of their support from costs savings due to reduced visits to their emergency rooms.

Charleston County Sheriff's deputies provide security for the facility and in exchange, now have quick access to services for people they encounter during routine patrols and when responding to a call where someone may not have committed a criminal act or may not otherwise be appropriate for arrest. Officers now have options, including a "crisis triage service" phone number for a master's-level social worker at the center who can provide expertise, information, back-up from a mobile crisis team, and even a short-term psychiatric treatment bed or detox and sobering services.

Intercept 1: Law Enforcement

There is significant overlap between Intercept 0 and Intercept 1, because diversions and services under Intercept 0 can be initiated by the community or through the assistance of law enforcement over the course of their interactions with the community. Intercept 1, however, focuses more fully on law enforcement, and opportunities for officers to connect individuals with appropriate community-based services and reroute them away from the justice system altogether prior to arrest.

States have acted to assist law enforcement personnel in recognizing people with behavioral health issues, and in some instances, have also provided the framework for non-traditional law enforcement response procedures.

At least 27 states and the District of Columbia have laws requiring officers to be trained to respond to mental health, substance use and behavioral disorder issues. These laws specify which officers are to be trained, which entity is responsible for conducting the training, whether funding is provided, and whether the training is mandatory. This kind of training can increase officers' understanding of mental health issues generally, but can also be used to increase awareness of available community-based services.

Additionally, at least 12 states have enacted legislation creating requirements and/or guidelines for establishing Crisis Intervention Team (CIT) training.[13] Generally, these teams are formal partnerships among police departments and mental health providers that train responding personnel to identify and assess crisis situations, de-escalate crisis situations if necessary, link individuals to services, and divert them from the criminal justice system when appropriate.

INTERCEPT 1 IN PRACTICE: LOCAL INNOVATION

Starting in 1999, the police department in Houston, Texas developed Crisis Intervention Response Teams (CIRT).[14] These teams include an officer with special Crisis Intervention Team (CIT) training and a licensed professional clinician. The program started out as a small pilot, but today the department has 2,654 officers trained in crisis intervention.[15] The units only respond to calls involving individuals in mental health crisis, and in 2016 alone, there were 35,457 calls for service.[16]

Houston has also worked to address mental health concerns even earlier in the process by identifying and rerouting 911/emergency calls for service where a mental health crisis is apparent. Callers are connected directly to a helpline counselor in the dispatch center through a partnership with the Harris Center for Mental Health.[17] This direct connection can help avoid police dispatch altogether for calls involving mental health crisis where there is no accompanying criminal act.

Intercept 2: Initial Detention and Court Hearing

Intercept 2 includes policies that connect people to services or divert them away from the traditional criminal justice process after arrest, from the point of arrest and booking through initial court appearances.

In 2017, Arkansas enacted Senate Bill 136,[18] which authorized and established the framework for operating crisis stabilization units (CSUs) across the state. The units are clinical facilities that provide short-term stays for people in need of assessment and treatment services for behavioral health conditions. Individuals can be referred to a CSU by a law enforcement officer who arrested the individual for a nonviolent offense. The facilities are also available to receive people referred by community mental health centers, an Intercept 0 intervention.

The intent in creating the units was to improve outcomes for those with behavioral health issues who would otherwise end up in jails or emergency rooms, which are ill-equipped to provide this kind of assistance.[19] The first CSU opened in Sebastian County in March of 2018.[20] As the three other CSU's open, they are expected to help alleviate jail overcrowding, assist first responders and improve the odds that those who need help can find it.[21]

