

The Mentally Ill and the Criminal Justice System: A Review of Programs

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Introduction

Scope of Study

Approaches to dealing more effectively with mental illness in the community are being adopted by city and county authorities at a rapidly increasing rate. Innovative approaches such as mental health courts, crisis intervention teams, and assertive community treatment programs are being employed to more effectively handle problems associated with mentally ill people who are homeless, frequently hospitalized, or having frequent mental illness related troubles with police and courts.

Changes are now being made to deal with the unforeseen consequences that resulted from the deinstitutionalization movement that virtually emptied state hospitals. Concurrent with this movement were changes in civil commitment laws in the 1960s and 1970s that made involuntary commitment of severely mentally ill people difficult prior to their committing some act of violence (Torrey 1988).

One issue that has emerged is concern for people in the community with serious mental illness who are receiving little or no care. It has been estimated that 200,000 of the nation's homeless population have a serious mental illness, and some 800,000 mentally ill people are being supervised by justice systems in jail or prison, on probation, or on parole. Some 50% of these groups are said to be dually diagnosed, i.e., being both mentally ill and substance abusers. The dually diagnosed individuals are part of a population of 500,000 to 1,000,000 mentally ill persons that are referred to as "treatment resistant" or "difficult-to-treat" and who will, at any given time, be homeless, in psychiatric hospitals, receiving limited community treatment, or being supervised in some capacity within the criminal justice system. (Flory/Friedrich 1996; Treatment Advocacy Center Undated) These individuals are not receiving effective care for their illness either because they refuse to accept treatment, are unable to access treatment, or cannot comply with the requirements of a treatment program.

There has been little consideration for the difficult-to-treat population as a social problem per se. The role of mental illness in homelessness and in the justice system has been widely studied, and the reasons that individuals become part of the difficult-to-treat population are well documented. But it does not appear that this group has been viewed as a social problem worthy of better definition and strategic, remedial action.

A second issue of concern involves our limited experience with some of the approaches being introduced. A large part of the rapid introduction of new protocols for dealing with mental illness in the community is related directly or indirectly to justice system considerations. Concern over problems in the use of traditional criminal justice protocols for dealing with mentally ill offenders has a long history (Torrey 1999a; Lamb 1998). A number of modifications to traditional approaches have been made over the years to handle mentally ill offenders more effectively. It is only recently, however, that programs to employ new approaches have begun to proliferate nationally. This movement is now being driven by widespread acceptance of the need

to act, and by growing recognition of the availability of better approaches. At present it appears that expansion is exceeding our ability to answer important questions regarding the impact of process variables or the identification models that will be most effective in different locations or with different client populations. Given the rapid adoption of new approaches to helping mentally ill individuals in the community, and the general scarcity of information on their applicability and effectiveness, especially as it applies to difficult-to-treat people, any overall discussion of methods should include special attention to these factors.

Objective

The objective of the present study was to develop an overview of system modifications that have emerged to deal with mentally ill people in the community. The processes examined were mostly those that divert mentally ill offenders into treatment rather than incarceration in jails and prisons. Attention was also given to approaches such as homeless “outreach” and “linkage” for individuals coming out of jails and prisons. The location of cost and outcome information, and experience that will provide insight on the efficiency of individual processes in dealing with the difficult-to-treat were given special attention.

Approach

The present study considered information for six categories of activity that appear to have application, directly or indirectly, to amelioration of problems associated with mentally ill people in the community. These are:

- PACT/ACT Teams
- Outreach Programs
- Crisis Intervention
- Post-Arrest Programs (except Mental Health Courts)
- Mental Health Courts
- Post Incarceration Support (Linkage)

These programs may be employed individually or in combination to engage mentally ill persons in treatment.

For each of these categories information was gathered from the literature and through personal and telephone contacts with management and operational personnel. The background information was used to frame an overview discussion that addresses the following:

- A brief description of the process and comment on the history of deployment
- Comment on results that have been obtained and the impact on the difficult-to-treat population
- Information on costs and evidence of cost-effectiveness
- Sources of further information for the reader.

The goal was to present a report that provides a reasonably complete picture without undue attention to details that can be obtained from referenced sources.

We acknowledged at the start that the quantitative information on the program outcomes would be scarce or incomplete. Also, it was anticipated that when data on program cost are available they may lack specifics that permit analysis of cost-effectiveness or program comparisons. For this report any information that is available for the study, and thought to be representative of that which is currently available, is presented if it has the potential to contribute to the analysis and discussion.

Assertive Community Treatment (ACT)

Background

ACT is a well-established model for delivery of community-based treatment to the most difficult-to-treat mentally ill individuals. It can be employed with a variety of diversion techniques that are being used to introduce clients to treatment. The concepts embodied in the ACT model were first employed in the Program for Assertive Community Treatment (PACT) model based on research carried out at Mendota State Hospital in Madison, Wisconsin in the late 1960's. This model, including its history of success and current status, is presented in a well-documented report "The PACT Model: A Manual for Start-Up" (Allness 1998). This report was published by NAMI's national office and is a primary reference for the material that follows. For this study it should be noted that the terms ACT and PACT are considered interchangeable except PACT refers to the Madison (WI) work, and ACT is generic and encompasses similar projects that employ the same principles that define PACT.

PACT Team Characteristics

The PACT model is defined by Allness as:

"a multidisciplinary mental health staff organized as an accountable, mobile mental health agency or group of treaters who function interchangeably to provide the treatment, rehabilitation, and support services that persons with severe mental illness need to live successfully in the community."

Unique characteristics identified by the authors are as follows.

- The PACT team is the primary provider of services involving treatment and rehabilitation and responds directly to clients and family, giving them a fixed point of responsibility for communication.
- The PACT team makes most of its client contacts in the community using a mobile, out-of-office approach that minimizes dropout of clients.
- Individualized treatment, based on knowledge of the client and his or her family, is provided to meet the immediate needs of each individual.
- The PACT team takes the initiative and assumes the responsibility for "whatever needs to be done to assist" a client's meeting individual goals.
- Continuous, long-term services are provided. Treatment and rehabilitation are provided in a coordinated approach that recognizes the changes over time in a client's symptoms.

The PACT team differs from many, if not most, community treatment programs in its ability to treat and manage people that make up the difficult-to-treat population of mentally ill individuals. The model provides outreach, individualized and continuous long-term services that are needed for treatment and rehabilitation at all stages of their clients' illness. The PACT teams respond when needed 24 hours a day, seven days a week.

A minimum staff size of 10 to 12 full-time professionals serve a maximum of 120 clients in an urban setting. For a rural team five to seven full time professionals serving a maximum of 80 clients is suggested. For established teams, a ratio of one staff member to 10 clients is maintained. The professional staff is supported by a psychiatrist and a program assistant whose time requirement is dictated by the number of clients in the program.

Adoption and Application of PACT Concepts

Since introduction of PACT in 1972, the model has been adopted, and applied nationwide. A 1995 survey of state mental health programs identified 340 ACT teams “distributed quite unevenly across 33 states” (Deci 1995). Michigan had 86, Wisconsin had 67, and the other 31 states had 1 to 14 each. By 1998 PACT or ACT programs were being implemented statewide in 15 states. Three states (Wisconsin, Delaware, Rhode Island) are cited as being “successful in linking providers’ development of sound PACT model programs with attractive financing mechanisms.” These states all provide for three critical elements in their program - structure, incentives, and accountability (Allness 1998).

- Structure has been introduced by the development of standards requiring adherence to the PACT approach and specified defining criteria for eligibility to assure that people most in need enter the program.
- Incentives in the form of funding for the ACT teams are provided to promote more effective management of difficult-to-treat individuals - revenue is said to come from reprogramming of existing funds and “innovative Medicaid financing.”
- Accountability is provided by requiring certification of teams to assure that state standards are met to qualify for special funding.

The emphasis placed on accountability is attributed in part to increased expectations on the part of concerned parties including families, mental health authorities and managed care organizations.

The intensity of treatment provided by a PACT model team is such that it is practical for the most severe and persistent illness. Possible applications cited by Allness and Knoedler (1998) are:

- Special populations including seniors, the homeless, clients that are dually diagnosed, long-term hospital residents and jail prisoners.
- Involuntary outpatient treatment pursuant to civil or criminal court proceedings.
- Intervention in the early stages of serious mental illness when it is most amenable to treatment.
- Treatment of rural clients, with varying levels of severity of illness, according to their needs.

Providing the capability to deal with difficult-to-treat clients in such diverse and problematic situations is expensive but, as discussed below, cost-effective.

Effectiveness/Cost-Effectiveness of ACT

Effectiveness

In the introduction to a special section of Psychiatric Services dealing with ACT (Drake 1995), assertive community treatment was said to be “perhaps the best studied of all models in community psychiatry.” Bond et al. (2001), in a review of ACT studies prior to 2001 referred to ACT as “the most extensively researched of all case management models” and cited eight review articles all of which conclude that “ACT increases the community integration of people with serious mental illness.”

Part of the Bond et al. review involved the analysis of the results from 25 evaluations of ACT effectiveness. The results are displayed in Table 1.

Table 1 - Significant Outcomes for Assertive Community Treatment in 25 Randomized Controlled Trials

Parameter	Effectiveness of ACT compared with control conditions		
	Number of trials (%)		
	Better	no different	worse
Psychiatric hospital use	17 (74%)	6 (26%)	0
Housing stability	8 (67%)	3 (25%)	1 (8%)
Symptoms	7 (44%)	9 (56%)	0
Quality of life	7 (58%)	5 (42%)	0
Social adjustment	3 (23%)	10 (77%)	0
Jail/arrests	2 (20%)	7 (70%)	1 (10%)
Substance use	2 (33%)	4 (67%)	0
Medication compliance	2 (50%)	2 (50%)	0
Vocational functioning	3 (37%)	5 (63%)	0
Patient satisfaction with services	7 (88%)	1 (12%)	0
Family members' satisfaction with services	2 (67%)	1 (33%)	0

Reproduced from (Bond et al. 2001) with permission from the publisher Wolters Kluwer Health, Pharma Solutions Div, Adis International.

Twenty-two of the evaluations were the subject of an earlier review (Mueser 1998). Bond et al. (2001) has integrated the results from that study with data from three additional studies to prepare Table 1. He refers the reader to the original paper for further details including a more complete discussion of the outcome domains and references to the original studies.

The data in Table 1 are considered sufficiently self-explanatory for present purposes.

The author points out,

“In agreement with most other reviews, we conclude that ACT substantially reduces

psychiatric hospital use, increases housing stability and moderately improves symptoms and subjective quality of life, but has little impact on social functioning.”