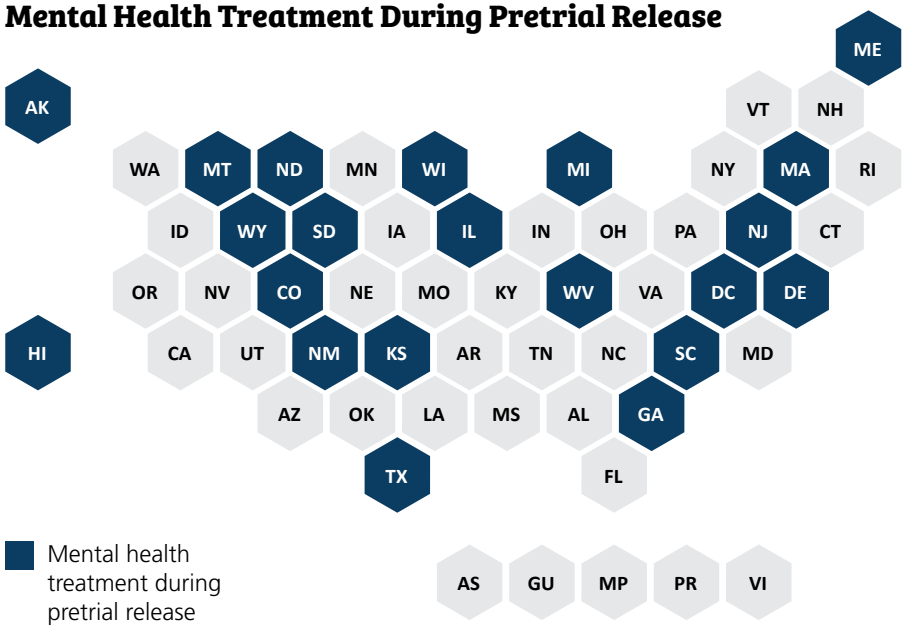
State and local action supporting immediate law enforcement led diversion options, like the legislation in Arkansas, is expected to continue expanding, but screening for mental illness, at or after booking, can also be a critical step to connect an individual to services. Those connections are often made by court-ordered conditions of pretrial release or pretrial services programs charged with supervising defendants prior to trial.

States have passed legislation to encourage these connections to services. Nearly half the states permit courts to authorize or order mental health treatment or counseling as a condition of release.[22] The majority of states also authorize courts to impose any reasonable conditions of release the court determines to be necessary, which can include a referral to services or a mental health screening or evaluation.[23]

The time frame from booking to initial appearance also provides an opportunity to identify defendants who may be suited for pretrial diversion programs in lieu of traditional criminal justice processing. Six states–California, Connecticut, Indiana, Mississippi, Nevada and Washington–have statutorily created pretrial diversion programs for individuals identified as having a mental illness.

An additional 37 states have statutory pretrial diversion programs that are not population specific, but can be used for people with mental health needs.[24] For example, many of these laws provide broad authorization for prosecutorial diversion agreements, where charges are held in abeyance or not sought in exchange for a defendant's agreement to voluntarily seek treatment.

States that Authorize or Require Mental Health Treatment During Pretrial Release



Source: NCSL, 2017

INTERCEPT 2 IN PRACTICE: STATEWIDE ACTION

The Vermont General Assembly enacted Senate Bill 295 in 2014[25] authorizing the use of pretrial needs screening on a statewide basis for specified defendants. The objective of the screening is to obtain a preliminary indication of whether a person has a substantial substance abuse or mental health issue that would warrant a subsequent court order for a more detailed clinical assessment.

Today, needs screening is available to most defendants in Vermont who are arrested, detained and unable to post bail within 24 hours if deemed appropriate by a pretrial services coordinator. The screening is voluntary, and information obtained during the screening can only be used for limited purposes.

Under this law, courts are authorized to order defendants to participate in a clinical assessment with a mental health treatment provider and follow the recommendations of the provider. Additionally, they can order a defendant to participate in pretrial services. Pretrial services may include connecting the defendant with community-based treatment programs, rehabilitative services, recovery supports and restorative justice programs. Failure to comply with either of these court orders does not result in a violation of conditions of release.[26]

Intercept 3: Courts and Jails

Intercept 3 includes policies that can connect people to services via the court system or while they are housed in jail. Courts can link a defendant to appropriate services by moving them to a specialized docket or treatment court designed to address their specific needs, often mental health or substance use.

Treatment courts, which serve individuals with mental illness, provide an opportunity to divert people away from the traditional criminal justice system. These courts emerged in the late 1990s, and have since rapidly expanded across the states.[27]

Today, 20 states have statutorily authorized mental health treatment courts.[28] Additionally, 19 state legislatures have authorized veterans treatment courts to address the needs, including those related to mental illness, of veterans and active members of the military.[29] Many more of these specialized courts exist at the local level,[30] and a vast number of resources exist, addressing everything from how to set up a court to how to evaluate outcomes.[31]

For those who are not appropriate for diversion from criminal processing, access to or continuation of services and treatment, including medication, can be critical. Screening for mental illness at booking or intake (Intercept 2), can help to facilitate initiation or prevent disruption of services while the defendant is incarcerated. Various tools are available to help jurisdictions identify individuals who need further evaluation or treatment.[32]

Treatment availability in jails is often limited because of inadequate resources. About two-thirds of the nation's just over 3,000 jails are located in rural counties, where tax bases are smaller and resources for even basic services can be sparse.[33]

Beyond resources, treatment can also be difficult because of the constant fluctuation in the jail population. About seven of every 10 individuals held in jail are being held pretrial and are not convicted of an offense.[34] Length of stay for defendants eligible for release can be unpredictable and vary greatly. The remainder of the population is generally serving a sentence of less than one year or sometimes being held for another agency.[35]

State legislatures can be key to ensuring that both rural and larger urban jails have the resources needed to provide services to help reduce recidivism and demands on the criminal justice system. This can be accomplished through legislation to create treatment programs or by distributing funding to local jails. Additionally, legislators can help increase capacity for treatment in local jails by leading regional or state-local collaboration efforts.

INTERCEPT 3 IN PRACTICE: JUDICIAL INTERVENTION

The Ramsey County Mental Health Court in Minnesota was established in 2005 and serves about 40 participants each year.[36] The court accepts individuals both pre- and post-adjudication who are diagnosed with a serious mental illness and charged with a nonviolent misdemeanor or felony offense. The program generally lasts one to three years, starts with screening for mental health and substance use needs, and involves four phases: engagement, active treatment, stabilization and program completion/graduation.

The court team consists of local judges, a program coordinator, case managers, a probation officer, prosecutors, a public defender, pro bono defense attorneys, graduate clinical interns and a law student who is certified to practice as a student attorney.[37] Some members of the team volunteer their time, but the program has also been sustained by funding from state, local and federal sources.[38]

Outcome data from the program show that Ramsey County Mental Health Court graduates are less likely to be charged with or convicted of a new offense and less likely to spend time in jail than those from a comparison group of similarly situated individuals.[39] A growing body of research evaluating mental health court outcomes has also found that mental health courts generally result in reduced recidivism rates for participants.[40]

INTERCEPT 3 IN PRACTICE: STATE AND LOCAL COOPERATION

The Utah Department of Corrections has implemented the Inmate Placement Program in coordination with 26 counties that operate jails across the state. By contract agreement, state inmates are housed in local jail facilities to the mutual benefit of both the state and the localities.[41]

One of the benefits to county jails under this arrangement has been the infusion of state funding for programming in the county jails. Traditionally, access to treatment is more robust in prisons than in jails. The average length of stay in prisons is longer and start-up and operating costs for programming can be prohibitive for locally run jails. In Utah, the statutory reimbursement rate is higher for jail beds in counties that operate treatment programs for state inmates.[42] In FY 2016, the Utah Legislature designated $508,000 for programming in local jails where state inmates were being held.[43] This state funding stream has helped establish programs that might not otherwise exist in county facilities.