Attention is also called to the high level of patient satisfaction and the dearth of negative outcomes as significant ACT positives.

Lamberti (2004) calls attention to the fact that the data in Table 1 also indicate that even though the ACT teams studied have demonstrated no positive effect on rates of arrest or time spent in jail, the model can be effective in such applications. The Lamberti report acknowledges the overall effectiveness of ACT and goes on to point out that ACT used in conjunction with criminal justice agencies can be quite effective in reducing the involvement of mentally ill persons with the justice system.

The Lamberti study used a survey of members of the National Association of County Behavioral Health Directors to identify ACT programs with three common characteristics.

- all enrollees have a history of involvement with the criminal justice system
- a criminal justice agency was the primary source of referrals
- a close partnership existed with a criminal justice agency to perform jail diversion

The survey was sent to 314 members; 291 responded and 16 ACT programs meeting the project criteria were identified.

Apart from the three common characteristics, the 16 ACT teams showed other interesting characteristics: thirteen of sixteen would consider offenders who had committed recent violent crimes for admission, only five were started before 1999, project client capacity ranged from 25 to 108 (one project indicated no limit).

Only three of the 16 programs have published outcome data. Two of the three, Project Link and the Thresholds Jail Project, are discussed in the Post-Arrest Diversion section of this report.

Lamberti et al, point out that the difference in Forensic Assertive Community Treatment (FACT) programs and standard ACT programs “lies in the extent to which the goals of preventing arrest and incarceration determine program structure and function.” They go on to suggest that “this blend has created a foundation for new interventions that offer enhanced community treatment as an alternative to involvement with the criminal justice system.”

Cost-Effectiveness

Measuring cost-effectiveness requires data for the program cost and estimates for the value of benefits that are realized, e.g., avoided costs associated with reduction in the required hospital time or reduction in time spent in jail for ACT clients. Bond et al. (2001) points out that the only documented benefit in the form of avoided cost for people receiving ACT care are reductions in hospital care cost after ACT care is begun. However, he indicates that the cost of intensive care provided by ACT is more than offset by avoided hospital care in most reported studies.

An example of cost savings realized through the use of PACT teams is illustrated by the experience of the Oklahoma Department of Mental Health and Substance Abuse Services. (ODMHSAS) (May 2004). PACT teams were established by ODMHSAS in Oklahoma City and Tulsa in May 2001 with \$2 million provided by the state legislature. Early results indicated these teams were successful in keeping difficult-to-treat, mentally ill individuals from being homeless or from being shuffled in and out of hospitals and jails. This led to the formation of teams in Norman, Lawton, Tahlequah and McAlester. The number of clients in treatment increased from 18 in 2001 to 318 in 2003.

A study of 130 clients admitted in 2003 attempted to quantify the impact of PACT treatment on time spent by the clients in jail or a psychiatric hospital. The number of days in jail or a psychiatric hospital in the year prior to admission was compared to confinements recorded for the year after admission. This showed:

- A reduction of days spent in the hospital from 6,695 days to 1,447 days. Seventy-two of the 130 clients had no hospitalization in the year subsequent to admission.
- A reduction of days spent in jail from 1,008 days to 473 days.

A reduction of hospital confinements (5,248 days) at a cost of \$400 per day for acute inpatient hospitalization alone amounts to \$2,099,200 in avoided cost. (May 2004)

The above estimate involved the use of averaged data for some clients that had less than 12 months in the program. This is believed, however, to be a reasonable estimate that will be confirmed by future data.

ACT and the Difficult-to-Treat Population

No recent estimates for the number of ACT teams currently deployed in the U.S. were identified. As noted earlier, some states have actively encouraged the use of ACT teams, but other states such as Ohio have been slow to adopt the concept. In Ohio it appears that about 40 ACT-type teams are in operation (Thom 2005). Many do not meet the criteria to qualify as true ACT models, but if this estimate is correct and the recommended maximum number of persons are being treated, only 4000 individuals would be receiving ACT treatment.

In an effort to promote greater deployment of ACT methodology in the State the Ohio, the Ohio Department of Mental Health and the Greater Cincinnati Health Foundation have funded establishment of the ACT Center of Ohio. The three initial tasks for the newly formed Center are:

- To assist the state's ACT workgroup as it finishes developing state ACT standards and processes, which will then be used by organizations to assess and improve the quality of their programs.
- To promote ACT throughout the state of Ohio, including introducing stakeholders to the ACT model, training providers in ACT, and consulting with established and developing ACT teams.

- To coordinate and monitor the evaluation of ACT teams around the state.
At present Ohio is said to have 80,000 mentally ill persons receiving treatment for their illness. The ACT Center is estimating 10% would need ACT treatment and has 40 new teams as an initial goal (Thom 2005). This seems conservative in that it does not consider mentally ill people that are not currently being treated; also estimates for the percent of the mentally ill population that need ACT-type treatment made by others run as high as 20% or more (NAMI 2004a).

The reasons for what appears to be underutilization of a proven, cost-effective methodology for treating the difficult-to-treat population are speculated to be:

- Difficulty in getting Medicaid reimbursement for team-delivered treatment
- Inertia associated with the status quo inhibits implementation.

Hopefully the demand for ACT treatment generated by the developing programs aimed at diversion of mentally ill people from jails, and work to provide housing for mentally ill homeless people will accelerate action to supply treatment that is known to be effective.

Outreach

Background

Outreach projects considered here are those that employ teams of mental health professionals working to help homeless, mentally ill people who are not in crisis meet their basic needs and provide services that will equip them to function at their highest attainable level as an integrated member of the community. The targeted group is difficult to quantify; one estimate is 127,000 to 159,000, i.e. 20% to 25% of the 637,000 adults estimated to be homeless in the United States (PATH 2002). Others estimate the mentally ill individuals to be one-third of the homeless population (NAMI 2004b).

The programs investigated vary in design and scope. Funding may be private or governmental, but most are supported at least in part by either of two grant programs, one state and one federal. The federal activity involves a program of grants to states managed by the Center for Mental Health Services which is part of the Substance Abuse and Mental Health Services Administration (SAMHSA). It was authorized by Congress in 1990 and began operation in 1991 and is known as Projects for Assistance in Transition from Homelessness (PATH). The state initiative (referred to as the “AB2034 program”) was begun in California in 1999, and is intended to provide services to an estimated 50,000 mentally ill people that are homeless in California. The program is administered by the California Department of Mental Health.

California’s AB2034 Program

California’s “AB2034 Program” refers to the assembly bill that increased the funding supplied by prior legislation for outreach projects to allow for initiation of statewide activity. Early work on a three-county pilot program was expanded to the 35 county and city programs currently in operation. Expenditures prior to AB2034 funding for the 2003-2004 fiscal year, including the pilot work in 1999, totaled \$185 million. For 2003-2004 the program was funded at the “base funding level” of \$55 million. The services provided are stated in the annual report to the legislature as follows (AB2034 2004):

State funding for these programs enables staff to directly or indirectly provide a comprehensive array of services including outreach, supportive housing and other housing assistance, employment, substance abuse, and mental and physical healthcare including medications. For years the perception has been that, due to economic constraints, traditional mental health programs have been forced to focus on delivering only those services eligible for Medicaid reimbursement. While these medical services are appropriate and necessary, they do not include the vast array of support services necessary to help someone obtain and sustain housing and employment. The flexibility of the funding provided under AB2034 has made it possible for these programs to provide and subsidize housing and deliver the comprehensive services necessary to support individuals living and working in the community. Another goal is to help an individual access treatment and begin recovery, this is not a requirement of the program and could deter a person’s willingness to accept services if initially emphasized.

The California program is unique in several ways. First it gives high priority to meeting the client's basic needs; appropriate housing and employment assistance are given highest priority. Treatment for mental illness is a goal, but housing and employment are said to support treatment not the reverse. A commitment to treatment is not a requisite for enrollment in the program, and an effort is made to keep any concern by potential clients regarding treatment from becoming a barrier to participation in the program. Second, AB2034 provides for flexibility in the use of funds combined with accountability for results using a structured data management protocol for program evaluation. The use of AB2034 funds to establish an integrated accountable program in cooperation with projects of others is illustrated by current operations in San Diego County.

The City of San Diego has approximately 2,500 homeless people living in their downtown area. Of these, more than 800 are mentally ill and approximately 50% (400) have a dual diagnosis including substance abuse. Both the county and the city have developed projects that aim to provide for basic needs, including outreach shelters and housing, but lacked the resources and coordination needed to effectively help the most difficult-to-treat get off the street and into programs that improve the quality of their lives.

The AB2034 integrated service program in San Diego is funded by a grant to the San Diego County Health and Human Services Agency. Services are delivered by three provider organizations under contract to manage the Integrated Services Program (ISP). These contractors are:

- Telecare Corp, San Diego REACH
- Community Research Foundation
- Episcopal Community Services

The three groups cooperate to support two "ACT type" teams comprised of a psychiatrist, a nurse, 14 case managers, five rehabilitation specialists and two employment/vocational specialists. The teams provide any service needs of the client at anytime and anyplace.

The categories of service supplied by the ISP and cooperating local agencies that the case managers will work with are shown below:

- Outreach and Engagements - The ISP team works with the City of San Diego Homeless Outreach Team, the County Homeless Outreach Team, the Psychiatric Emergency Response Team, a Homeless Court (established to divert homeless people from the justice system to treatment) and the Sheriff's linkage program for discharged mentally ill offenders.
- Case-Management - A case manager supplied by San Diego REACH works with each client and is solely responsible for coordinating contacts necessary to obtain all needed services.
- Bio-psychosocial Rehabilitation Service - A multi-disciplinary team (clinicians, substance abuse specialists, and rehabilitation specialists) supplied by the Community Research Foundation provides substance abuse and vocational services.
- Physical Health - Case managers work with the Family Health Center/Downtown Health Center, and the San Diego Psychiatric Hospital.
- Resource and Drop-in Services - Episcopal Community Services, Catholic Charities, Rachels' Women Center have expanded service to support the ISP.
- Housing Program - Shelter options, including emergency, transition, and permanent housing

support are provided by Episcopal Community Services, City Center Development Corp. and the San Diego Housing Commission.

As of this writing 253 clients are enrolled in ISP and are eligible to receive these services. The AB2034 funding for fiscal year 2002-2003 was \$3,581,000. Matching funds came to about \$1,000,000 to \$1,250,000 (mostly for housing) making the total support for 253 clients an estimated \$4,800,000 or \$19,000 per client (Hubbard 2004). Information on avoided costs attributable to these expenditures was sent to the state for incorporation in summary data presented in the Effectiveness/Cost-Effectiveness section that follows.

Federal PATH Program

The federal PATH program funds grant awards to 50 states, Washington, DC and four territories. Since the inception of PATH in 1990 the annual funding has varied from \$20 million to \$36 million a year; total federal funding for the first 12 years came to \$341 million exclusive of matching funds. Federal funding of \$36 million in fiscal year 2002, with matching funds of \$25 million from the states, made \$61 million available to fund 419 projects that reported 54,000 PATH enrollees. The work is performed by approximately 400 provider organizations that use \$61 million in federal and state money as part of the over \$240 million they spend on all services for homeless people with serious mental illness (Hutner 2004).

The outreach activity for fiscal year 2001 involved contacts made with just under 109,000 people and enrolling of just over 46,000 (about 42%). An estimated 57% are reported to be dually diagnosed.

The services supplied to clients vary with provider but most supply services for:

- Outreach
- Screening and diagnostic treatment
- Rehabilitation
- Community mental health
- Alcohol and drug abuse
- Care management
- Support in residential settings
- Housing and employment

Estimates for expenditures by category are not reported.

PATH funding records for state grants show that for fiscal year 2002, Ohio received federal funding of \$1,424,000 and with state matching funds of \$475,000 had \$1,899,000 for support of 12 projects that included Hamilton County discussed below.

The Hamilton County PATH program has a staff of four full-time and one part-time outreach worker. They work as a team; the process involves making contacts, enrollment of clients, and working to find suitable housing and engage them in treatment for their mental illness and substance abuse problems. Their efforts are concentrated on the “chronic homeless,” i.e., individuals that have been homeless for a year or more or have frequent episodes of

homelessness. Over 52% of their clients have substance abuse problems in addition to mental illness. The team works closely with police efforts to clear the streets of homeless people. Also the PATH team has been instrumental in forming the Homeless Outreach Group that brings together the police and providers for monthly meetings to coordinate outreach work.

For the three years the PATH team has been in operation it has made about 400 new contacts per year and has enrolled an average of 203 clients per year. A total of 61% of those enrolled have been placed in some sort of housing and 55% have connected successfully to mental health services.

At any given time there is a pool of individuals that have been contacted one or more times but have not as yet decided to enroll. Also there are a number of clients that have been “closed” as enrolled clients. The reasons for closing are shown below with data for fiscal year 2002 to give perspective on the distribution across categories for 144 closures.

- Successful transfers to needed services – 84
- Dropped from program – ineligible (6), deceased (2), institutionalized (6) – 14
- Lost contact – left town (6), missing (25) – 31
- Other – mostly individuals that were reconnected to mental health treatment – 15

At present data for tracking of outcomes are limited to the keeping of records to show results for efforts to connect with individuals and getting them into housing and treatment. The closure data reflects the ratio of clients placed in treatment for their illness to clients who drop out. The 2002 results show a 58% success rate for the clients in staying connected. In 2005 new state requirements for keeping more extensive data on outcomes are being implemented.

The Hamilton County PATH program funding for 2002 through 2004 was \$600,000. This expenditure resulted in: (Pieples 2005)

- 609 enrollments
- 371 clients placed in housing
- 335 clients engaged in treatment

The distribution of services among clients is not given. The cost per client receiving either housing or treatment or both would be \$1,671 assuming that all 335 clients getting treatment are also placed in housing and 36 are placed in housing but not engaged in treatment.

Other Community Outreach Activities

Information on community programs not covered by the federal PATH program or California's AB2034 program is limited. NAMI's earlier report (NAMI/Ohio 2001) provides information on Portland's (OR) Project Response and San Diego's (CA) Friend-to-Friend Clubhouse.

A project thought to be a unique approach in helping homeless mentally ill people was begun in St. Petersburg (FL) in 1998 with the establishment of Benedict Haven. The project was undertaken "to provide high quality, long-term care for adults with severe and persistent mental illness" (Castaldo 2005). A residential unit built in a middle-class neighborhood is a permanent home for seven clients, each of whom has a private room and a bathroom shared with one other client. Staff supervision is provided 24 hours per day. Services include an extensive day treatment program and the descriptive literature from the facility lists the following additional services:

- Medication monitoring
- Case management
- Assistance with entitlements
- ADL (Activities of Daily Living) Skills Training
- Budgeting Skills
- Community Meetings
- Transportation

Benedict Haven's expense report for 2003 and budget for 2004 shows their annual operating expense to be \$34,000 to \$36,000 per year per client.

In its five years of operation Benedict Haven has had 10 tenants. All were too ill to care for themselves in unstructured conditions without close supervision. In addition to the seven current residents, three were admitted and have subsequently been terminated, one died of natural causes, one left to live with family and one could not adjust to the Benedict Haven routine.

Effectiveness/Cost-Effectiveness

California's AB2034 Program

As of January 31, 2003, 4,881 of California's estimated 50,000 homeless people with serious mental illness were being served by the 35 city and county programs supported by AB2034. Information on the enrolled population of 4,881 shows that 4,071 are in housing, and, as a group, they spent fewer days hospitalized, incarcerated, or homeless and more time employed, after enrollment in the program than in the 12 months prior to enrollment. These data are shown in Table 2.

Table 2. Jail, Hospital, and Employment Data for 4,881 AB2034 Clients

	12 Months to Prior Enrollment	Since Enrollment (Annualized to Represent 12 Months)	Percent Increase/Decrease
Number of Days Hospitalized	37,938	16,778	-55.8%
Number of Days Incarcerated	213,106	59,434	-72.1%
Number of Days Homeless	938,709	321,667	-67.3%
Number of Days Employed (Full-Time)	36,971	61,157	+65.4%
Number of Days Employed (Part-Time)	79,758	122,083	+53.1%

The data from Table 2 purportedly show avoided cost for jail time and hospital stays that generate an offset of \$24.7 million for the annual cost of \$55 million for the 35 programs. An additional cost avoidance of \$2.7 million is said to result from reduced use of emergency rooms for psychiatric episodes. Additional cost avoidance associated with reductions in homelessness, and reductions in judicial system involvement (police and court personnel) are being investigated as part of the continuing assessment of cost-effectiveness of the program.

Federal PATH Program

For the PATH program in 2002, grantee organizations reported that they enrolled 54,000 clients. The amount awarded was \$61 million (PATH funding plus state matching funds) which was part of an estimated \$240 million spent by the grantees on the target population using funds from all sources. This comes to just over \$4,400 per year per enrolled client. At this time data to measure clients’ progress or judge effectiveness of the federally funded programs, e.g., the dropout rate for enrollees, the number of “graduates” from the program, and changes in level of need for psychiatric care are not available. Planning for evaluation is now underway, but results are not expected for several years.

Other Community Outreach Activities

For Benedict Haven, the only program in this category for which cost data have been acquired, no information on client history is available for jail incarcerations, hospital confinements, etc., hence no client-specific, before-and-after comparisons can be made to show cost avoided by entering the Benedict Haven program. A comparison is, however, made with the local cost for jail confinement (\$40,000/yr), confinement in the state hospital (\$105,000/yr) or simply remaining homeless (\$40,000/yr). (Castaldo 2004). This illustrates that \$36,000/yr for living at Benedict Haven is not only more humane it is more economical when compared to alternatives.

Outreach and the Difficult-to-Treat Population

The outreach programs target an estimated 150,000 to 200,000 mentally ill homeless people representing a large segment of the difficult-to-treat population. Benedict Haven and San Diego's Integrated Service Program provide evidence to show that a wide variety of outreach projects can be effective in providing comprehensive care for this underserved group.

Crisis Intervention

Background

Since the number of mentally ill people in the community began increasing in the 1960s and 1970s, the need to deal with emergency situations arising from public displays of unacceptable behavior attributed to mental illness has become widely accepted as necessary. Communities have tried different approaches to handling mentally ill individuals in crisis, but most involve cooperative projects in which the police and mental health professionals work together. The primary goal is to handle such episodes without injury to the parties and to place the mentally ill offender in treatment for their illness rather than in jail.

The approaches that have been used for crisis intervention are generally in one of three categories: those that use specially trained police officers to manage crisis intervention situations; those that use mental health professionals to assist the police with mental health emergencies; and those that use mental health professionals to respond and call on police as needed. These have been discussed in several publications that provide considerable background on crisis intervention in general. (Borum 1998; Deane 1999; Reuland 2004). These reports refer to three crisis intervention approaches:

- Police-based, specialized police response model (Crisis Intervention Team or CIT)
- Police-based, specialized mental health response model (Co-Responding Police and Mental Health Professionals)
- Specialized mental health response model (Mobile Crisis Unit)

All three models have been applied widely. A 1996 survey of 194 cities with populations greater than 100,000 resulted in 174 responses that indicated only 78 (45%) employed any of the three models. The 78 responses with special programs included 6 using CIT, 20 with co-responding teams, and 52 with mobile crisis units (Deane 1999). The survey results appear to represent the national picture in 1996 but not current practice. For example, CIT was reported to be employed by only six departments. The Memphis model included in this category is now said to be used by well over 100 departments across the U.S. (Cochran 2004).

CIT

The Memphis model has the longest, best-documented history of CIT application and is thought to illustrate what a well-designed, specialized police response model can accomplish. It combines proven training methods developed by the University of Tennessee's law enforcement training program with demonstrated team management principles that have produced over 15 years of documented success.

The training incorporates several important features including role-playing techniques and verbalization skills, and eight hours of officer interaction with mentally ill individuals. The interaction is said to be one of the most important parts of the training.

The specific management issues of importance include:

- The officers trained for the CIT Program are a select group. All are volunteers who are interviewed and given “skills and traits” testing to assess their ability to communicate, level of interest, and motivation.
- CIT officers are given recognition by the community through awards for service, and the organization has achieved national prominence both of which contribute to esprit de corps valuable incentive factors.
- The CIT officers have regular patrol duties but are dispatched to all crisis incidents when they are nearest to the scene. They thus acquire field experience in crisis management that cannot otherwise be gained.

The training part of the program forms a basis for building the organizational competence that results from the use of special management practices.

The Memphis model as indicated earlier has been adopted in over 100 communities in recent years. The growth has, in the absence of a central monitoring point, been difficult to assess. For example, Akron was the first city in Ohio to adopt the Memphis model, in May of 2000. Success in its application there led NAMI Ohio to establish a statewide program to provide assistance in this model in other cities. As of July 2004 it was operating in 14 Ohio cities and is being actively considered by another 16 (Young 2004).