Intercept 4: Reentry

Intercept 4 focuses on policies directed at assisting people who are leaving jail. According to the National Institute of Corrections, jails in the United States process approximately 12 million releases per year.[44] Helping these individuals successfully transition from an incarceration setting to the community can have a significant positive effect on public safety and poses an opportunity to reduce recidivism.

The relatively short length of stay for individuals in local jails and the lack of resources can make implementing robust reentry programming difficult. The vast majority of jail inmates remain incarcerated for less than a month,[45] so the time frame for treatment during incarceration is very brief. This can make the transition and connections to community resources vital, specifically if services, treatment or medication were interrupted by the jail stay.

Because the opportunity for intervention can be so brief, it is important to coordinate available community- and jail-based resources and consider interventions along the jail-to-community continuum. This starts with interventions and screening at intake developed under Intercept 3. Tying jail-based programming to reentry interventions under Intercept 4 will ensure continuity of treatment and services.

Continuity of care can be improved if a jail uses an approach known as "community in-reach," a practice allowing community-based organizations to work within the jail.[46] Community in-reach can facilitate a smoother transition, and help to bolster services that might not otherwise be available to jailed inmates. In-reach services can assist with a number of key reentry challenges, including housing, employment, behavioral or mental health treatment, physical health care and government benefits.

Community in-reach can also help prepare an individual for those critical first hours and days after release, a time when inmates are at a particularly high risk for drug relapse, homelessness, missing doses of medication or other problems that can lead to recidivism.[47] Most people leaving jail are not subject to continued supervision, like inmates leaving prison might be, so strong case-management services and setting up initial contacts and appointments can be crucial to making a more successful transition.

A study of The Jail Inreach Project in Harris County, Texas, found that "directly linking," or physically escorting inmates to initial appointments the morning after they are eligible for release was more successful than allowing inmates to "self-release." That is the standard procedure, where inmates are released in the middle of the night without any additional assistance in contacting service providers.[48] Inmates who elected to self-release were six times less likely to be successfully connected to services.[49] Ensuring connection to services is crucial. Initial data from the program indicates that successful linkage to treatment has so far appeared to reduce the likelihood of rearrest.

INTERCEPT 3 AND 4 OVERLAP: USING STATE FUNDING

The Colorado legislature sought to assist county sheriffs with providing screening, assessment and treatment for individuals with substance use and mental health disorders when they created and funded the Jail Based Behavioral Health Services Program in 2010.[50] In addition to funding jail-based interventions, the program also has a significant reentry component that creates partnerships for continuity of care in the community for individuals who need services upon their release. Most counties in Colorado now operate a program that has, at a minimum, a clinician to offer screenings, assessment and treatment in jail, and a case manager dedicated to transitional care and seamless continuation of treatment services in the community.[51]

The Colorado legislature continued its jail reentry work in 2017, when it enacted Senate Bill 21. The law establishes a program to provide housing vouchers and supportive services to persons with behavioral or mental health disorders who are being released from jails or other correctional settings.

INTERCEPT 4 IN PRACTICE: USING PUBLIC BENEFITS

A recent report from the National Association of Counties highlighted work being done in Cook County, Illinois.[52] The county established a Medicaid enrollment process through a partnership with local entities and hospitals. Under the partnership, staff are available seven days a week at the jail intake area, where they screen people for Medicaid eligibility as they wait for results from health and mental health assessments. Staff enroll these individuals into Medicaid if they are eligible.

Additionally, the county is now providing prerelease services in its "discharge lounge" for those with serious mental illness. These services include providing individuals with resources for housing, doctors' appointments, continuation of medication and more.