Co-Responding Police and Mental Health Professionals

A number of major cities have implemented co-response teams. Those identified include the City of Los Angeles System-wide Mental Assessment Response Team (SMART), and the Los Angeles County Mental Evaluation Team (MET), discussed and referenced in our earlier report (NAMI Ohio 2001). Another that began as a pilot program with the San Diego Police Department in 1993 is the Psychiatric Emergency Response Team (PERT) serving San Diego County with nine teams. Each team consists of a law enforcement officer and a licensed clinician that responds to reports of mentally disordered persons needing attention and places the subjects in appropriate treatment (Georgescu 2004).

The use of the co-responding teams of police and mental health professionals has also been reported successful for a smaller community, Framingham (MA), which has a population of around 67,000 with a police force of 120 (Abbott-Carr 2004). The department responded to over 37,000 calls including over 14,000 to calls to 911 in 2003. The number of calls involving mental illness is not available, but a survey of police officers indicated that “Framingham patrol officers had extensive contact with individuals with a mental illness on a regular basis.” Repeat encounters with some of the same individuals were said to be common. Concern over mentally ill offenders in jail led to implementation of the Framingham Jail Diversion Program (JDP). Police work with mental health professionals in pursuing a pre-arrest diversion approach to directing non-violent mentally ill offenders to treatment instead of jail. The mental health professionals are associated with the Psychiatric Emergency Services arm of Advocates Inc; they are on-duty at the police station 40 hours/week and are available on-call 24 hours per day, seven days a week. The assistance provided includes consultation to police on calls involving individuals believed to have mental illness, conducting full psychiatric

examinations, and making referrals to appropriate service agencies.

Mobile Crisis Units (MCUs)

MCUs have a history that goes back to the 1970s but little information on the circumstances driving deployment of the approach is available.

A 1993 survey of mental health agencies in the states and territories of the U.S. (Geller 1995) reported that 51 of 53 respondents had some type of county or state funded “emergency service or crisis evaluation service” and were operating a total of 1,480 sites. The number of sites per respondent varied from one in Washington, D.C. to 143 in California. It is then reported that 37 respondents had mobile capability but does not indicate the number of units per respondents. The report concludes:

“The claims of efficacy made for mobile crisis services, which have led to their widespread dissemination, are based on little or no empirical evidence. More rigorous evaluation of new and existing modes of service delivery is needed.”

The survey of police departments referenced earlier (Deane 1999) indicated that 52 MCUs were identified, but the survey was limited to cities with a population of greater than 100,000 and the authors point out that only programs that rely solely on mobile crisis units have been included in their analysis.

No more recent information has been found to clarify the present status of deployment for mobile crisis units, but the absence of any indication of expanding application suggests it is currently not the most favored approach to crisis intervention.

Effectiveness/Cost-Effectiveness

Memphis CIT

Although crises intervention programs are now being widely applied, data on the effectiveness of different approaches are limited. The Memphis model seems to be the most discussed. One prior report on diversion activities (NAMI Ohio 2001) identified six benefits, shown below, of employing the Memphis CIT.

- Fewer injuries to police are incurred in dealing with offenders with mental illness.
- The arrest rate and incidents requiring the use of force are reduced.
- Fewer incidents involving repeat commitments occur.
- Patient violence and the need to use restraints are minimized.
- Less officer time is diverted from traditional law enforcement duties.
- Time spent in jail by offenders with mental illness is lowered.

Further information in connection with these factors is available from the original report (DuPont 2000).

A subsequent study considered patient outcomes for 609 subjects that were dually diagnosed as mentally ill and substance abusers (DuPont 2003). Participants were divided into two groups. The first included 301 subjects that were diverted from arrest for a misdemeanor offense to treatment for their illness. The second was a comparison group of 308 individuals that were

arrested and allowed to proceed without diversion through normal justice processing.

The study considered a wide range of variables and data on outcomes collected at intervals of three months and 12 months subsequent to entry into the program. Three “key outcomes” based on statistically significant comparisons are identified.

- Diversion clearly increased the connection with community-based treatment when compared to the non-diverted group.
- The Memphis program has an impact beyond that of providing access to community treatment. Diversion appears to have favorable impact on mental illness related symptoms.
- The CIT program had a significant positive impact on re-arrest rates.

Mental health symptoms (as measured by the Colorado Symptom Index) were significantly improved for the diverted group as compared to the non-diverted group. This improvement appeared to be independent of participating in community-based treatment and is considered to be a result of handling in the CIT and the CIT related emergency intake process.

Birmingham, Knoxville and Memphis Compared

Although crisis intervention programs have been widely adopted, very little evaluative data have been published. Two reports (Borum 1998; Steadman 2000) that deal with the three approaches to crisis intervention as applied in Birmingham AL, Knoxville TN and Memphis TN provide some comparative data. Birmingham uses mental health professionals to support police. Knoxville uses a MCU and Memphis is the CIT example.

The Borum study involved inquiry into officers’ perceptions of program effectiveness. A total of 452 officers participated. This included four groups: 189 from Birmingham; 55 from Knoxville; 36 trained officers from the Memphis CIT, and; 171 officers from Memphis that were not members of CIT. Results are shown in Table 3.

Table 3. Police Officer Perceptions of Program Effectiveness by Program Site

% moderate to very effective	Birmingham n = 189	Knoxville n = 55	Memphis non-CIT n = 171	Memphis CIT n = 36
Meeting the needs of people with mental illness	39.7	52.7	70.7	88.8
Keeping people with mental illness out of jail	47.9	41.8	67.2	83.3
Minimizing the amount of time of-ficers spend on these types of calls	20.6	7.3	53.8	72.2
Maintaining commu-nity safety	50.0	51.9	68.4	94.4

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The data in Table 3 show the percentage of officers in each group that felt the method of intervention employed by their department was “moderate to very effective” in meeting the four goals on the left of the table.

Conclusions that might be drawn are largely self-evident. For example, the Memphis police are more confident regarding attainment of all goals. The goal of “minimizing the amount of time officers spend” on calls involving mental illness is the goal fewest officers in every group felt was being attained.

The report calls attention to several study limitations of the data in Table 3. First, the study did not include a department without a specialized intervention group to provide baseline data. Second, the sites were selected to be representative of their class, but the possibility that results are influenced by the infrastructure in which it operated cannot be discounted.

The Steadman study examined the records from the same operations studied by Borum in Birmingham, Knoxville and Memphis. The results are shown in Tables 4 and 5.

Table 4 - Proportion of Mental Disturbance Calls in Specialized Police Responses and Arrests at Three Sites

	Birmingham (N = 100)		Knoxville (N = 100)		Memphis (N = 97)		Total (N = 297)	
Response and arrest	N	%	N	%	N	%	N	%
Specialized response on the scene	28	28	40	40	92	95	160	54
Arrested	13	13	5	5	6	6	24	8

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Table 4 shows the number of responses by specialized personnel to about 100 calls classified by dispatchers as “mental disturbance” calls. The top row compares the responsiveness of the three models. The bottom row indicates the number of arrests resulting from the contacts.

Table 5 - Dispositions of Cases Handled by a Specialized Police Response at Three Sites, in Percentages

Disposition	Birmingham (N = 100)	Knoxville (N = 100)	Memphis (N = 100)	Total (N = 300)
Taken to treatment location	20	42	75	46
Situation resolved on the scene	64	17	23	35
Referred to treatment	3	36	0	13
Arrested	13	5	2	7

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Table 5 shows the results from the analysis of 100 cases in which a specialized response occurred to determine how they were resolved.

Framingham, MA

In the first year of operation the Framingham Jail Diversion Program (JDP) experienced 469 interventions that involved 207 consultations and 262 evaluations. These contacts resulted in only 29 arrests and diversions of 84 people that would otherwise have been arrested to treatment.

The cost of the program is said to be around \$150,000 per year: \$123,000 for personnel, most of the balance for training, the rest for supplies, etc.

The JDP “considers program evaluation an essential tool” and keeps a log for basic information on all calls. In addition, it maintains a data base for recording 112 variables on every incident that results in a complete psychiatric evaluation: 225 cases were entered in the data in the first year of operation. To date information on cost avoided (reduced arrest, reduced jail days, court

costs) has not been generated. It is, however, being documented and the operation is expected to be demonstrably cost effective.

Crisis Intervention and the Difficult-to-Treat

Data are not available to support informed speculation regarding the effectiveness of present crisis intervention activities in coping with problems presented by the difficult-to-treat population. Data that are missing include:

- How many crisis intervention teams are in operation?
- How do they handle difficult-to-treat individuals?
- What are the outcomes for the disposition alternatives shown in Table 5?
- What is the cost of crisis intervention activity?

It appears that some success in reducing the flow of mentally ill going to jail is being attained. We also seem to be generating data needed to show that this activity is introducing or returning difficult-to-treat individuals to treatment providers. And the Memphis study, which shows a reduction in recidivism, suggests that CIT can reach and help repeat offenders with mental illness. The impact of such activity is promising, and as it continues to expand may become an important factor in helping the difficult-to-treat.

Post-Arrest Diversion

Background

The scope of the current problem with mentally ill people in jails is illustrated by a recent report which indicates that of the roughly 11 million people who are booked in U.S. jails annually, about 800,000 have some serious mental illness, and three quarters of these, or about 600,000, have co-occurring substance abuse disorders (GAINS Center 2004). From these data, it is apparent that jail intake is an important contact point for initiating activities designed to improve treatment for the underserved, difficult-to-treat population.

Efforts on the part of criminal justice system personnel to place mentally ill arrestees in a treatment setting rather than jail have been underway for decades. Jail-based diversion projects have taken different configurations, but the results have not been well-documented. A survey of 1,263 jails published in 1994 indicated that although 230 reported that they had diversion programs, further investigation revealed that only 52 had formal programs that included the following four elements, the presence of which are useful for differentiating jail-based diversion programs from other less complete jail protocols (Steadman 1994):

- Screening of incoming jail detainees to identify those with evidence of mental illness
- Assessment to determine if the qualifications for diversion have been met
- Negotiations for approvals necessary to allow treatment in lieu of prosecution
- Placement of offenders with mental illness in an appropriate setting for treatment

Since this survey, jail-based programs have proliferated, and some, such as those discussed below, have been shown to be quite effective.

As jail-based diversion programs have evolved, variations include those that divert either before or after the first court appearance. Individual programs may have direct involvement of personnel from the jail, pretrial services groups, community mental health agencies, court staff, or probation departments in a variety of combinations to implement the four elements, or procedures, listed above. In some procedures, the court has taken a prominent role, so that the distinction between jail-based and court-based programs is not clear. Mental health courts present no problems in this regard, because the judges have a central, clearly-defined role that sets them apart. Other programs are more difficult to classify, such as those where two or more courts refer clients to a treatment provider, those where the judges are active, but have a limited role in assuring that prescribed treatment takes place, or those in which a third party has a central role in coordinating the activity, and is primarily responsible for supervising treatment compliance, calling on the court only when assistance is needed. These borderline situations are dealt with in the present section along with “non-specialty, first appearance court models” that are concerned with the use of pretrial release and deferred prosecution as tools for addressing mental illness in the court systems. Mental health courts are considered independently in the next section. Some operating programs that illustrate the variation in what has been included in our post-arrest category are presented on the following pages.