Intercept 5: Community Corrections

Intercept 5 focuses on intervention policies for those on community supervision, which primarily involves individuals on probation.[53] The most recent numbers from the Bureau of Justice Statistics estimate that nearly 3.66 million people were on probation at the end of 2016.[54]

Similar to people in jail, those on probation also disproportionately suffer from mental illness.[55] Well-tailored community supervision provides an opportunity to link offenders to appropriate services, but it can also be difficult for those with mental health issues to comply with rules under a system that is not designed to meet their mental health needs.[56]

Probationers with mental illness face a unique set of challenges with supervision that are directly related to their conditions; however, they also struggle more than others with meeting basic needs. They are more likely to face socioeconomic challenges—such as homelessness, unemployment and reliance on public assistance—that make supervision compliance difficult.[57] Thirty percent of local jail detainees with mental illness are homeless in the year prior to their arrest, compared with only 17 percent of individuals without mental illness.[58] Additionally, 44 percent of probationers with mental illness are unemployed compared with 24 percent of those without mental illness.[59] Because of these and other challenges, offenders with a mental illness are twice as likely to have their probation revoked.[60]

State support for programs that help individuals overcome these challenges can be key to preventing rearrest and further contact with the criminal justice system.

INTERCEPT 4 AND 5 OVERLAP: HOUSING FIRST

Housing First is a program that connects individuals to stable housing. Housing First is differentiated from other housing programs because it does not require sobriety and people are not eliminated based on a criminal record or poor credit history—common barriers for justice-involved individuals. Housing First prioritizes establishing a stable environment and then focuses on placing participants with voluntary treatment and other service programs.

In 2013, the Hawaii legislature enacted Senate Bill 515, appropriating funds to the human services department for Housing First programs.[61] Implementation in Honolulu has been studied by the University of Hawaii. Two years in, the study found that individuals in the program are 55 percent less likely to be arrested after one year and 61 percent less likely to be arrested after two years.[62] Researchers also found a 21 percent improvement in general health and participants were 64 percent less likely to be admitted to the hospital.[63]

INTERCEPT 5 IN PRACTICE: HOLISTICALLY TREATING CO-OCCURRING DISORDERS

The number of people with co-occurring mental and substance use disorders involved in the justice system is significant. People with mental disorders are more likely than those without a mental disorder to also have an alcohol or substance use disorder.[64] One way states are trying to address the needs of this population is by expanding the use of medication-assisted treatment (MAT) for those with opioid disorders.[65] MAT has been defined by legislatures as the use of medications and drug screening, in combination with evidence-based counseling and behavioral therapy, to provide a holistic approach to treating substance use disorders.[66] MAT has been shown to have positive outcomes, including improved patient survival rates, increased retention in treatment, decreased illicit opioid use and other criminal activity, increased ability to gain and maintain employment, and improved birth outcomes for pregnant women with substance use disorders.[67]

In 2015, the Indiana legislature moved to incorporate MAT as an option throughout the state's justice system, including for individuals being supervised in the community. Senate Bill 464 authorized community corrections programs to coordinate or operate drug and alcohol abuse counseling programs, including programs that use MAT. The new law also required the corrections commissioner to prioritize community corrections and court-supervised recidivism reduction grants for programs that provide alternative sentencing options for persons with mental illness, addictive disorders, and intellectual and developmental disabilities. Programs for addictive disorders were authorized to include MAT. Courts with probation jurisdiction that seek state financial assistance are now required to consult with the corrections department and the division of mental health and addiction to more effectively address the need for substance abuse treatment, including MAT. Medication-assisted treatment was also authorized to be ordered as a condition of probation.[68]

To further ensure implementation of MAT, the legislature enacted House Bill 1304, which required training for judges, prosecutors and public defenders on the availability of probation programs for offenders with addictive disorders, including information on MAT.[69]

Conclusion

State lawmakers have an opportunity to make informed policy and budget choices that can help improve outcomes for people with behavioral health needs while maintaining public safety. Recent actions in state legislatures reflect growing bipartisan cooperation to divert and treat individuals with mental illness who are under correctional control or are at risk of coming into contact with the justice system. Moving forward there is an opportunity for lawmakers to reduce use of jails to house the mentally ill, while also creating a more fair and just criminal justice system.

Notes

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