Project Link

Project Link is a consortium formed in 1995. It was sponsored by the Department of Psychiatry at the University of Rochester to deal with problems presented by mentally ill offenders with a history of recidivism in the Monroe County (NY) jail. As the program has evolved, the scope of its activity was expanded to give attention to homeless, mentally ill people living on the streets.

By 1999 the program was developed to the point where it was serving 100 clients, had an ACT-type team delivering service as needed 24 hours per day to 40 of the most difficult-to-treat clients, and had a treatment residence for dual-diagnosed clients. Project Link received the American Psychiatric Association's Gold Achievement Award for 1999 "in recognition of its achievement in meeting the clinical, social, and residential needs of a vulnerable and difficult-to-treat segment of the chronically mentally ill population" (Anonymous 1999).

The first group of 41 clients to complete one year of participation in the Project Link program appeared to qualify as difficult-to-treat. In addition to their severe mental illness, 95% had substance abuse problems, 95% were unemployed, 98% were unmarried, 71% had less than high school education, and 61% had prior felony convictions (Lamberti 2001).

The Nathaniel Project

The Nathaniel Project provides a diversion option for mentally ill offenders that are facing a felony sentence in the NY State prison system. The requirements for acceptance in the program beyond the impending prison sentence are that the offender be seriously mentally ill with an Axis I diagnosis and be "motivated to engage in treatment."

Referrals to the program are made mostly by defense attorneys but also come from families, mental health workers, judges, and prosecutors. Screening decisions are based primarily on an interview that takes about an hour in which a judgment is made about the client's motivation to engage in treatment and public safety issues. In connection with public safety issues, the following statement reflects the program's philosophy:

"The Nathaniel Project has never rejected a potential client because of the severity of the offense or because the individual has a history of violence.

The project is careful to draw the distinction between criminal charges and actual risk to public safety. Each case is closely evaluated, and those that pose a real public safety risk are screened out" (GAINS Center 2002).

This position is noteworthy because it contrasts so sharply with that of many other diversion approaches that use blanket exclusions that are unrealistic measures of the risk to screen candidates. For those accepted as clients for the Nathaniel Project intensive case management is provided. Workers accompany clients for all appointments and insure that they receive all the service they need and are on call 24 hours a day seven days a week. The need for intensive treatment is apparent from the characteristics of the first 53 clients enrolled: 85% has co-occurring substance abuse disorder; 92% were homeless at intake, and 74% had prior felony convictions (GAINS Center 2002).

Substance Abuse and Mental Health Services Administration (SAMHSA)

Initiative

The SAMHSA began a study in 1997 - the Knowledge Development and Application Program - that included investigation of the effectiveness of diversion activities at nine sites operating 16 diversion programs of different types. The study “aimed at studying jail diversion programs that serve individuals with co-occurring disorders who come in contact with the criminal justice system. The results will determine when diversion works, for whom, and under what circumstances.”

The SAMHSA initiative included four sites with five programs that are jail-based or have a jail-based component. These are described in literature prepared by the GAINS Center that provided technical support for the project: (GAINS Center Undated; Steadman 1999)

- The Maricopa County (AZ) program starts with a jail-based identification of mentally ill candidates who are referred to a treatment provider organization (ComCare). ComCare works “directly with the police departments, mobile mental health teams, urgent care centers, prosecutors, public defender, attorneys, and judges to advocate for treatment of referrals.”
- Pima County (AZ) has a program that includes screening for mental illness at the jail by Pre-Trial Services; a report is sent to the Community Partnership of Southern Arizona for handling by a full-time criminal justice specialist who “develops, implements and coordinates diversion program through the community.”
- The Oahu (HI) diversion process has several points of intervention; the jail-based activity is carried out by a provider organization (Helping Hands of Hawaii). Clients are screened at the jail at 3:00 A.M. and transported to the courthouse at 6:00 A.M. where they are seen by a Diversion Care Coordinator who decides if diversion is appropriate.
- For Lane County (OR) the diversion process starts with a screening and assessment at the jail to identify mentally ill, substance abusive individuals who are candidates for their Co-Occurring Diversion (COD) program. Eligible candidates who are accepted are assigned a mental health specialist who acts as a case manager. The case manager acts as an interface between the court system and the mental health treatment providers.
- Montgomery County (PA) Emergency Service (MCES) has both pre-arrest and post-arrest diversion activities. The jail-based post-arrest activity begins with contact with the county jail, where screening activities have identified potential candidates for diversion. MCES operates an inpatient Dual Diagnosis Program, a 24-hour crisis response team, and provides case managers that support the diversion effort.

Results from the SAMHSA program that have recently begun to appear in the literature are discussed below.

Pretrial Release/Deferred Prosecution Used for Diversion

A recent publication by the GAINS Center (Clark 2004) summarizes the results of projects that have been undertaken to use pretrial release and deferred prosecution protocols for diversion of mentally ill offenders from jail to treatment. The report presents information from a survey conducted by the Pretrial Services Resource Center (PSRC) of the National Association of Pretrial Services Agencies. Surveys were sent to 257 jurisdictions; 203 returned information used to identify 30 jurisdictions that had early intervention procedures, for further study.

The normal pretrial release decision is made by the judge based on information supplied to help him decide whether the offender will be free pending trial. The judge considers 1) is he likely to appear for future court proceedings, 2) would his release represent a threat to public safety. The judge can make release conditional by setting bail. Where a mentally ill offender is concerned, release can be contingent upon the offender engaging in treatment for his illness.

Deferred prosecution is a process that the judge or the prosecutor can employ with mentally ill offenders. The offender can be offered an opportunity to have prosecution deferred, contingent on his participating in a specified program, with charges being dropped if the program is successfully completed.

Follow-up study of the 30 projects selected from the PSRC survey identified 12 jurisdictions using pretrial release and two jurisdictions (Connecticut Statewide and Jefferson County, KY) that use both pretrial release and deferred prosecution to deal with mental illness in the courts. Table 6 presents data from the PSRC report.

The table shows that larger jurisdictions are the main users of these methods but the Wayne County, NY (Population 50,000 to 100,000) example suggests that they can also be used in smaller jurisdictions. Based on the Hamilton County experience described below, deferred prosecution may supplement other programs.

Hamilton County, OH courts dealt with 9,505 mentally ill offenders in 2004. Dealing with the mentally ill begins with a screening by Pre-trial Services. Offenders thought to need further evaluation are referred to the Court Clinic where they are assessed and diverted as appropriate to the following programs:

- Alternative Interventions for Womens Program - The screening step includes standard testing for all women to identify candidates for this diversion. After in-depth assessment, treatment recommendations are made to the Court and the Probation Department for community treatment for accepted candidates. This program considered 10,280 women and recommended community treatment programs for 572 in a recent 40-month period.
- Pretrial release - The court used pretrial release for 584 offenders in 2003. Most of these individuals were already connected with the mental health system.
- Mentally Disabled Offender Program - Six Probation Office specialists are employed to supervise mentally ill adults on probation. In 2004 the program had 696 new referrals, 204 successfully completed their program and 119 cases had violations that led to revocation of probation.
- Mental Health Court - This program, which started in the spring of 2002, oversees treatment for offenders guilty of non-violent misdemeanors. Through December 2004, 34 had been placed under court supervision. Admission, which was restricted when the process was being institutionalized, is now reported to be less tightly controlled.

Table 6 - Characteristics of Jurisdictions Meeting Criteria

Jurisdiction	Target Population for Mental Health Intervention	Year Mental Health Intervention Began	Population Size of Geographical Area
District of Columbia	Misdemeanors and nonviolent	2002	Between 500,000 and 1,000,000
Winnebago County, IL	All defendants	1990	Between 100,000 and 500,000
Montgomery County, MD	All defendants	2001	Between 500,000 and 1,000,000
Wayne County, NY	Misdemeanors and nonviolent felonies	Unknown	Between 50,000 and 100,000
Cuyahoga County, OH	All felony defendants	2000	Over 1 million
Hamilton County, OH	All misdemeanor defendants	1999	Between 500,000 and 1,000,000
Tulsa County, OK	All defendants	2000	Between 500,000 and 1,000,000
Montgomery County, PA	Misdemeanors and nonviolent felonies	1985	Between 500,000 and 1,000,000
Shelby County, TN	All defendants	1998	Between 500,000 and 1,000,000
Harris County, TX	All defendants	1993	Over 1 million
Connecticut-State-wide	Misdemeanors	1994	Over 1 million
Jefferson County, KY	All defendants	1992	Between 500,000 and 1,000,000

The post-arrest programs are supported by the Court Clinic which performs about 2,000 in-depth mental health assessments per year. These are in connection with three issues: competency to stand trial, not guilty by reason of insanity pleas, and “advisability of treatment” recommendations (Central Clinic 2004).

Effectiveness/Cost-Effectiveness

Effectiveness

A recent publication (GAINS Center 2004) summarizes the results of the limited amount of empirical research that has been conducted on jail-based diversion work in the U.S. This analysis considers 14 diversion projects, six of which are jail-based. Three of the jail-based programs are part of the (SAMHSA) Jail Diversion, Knowledge Development and Application program (KDA). The six jail-based projects are:

- Maricopa and Pima Counties, AZ (SAMHSA KDA Program)
- Oahu, Hawaii (SAMHSA KDA Program)
- New York City (SAMSHA KDA Program)
- Rochester, NY (Project Link)
- New York City (Nathaniel Project)
- Mid-Size New England City

The results of this analysis indicates that all projects can point to accomplishment.

Collectively they suggest that jail-based diversion can impact favorably on the problems associated with co-occurring mental illness and substance abuse disorders in the justice system. However, the projects differ in structure, intake criteria, etc., and cannot be directly compared or shown to be cost-effective. For some, no evaluation data have been cited. In New York City the accomplishments that are cited are general, i.e., improved collaboration on planning by local partners and “growing awareness of jail diversion and forensic mental health issues on local and state levels” (GAINS Center 2004).

The results reported for the early operation of the Nathaniel Project illustrate the kinds of quantitative information that has been generated. Four key indicators are monitored for the 53 people accepted as clients.

- Arrest rate is monitored as a measure of impact on public safety - The first 53 clients showed a decrease in total arrests from 101 in the year prior to acceptance in the program to seven in the year after intake.
- Retention in the program - clients with a history of repeatedly dropping out of treatment shows 88% retention for six months and 80% for two years.
- Treatment compliance - 100% of the clients were in treatment
- Housing - 92% of the clients were homeless coming into the program and after one year 79% had permanent housing.

These data, as indicated earlier, are obtained on clients who seem to qualify as some of the most difficult-to-treat.

Another example of outcome reporting supported by data is provided by Project Link. Analysis of performance for one year before admission to the project with that for one year after indicated the following:

- Mean yearly jail days per person dropped from 107.7 to 46.4
- Mean yearly hospital days per person dropped from 115.9 to 7.4.

The avoided costs associated with these changes for the test group of 41 would be substantial. Other favorable outcomes included reduction in number of arrests, incarcerations, and

hospitalizations. Also, no arrests or suicide attempts were reported for the test group (Lamberti 2001).

Cost-Effectiveness

The only data on cost-effectiveness of post-arrest diversion operations are those that have been generated by the SAMHSA KDA program. Four of the 16 studies were evaluated formally for cost-effectiveness but only two were post-arrest as defined here, i.e. Lane County, OR and Tucson, AZ. Both studies were designed to determine:

- How different is the cost of the jail diversion program for the average participant from the cost of the traditional criminal justice system?
- What effect does the (Lane County or Tucson) diversion program have on each of a broad range of outcomes?

The cost-effectiveness studies were conducted by Research Triangle Institute and reported data from SAMSHA projects in Tucson, Pima County, AZ (Cowell 2002a) and Eugene, Lane County, OR (Cowell 2002b). Both studies considered similar sets of cost domains that analyzed the cost of mental health care and justice system cost for both diverted and not-diverted groups. Both studies showed no significant difference in the overall cost incurred by the two groups (diverted vs. non-diverted) during the 18 months subsequent to beginning the study. In both studies the diverted group had higher cost for treatment of mental illness and the non-diverted group had higher cost for subsequent contact with the justice system. In both studies the two categories of cost were offsetting in that there were no significant differences in the cost incurred by the diverted group and on the cost side of the study. An identical set of nine outcomes were used as measures of effectiveness for both studies. These were:

- Criminal Behavior
 - Whether arrested in the past 30 days
- Quality of Life
 - Whether seriously victimized in the past three months
 - Whether nonviolently victimized in the past three months
 - Whether currently homeless
 - Physical health score (PCS)
- Substance Use
 - Whether abused alcohol in the past three months
 - Whether used drugs in the past three months
- Mental Health Status
 - Colorado Symptom Inventory Score (CSI)
 - Mental health score (MCS)

The mean effectiveness results from both studies were internally inconsistent in showing outcomes that support the usefulness of diversion. For example, the Eugene study showed that the diverted group was more likely to have been in jail in the past 30 days than the non-diverted group, but the diverted group had a lower incidence, of drug use than the non-diverted group. For the Tucson study they were also internally inconsistent and in this study the diverted group had a better jail experience but a worse record of drug use.

It is also indicated that only one outcome result out of nine is statistically significant in each study. For the Tucson study, the Colorado Symptom Inventory (CSI) was 5.95% better for the diverted group. For the Eugene study, the probability of drug use in the past 30 days was reduced by 80%. No other outcome measure showed statistically significant improvement. The improvement in CSI score of 4.5 (6% increase) is used with the apparent cost of diversion of \$857 to calculate a cost-effectiveness ratio of \$190 for the Tucson study. That is, \$190 produced a one point increase in CSI score.

Overall it appears that the results for both studies provide little economic justification for diversion operations, but the analyses do demonstrate the use of a standard methodology for evaluation of cost-effectiveness of post-arrest diversion.

Post-Arrest Diversion and the Difficult-to-Treat

The potential for post-arrest diversion programs to contact difficult-to-treat and engage them in treatment has been demonstrated. Diversion to treatment such as intensive case management (Nathaniel Project) or ACT team follow up (Project Link) can be very effective, and the reported results, in terms of jail days and hospital days avoided, suggest that treatment is cost-effective. But the number of post-arrest programs is unknown. The GAINS Center has files for 111 post-arrest programs and is conducting a survey to better define details of their operation. The survey is expected to be completed in 2005 (Naples 2004). However, until better data are available it seems reasonable to assume that the impact of post-arrest diversion programs linked to intensive treatment needed for difficult-to-treat individuals is small, though the potential for impact is great.

Mental Health Courts

Background

As indicated earlier, courts have used a number of post-arrest approaches to divert mentally ill offenders from jail to treatment. They have taken the lead in locally tailored projects to identify mentally ill offenders and clear legal requirements needed to have them enrolled in treatment, have used pre-trial release and deferred prosecution protocols for diversion, and have organized mental health courts. Most court-based activity has, however, been in connection with mental health courts.

The four elements of a MHC have been defined by Steadman (2001) as:

- All identified mentally ill defendants are handled on a single court docket
- All include the use of a collaborative team which includes a clinical specialist who recommends and makes linkages to treatment
- All include assurance of availability of appropriate clinical placement prior to the judge making a ruling
- All have specialized court monitoring with possible sanctions for noncompliance

The variability in the handling of these four functions is extensive and illustrated by the descriptive material below.

The first two MHCs began in Marion County, IN in 1996 and in Broward County, FL in 1997. These programs have been followed by what has become a rapidly expanding population of MHCs in all parts of the U.S. The MHC start dates reported in the Survey of Mental Health Courts (NAMI/Gains/Consensus 2005) show 11 courts at the end of 1999, 40 by the end of 2001, and 83 at the end of 2003 and over 100 as of October 2004. The survey, which is a joint product of NAMI, Gains Center/TAPA Division, and the Counsel of State Government/Consensus Project, is believed to be the best source of information on the MHC population.

The high rate of establishment of mental health courts shown by the “Survey of Mental Health Courts” data has been stimulated by several government programs. SAMHSA has supported a Target Capacity Expansion Program for Jail Diversion, the Bureau of Justice has supported a Mental Health Courts Program and the State of California’s Mentally Ill Offenders Crime Reduction Grant program (discussed in the linkage section that follows) has been used by some grantees for start-up of MHCs.

As the MHCs have expanded in number, wide variations in the basic model (i.e. projects including the four elements indicated above) have emerged. Although many courts are limited to adult misdemeanors and non-violent felonies, some notable exceptions have been reported.

- Seneca County, OH, Los Angeles County, CA and Hamilton County, OH have MHCs for juvenile offenders.
- Atlanta Municipal Court conducts a “community court for drugs, mentally ill, and homelessness.”
- Two courts - Butler County, OH Substance Abuse Mental Illness Court and the Lane County, OR Co-Occurring Disorders Court - serve only felony offenders with a history of mental

illness combined with substance abuse problems.

In addition to these specific examples, numerous variations in MHCs have been noted. For example, developmentally disabled and brain-damaged offenders are admitted to some MHCs but not others; a prior criminal history is required for admission to a few courts, but others tend to reject repeat offenders especially if any suggested violence is involved. An analysis of five early MHCs that discuss differences and commonalities illustrates how communities have adapted MHC to the needs of their community and available resources (Goldkamp 2000).

Effectiveness/Cost-Effectiveness

Effectiveness

A number of MHCs have generated reports dealing with their effectiveness in accomplishment of predetermined goals. Seven such reports believed to be typical are discussed briefly below.

- Clark County, OR (Herinckx 2003) - The Regional Research Institute for Human Services of Portland State University conducted an evaluation of the Clark County MHC using qualitative and quantitative assessments of results in attaining three goals: 1) Reduce the number of mentally ill people arrested; 2) Improve the quality of life for mentally ill offenders; 3) Reduce service barriers between the mental health system and the justice system.

The qualitative interviews with consumers and stakeholders indicated progress on the service and their objectives. The quantitative part of the project involved analysis of their record for 119 MHC clients for six months prior to, and six months after, enrollment in the program. Results showed that 85 (71%) had no criminal activity in the post-enrollment period.

- Probation violations were reduced from 110 involving 54 clients to 62 involving 32 clients in the pre-MHC period compared to the post-MHC period.
- The repeat offenders, defined as those with four or more arrests in the pre-MHC period, were reduced from 26 (22%) to 6 (5%) in the post-MHC period.

It was concluded that success in reducing the arrest rate for MHC clients eased the burden on the justice system. In addition, consumers reported improvement in quality of their life, stake holders felt that public safety was improved. It was decided, on the basis of these results, that MHC should “be continued in the future and perhaps be expanded.”

- Santa Barbara, CA - A study to evaluate the Santa Barbara’s Mental Health Treatment Court (MHTC) was performed by the Gevirtz Graduate School of Education, University of California at Santa Barbara (Cosden 2003). The study involved the participation of 235 volunteers entering the MHTC; 137 were enrolled as MHTC clients and 98 were placed in a “treatment as usual” (TAU) group. The records for the two groups were assessed to determine how quality-of-life factors were impacted by MHTC participation and whether criminal activity was diminished by MHTC participation.

The results indicated that both groups showed improvement with respect to both quality of life and justice system involvement over the test period of one year.

-Quality of life as measured by standard tests showed that participants in MHTC showed more improvement in independent living skills and a reduction in drug related problems.

-Both the MHTC and the TAU group had the same level of contact with the justice system, the MHTC more likely to be cited for probation violation and the TAU group was more likely to be involved with new crimes.

The MHTC group was under the care of an ACT team and the TAU group was receiving attention that would exceed the norm in many, if not most communities.

Factors cited as tending to make TAU somewhat unusual were as follows: case management that was committed to continuous care for the TAU group during the test period, the TAU group was receiving care at a time when the treatment system was being upgraded, and participants were paid for interviews in the assessment period. Both groups apparently received what could be considered some form of intensive case management.

- Seattle Municipal MHC (SMMHC) and King County District Court MHC (KCMHC).

The two MHC's in Seattle began operation in February 1999 for KCMHC and April 1999 for SMMHC. Both had early results evaluated by the University of Washington. (Trupin 2000; Trupin 2001; Trupin 2003)

The first publications presented qualitative and quantitative results but were considered preliminary. The studies combined process analysis based on interviews and surveys of key informants and stakeholders with limited data on results. The 2003 report summarizes and compares the two programs and cited several respects in which the two similar courts had notable differences.

- The SMMHC has jurisdiction over a primarily urban area. The KCMHC jurisdiction is over an area that is suburban.

- The KCMHC was better recognized as a separate entity in the County Court system. The SMMHC "had a less formal existence in the Seattle Municipal Court Structure."

- The SMMHC had a substantially higher occurrence of offenders diagnosed with a psychotic disorder than that in the KCMHC.

These contributed to some differences in the outcomes for the two courts but the comparative report concluded:

"Although causality cannot be clearly attributed from studies of this type, we find it more reasonable than not to conclude that both MHCs described here made significant impacts on both the participants and non-participants referred to them. Both interviewees and quantitative data indicators point to a criminal justice system that has been positively impacted by a new

ecological presence, the MHC.”

Both MHCs have continued successful operations. No comprehensive analysis of effectiveness has been reported but some data are available.

The SMMHC has collected operations data for the first five full years (2000-2004) of operation (Smith 2004). That data provide insights on both the clients served and court operations. The court has undergone four relocations with corresponding changes in presiding judges and courtroom staff. As a result, some of the data collection may have been compromised. While data is not available on each variable for each year, the earlier data considered here is believed to be representative for the SMC MHC program.

The 3,770 cases referred to SMMHC over five years included many with difficult-to-treat defendants. Defendant demographic data such as these presented below were available for only three of those years (2000-2003).

- Over 58% had co-occurring mental illness and drug or alcohol disorder.
- Over 57% were homeless when they were referred to the court.
- About 52% did not have MH services when they were referred to the MHC.

The conclusion that the referred population was difficult-to-treat is further supported by annual data that show almost 75% of the offenders had at least one prior case in the Seattle Municipal Court.

The annual data indicate that despite changes in the point of intervention (arraignment, pre-trial, or competency hearing), the court goal of early intervention was met over 90% of the time.

The court, over its initial five years, had an almost 100% increase in the proportion of defendants who were found not to be competent to stand trial. Team members hypothesize that this is due to the assessment expertise developed by team members, including the prosecuting and defense attorneys. Conversely, during this time period, the proportion of defendants who “opted in” to MHC decreased similarly.

The data indicate a significant reduction in the proportion of cases over the five years that were terminated from MHC for non-compliance. One hypothesis is that defendants in the early MHC might have had competency issues which were not clear to the unpracticed team. As the team gained experience they were able to identify candidates that would be incapable of compliance with a treatment plan.

In summary, the SMMHC appears to be introducing or returning an average of 100 to 125 mentally ill offenders per year to treatment for their illness rather than jail. Data that has not been reported includes defendants who complete the course of supervision which is typically two-years. The failure of MHC participants for non-compliance for the last three years has been very low so that the jail time avoided by the successful participants is believed to have provided considerable justification for

the effort.

The latest study of King County MHC is being conducted by John R. Neiswender at the Washington State University (Neiswender 2005). Early results of interest here involve study of the first 114 “graduates” to have successfully completed their mental health treatment program under the supervision of the King County MHC. The time period involved was from the first court hearings in February 1999 to the fall of 2003, the end date for the study.

Two justice system variables were considered for the study group, i.e. days spent in jail and recidivism ratio. The jail days were determined for three time periods: one year before entry into the program, the period of participation in the program, and one year after completion of prescribed treatment and graduation. The average number of days in jail, per graduate for these periods were:

- One year prior to program entry - 15.5 days
- During the two-year program - 2.2 days/year
- One year after graduation - 1.8 days

The impact of the MHC program on recidivism was demonstrated by comparing the number of arrests one year prior to entry into MHC program with the number of arrests one year after graduation (see Table 7).

Table 7 - Number of Offenses and Number of Participants Committing a Corresponding Number of Offenses

Number of Offenses per Participant	Number of Participants (One year prior to program entry)	Number of Participants (One year Subsequent to Graduation)
0	52	86
1	22	13
2	19	8
3	8	3
4	4	0
5	5	2
6	1	1
9	1	0
14	2	1
	114	114

The data in Table 7 show that 52 of 114 participants had no arrests in the year prior to entering the MHC program and 86 had no arrests in the one year after graduation. In all other categories in which participants had one or more arrests, the number of participants in all but one number-of-offense category was lower for the year after graduation.

- Butler County, OH - The Substance Abuse and Mentally Ill (SAMI) Court was evaluated by the Butler County Mental Health Board. Thirty clients in treatment for the year 5/1/01 to 4/30/02 were studied. The cost incurred while in the SAMI program was compared with the cost for one year prior to enrollment. The items and the cost are shown below:
 - Cost of hospital care; reduced from \$262,000 to \$85,600
 - Cost of jail days; increased from \$34,900 to \$61,300
 - Outpatient treatment cost; increased from \$59,467 to \$360,092
 - Court cost; not available prior to enrolment, after enrolment, \$74,368

These figures show a net cost of \$243,400 for SAMI Court treatment over the total avoided cost for jail time served and hospitalization. When the cost for prison days avoided while in treatment (\$460,300) was taken into consideration, the balance was shifted; the cost of treatment in the SAMI program was exceeded by the total avoided cost by \$76,400 (Spaite 2003).

The study considered only the treatment period and pre-treatment history. Post-treatment studies are planned for 2005. The study was small and is included here because it is one of few that considered cost. Even though assumptions were conservative with respect to the main conclusions, results were positive, i.e. putting the defendants in the program was less expensive than sending them to prison.

- Broward County, FL - The University of South Florida's Department of Mental Health Laws and Policy is in the final phase of an evaluation of the Broward County, FL MHC. The evaluation process is planned to have four parts:
 - A series of key informant interviews to provide qualitative information on operational issues and success in attainment of goals.
 - Study of the court process that involved comparison of the MHC's mode of operation with that of Hillsboro County's conventional misdemeanor court.
 - A series of interviews with 100 people whose cases were heard in the MHC and 100 people tried in Hillsboro County's misdemeanor court "to determine whether individuals perceive the court as fair and whether individuals perceive their participation in the court as voluntary or coerced."
 - Collection of cost data, from a variety of sources, to quantify the results of MHC activity (Petrila 2001).

The results of this study, begun in 1999, have been reported in four publications. Two more articles are undergoing prepublication review and a final summary report is planned for 2005. The first report (Petrila 2001) presents the background for the Broward County MHC, discusses the finding of the key informant interviews, and presents tentative observation from the MHC study. The second published report (Poythress 2002) established that offenders participating in the Broward County MHC did not feel that they had been coerced and felt that they had been fairly treated. The third report (McGaha 2002) reviews progress on the evaluation project and discusses "the challenges we encountered in doing field research in this unique legal setting." The fourth report (Boothroyd 2003) established that participation in the

Broward County MHC contributed to the increased engagement of mentally ill offenders in treatment, but observed that the benefits in terms of improved mental health and recidivism remain to be demonstrated. The two additional papers being reviewed for publication will deal with the evaluation of treatment outcomes and recidivism results (Poythress 2004).

Summit County, OH - The Akron Municipal Mental Health Court was the first in the State of Ohio. It started in January 2001 (Teller 2004). Between startup and January 31, 2004, 472 referrals (about 13 per month) were considered of which 229 were accepted. As of January 31, 2004 the status of those in the accepted group was:

- 88 Active clients under court supervision
- 97 Terminated for non-compliance
- 40 Graduated from court supervision

Four of the original 229 accepted clients died prior to the study which ended on 1/31/04.

A first test of the effectiveness of the program was conducted by comparing two groups that were admitted during the first year of operation: the 40 graduates from the court program and 47 individuals that were terminated in the first year. The study variables of interest here were time spent hospitalized or incarcerated in jail or prison. The year prior to the year of admission to the program (2000) and for the year subsequent to their separation (2003) were compared.

The data in Table 8 show that the graduates have a better record after treatment. The bed-day total is reduced from 1004 days before treatment to 107 days for the year after treatment with the biggest reduction being in a reduction of 430 jail days per year. It is also indicated that the terminated group was institutionalized more than the graduates both before being admitted and after being terminated, raising the question of possible basic differences in treatability of the two groups.

The results are a very early product of what is a comprehensive, longitudinal study of the client outcomes for those who:

- successfully completed the Akron Mental Health Court program
- failed to complete the court program
- declined to enter the program, or
- were outpatient civilly committed

The outpatient commitment group includes individuals that have undergone standard court-ordered treatment and will serve as a control group. The study includes 710 participants. The outcomes variable for study includes data for criminal justice involvement, hospitalizations, mental health treatment, and related services.

Table 8 - Graduates/Terminated Clients Bed Day Comparison (Teller 2004)
MHC Grads, Bed Day Utilization

Graduates (n = 40) Admitted in 2001	Number of People Affected	Number of Incidents	Number of Days
Summit County Jail (33)			
2000	9	16	464
2003	3	8	34
State Prison (2)			
2000	1	1	168
2003	0	0	0
Psychiatric Hospital (9)			
2000	5	5	106
2003	1	1	19
General Hospital (13)			
2000	6	11	66
2003	4	5	54

Terminated from MHC, Bed Day Utilization

2001 Accepted Date Terminated (n=47)	Number of People Affected	Number of Incidents	Number of Days
Summit County Jail (47)			
2000	24	44	906
2003	26	48	1480
State Prison (13)			
2000	4	4	737
2003	4	4	916
Psychiatric Hospital (9)			
2000	5	7	205
2003	2	2	39
General Hospital (20)			
2000	8	12	82
2003	5	6	60

Numbers in parentheses = Number of subjects in category

Cost-Effectiveness

To date there apparently has been no comprehensive cost-effectiveness study for MHCs comparable to that which has been carried out for drug courts. Given the diversity in MHCs, any such study would likely be highly site-specific; however, some of the drug court work on analysis of cost and benefits appears applicable to development of MHC evaluations (Finigan 1998; Carey 2004).

The Finigan report dealt with an evaluation of Multanoma County's drug diversion program. The study involved a comparison of outcomes for 150 program graduates with 150 subjects that were eligible for the program but were not admitted. Results indicated that program participants had less involvement with the justice system and there was an overall net savings in avoided cost associated with diversion. The Carey report deals with a more intensive study of the same court in which some assumptions were tested and the results verified.

MHCs and the Difficult-to-Treat

Several characteristics of MHCs make their applicability and potential impact on reduction of the difficult-to-treat population uncertain. Admission for most courts required that clients be mentally competent volunteers that have no record of violent offenses. How much issues of competency, prior offenses, history of violence, or offender refusal to participate, restrict the intake of difficult-to-treat individuals has not been quantified. However, given the courts willingness to accept difficult-to-treat individuals, they can be helped effectively. Some courts have been loosening admission criteria as they gain experience, so potential problems with admission restrictions should be self-correcting and the positive impact on the difficult-to-treat population will increase over time.

Linkage

Background

Linkage, as the term is used here, refers to transition service for mentally ill people leaving jail and prisons and re-entering the community as probationers, parolees, or offenders that have served their sentences. Linkage of mentally ill releasees is a significant but ill-defined subset of a larger problem involving re-entry of the growing population of people discharged annually from jails and prison.

Growth in the number of people incarcerated in jails and prisons, beginning in the early 1970s, has resulted in a four-fold increase in the per capita rate of incarceration from around 110 per 100,000 to 476 per 100,000 in 2000 (Travis 2001; Blumstein 1999). The number of prisoners being released yearly has grown from just under 150,000 in 1973 to 585,000 in 2000 and 650,000 in 2004. It is estimated that nearly 75% of this population has substance abuse problems and 14% have a mental illness (Beck 2000; Harrison 2005).

The populations of prisoners in 2003 were reported to be 1,226,000 in state prisons, 162,000 in federal prison, and 691,000 in jails (Harrison 2004). Re-entry programs have emerged as a tool to deal with problems of recidivism in jails and prisons. The magnitude of the recidivism problem is illustrated by a U.S. Department of Justice study (Langan 2002) that traced the history, for three years, of prisoners released from the prisons of 15 states in 1994. This group of 272,211 offenders represented two-thirds of all those released in the U.S. that year. The four measures of recidivism that were used and percentage of the group having an involvement within the three-year study period were:

- 67.5% of the prisoners were rearrested for a new offense (almost exclusively a felony or a serious misdemeanor).
- 46.9% were reconvicted for a new crime.
- 25.4% were re-sentenced to prison for a new crime.
- 51.8% were back in prison, serving time for a new prison sentence or for a technical violation of their release.

A similar study conducted for 1983 releasees showed the re-arrest rate was 5% lower and the re-incarceration rate was about the same.

Many state prisons and some jails provide re-entry assistance, but it appears that only a few have comprehensive programs for mentally ill people being discharged. A recent report by the Department of Justice (Hills 2004) defines “aftercare” as a process “creating a continuum of care pertaining to mental health and substance abuse services as an inmate is released to the community.” Specific services include:

- Case management
- Supported housing
- Supported employment
- Relapse prevention service

No report of the extent to which such services are being supplied by programs operating in the U.S. has been found. It has become apparent, however, that some support of linkage programs for mentally ill releasees is being provided at the federal, state, and community levels. Those vary in scope from community programs to limited state programs, to California's multi-million dollar Mentally Ill Offenders Crime Reduction Grant (MIOCRG) program.

California's MIOCRG Program

The MIOCRG program was begun in 1998 and as of June 2004 had provided about \$86 million in grants to 30 counties. The funds were to be used to "reduce the number of mentally ill persons moving through a 'revolving door' between the local criminal justice system and the community due largely to inadequate and/or inconsistent mental health treatment and support services". (MIOCRG 2002)

The legislation establishing MIOCRG recognized the importance of collaboration among law enforcement, corrections, and service providers. It required that all grantees form a Strategy Committee to address identified gaps in the local system of care for the people with serious mental illness. The committee membership requirement was:

"At a minimum, members of the Strategy Committee had to include the sheriff/director of corrections; the chief probation officer and representatives of other local law enforcement agencies; a superior court judge; the county's mental health director; a consumer of mental health services; and one or more representatives of organizations serving the mentally ill population." (MIOCRG 2002).

This committee was to develop an assessment of local needs for effective linkage of discharged mentally ill offenders with appropriate community services and development of a plan for addressing gaps in the existing system. The legislature provided that the counties would have flexibility to tailor the program to fit local needs. This produced wide variations in the programs that evolved in the 30 counties. Strategies reported to have been employed include:

- Multi-disciplinary teams were used by most projects; teams included mental health clinicians, case managers, and probation officers.
- An ACT team mode of operation was used to provide intensive case management by a majority of projects.
- Mental Health Courts were initiated by "about half" of the projects.

Information on individual projects is available on the Board of Corrections website (www.bdcrr.ca.gov) and in the last annual report (MIOCRG 2004).

Evaluation of the effectiveness of projects in meeting the goal of reducing crimes committed by mentally ill offenders was a major legislative concern. Consequently a comprehensive plan for collection and analysis of data was developed and the grantees have submitted data for evaluation of outcomes at six month intervals until the program ended in July 2004. In March 2005 a report (MIOCRG 2005) presenting quantitative data was released, and is discussed below.

Transition from State Prisons in General (Ohio Example)

The Urban Institute initiative “Returning Home: Understanding the Challenges of Reentry” is currently investigating the reentry experience in a number of states including Illinois, Maryland, Ohio, and Texas. An interim report (LaVigne 2003) presents their findings for Ohio’s linkage program, which taken with material generated by Ohio State agencies, provide the information for this discussion.

Ohio’s program for providing mental health services for prison inmates is a continuing management response to a class-action suit that resulted in a consent decree calling for improvements in the system (i.e., *Dunn v Voinovich* in 1995). What was initiated there has become an ongoing program of reform that has been acknowledged as superior (Haddad 2001). It also appears that the emphasis on linkage, starting in 2001, has produced a program still in development or demonstration phases.

In February 2001 the Ohio Department of Rehabilitation and Correction (ODRC) committed to carry out “The Ohio Plan for Productive Offender Reentry and Recidivism Reduction” (Rhine 2004). The Ohio Plan is comprehensive in covering six main categories affecting reentry:

- Offender Planning and Tracking
- Offender Programming
- Discharge Planning and Employment
- Family Involvement
- Offender Supervision
- Community Justice Partnerships

Forty-four specific recommendations are made in connection with these categories.

All activities pursuant to the Ohio Plan will consider help for the mentally ill prisoners to some degree but only those most applicable are indicated here.

- Serious and Violent Offender Reentry Initiative (SVORI)
Community-Oriented Reentry Program (CORE)
A \$2 million federal grant was awarded in 2002, for three years, to support the SVORI program to work with high-risk serious and violent offenders. The project was supplemented by an award of \$234,000 in 2003 to add support for dealing with drug and alcohol addiction and mental illness, and by another \$317,000 in 2004 for expansion of the ACT teams supporting the work with mentally ill releases.

The program is scheduled to accept 200 participants; 155 have been identified and Reentry Accountability Plans have been developed. Ohio has been designated as one of the sites to be included in a study to evaluate the federal program.

- Forensic Assertive Community Treatment (FACT)
The ODRC is helping to support two FACT programs; one in Cuyahoga County and one in Hamilton County. They are working with seriously mentally ill offenders being discharged. Each team has a psychiatrist, psychiatric nurse, three case managers and a parole officer. They work closely with prison staff prior to

release, adhere to ACT standards and are said to have “enabled some of the most at-risk offenders to stay out of jail.”

- Urban Institute Research on Offenders with Medical and Mental Health Needs (Visher 2005)

The Urban Institute conducted an exploratory study of 81 prisoners released from Ohio prisons and returned to Cincinnati with physical or mental health problems that limited their ability to work. The study reports the results of focus group meetings with the former prisoners and subsequent meetings with 14 representatives of local service providers. The focus group meetings provided suggestions for improved transfer of released prisoners to community services. It is indicated that:

“as evidenced by the information collected from our study participants and presented herein, significant problem areas, gaps in services, and barriers to service delivery remain, specifically as they relate to former prisoners with mental and medical health care and substance abuse treatment needs.”

The Ohio Plan, started in the fall of 2002, is expected by service provider participants to ameliorate most linkage problems by 2007 if funding is made available.

Community Linkage Programs

As indicated earlier an unknown number of local organizations have been formed to provide transitional help for prisoners leaving jail or prison confinement. A recent report by the Urban Institute (Solomon 2004) provides some perspective on the nature of re-entry projects organized to provide help with prison-to-community transitions. The study identified 96 community-based, prisoner re-entry programs located by a non-exhaustive, “national scan” of activities. These programs provide individualized approaches to reducing recidivism by helping with housing, education, employment, reconnecting with family, health problems, or combinations of such services. The report identifies 25 of the 96 community based projects that provide assistance with health matters, but only six dealing specifically with mentally ill releasees. These are:

- Case Management Support Services (CMSS) and Community Reintegration of Offenders with Mental Illness and Substance Abuse (CROMISA)
The CROMISA program was started by CMSS in Erie, PA in 1994 to provide services for mentally ill offenders who have co-occurring substance abuse disorders. Potential clients must be residents of Erie County or neighboring counties.
- Dangerous Mentally Ill Offender Program (DMIO)
The DMIO program was established in 2000. It is a government program created by the State of Washington legislature. Potential clients must be mentally ill or developmentally disabled and determined to be a danger to self or others to receive re-entry assistance.
- Hampden County Correctional and Community Health Program
The Hampden County, MA program is operated by a non-profit group established in 1996. It provides mental health services and substance abuse treatment as a part of a broad project to provide prisoners discharged from the Hampden County jail with health care that hopefully reduces recidivism.
- Iowa Reentry Court

The Iowa Reentry Court began in 2000 in Cedar Rapids and is one of nine Department of Justice sponsored specialty courts, patterned after drug courts, being piloted to determine if recidivism, on the part of mentally ill or dual diagnosed prisoners that are discharged, can be reduced.

- Mental Health Services Continuum Program
In July of 2000 the California Department of Corrections began implementing a Mental Health Service Continuum Program designed to keep discharged mentally ill offenders in treatment for their illness in the community. The goal is that connection with community agencies which provide comprehensive and continuous treatment will reduce recidivism.
- Thresholds Jail Program
The Threshold Jail Program was established in 1997 to provide linkage for prisoners being discharged to Chicago and suburbs, and is discussed below.

The above activities are all discussed further in the Solomon report.

One especially notable community program, the County Collaborative Jail Linkage Project (CJLP), established by the Thresholds Jail Program, was awarded a Gold Award by the American Psychiatric Association. A recent article reports on outcomes for the first participants that entered the CJLS program (McCoy 2004). A group of 24 mentally ill individuals considered to be high risk for return to jail or hospital were studied to evaluate the impact of CJLP treatment on their lives. Some comments from the discussion of risk factors affecting return to jail or hospitals are as follows:

- Poverty - All 24 were receiving SSI benefits when they enrolled in CJLP, or shortly thereafter. Poverty was cited by many as a cause of their problems.
- Homelessness - Most participants had a history of homelessness and indicated that this was a factor that had led to arrests.
- Substance Use - Most reported a history of usage and some participants indicated it had led to violent crime.
- Violence and Victimization - Over half the participants had been involved as victims or perpetrators in violent acts.
- Self-harm - 25% of the participants had attempted suicide.

In addition to the above, one-third began using drugs or alcohol in high school and were said to have a “high co-occurrence of substance use and violence in their lives.” The 24 people had, on average, 18 hospitalizations and 47 arrests during their lifetime.

Effectiveness/Cost Effectiveness

Effectiveness

The MIOCRG program collected data for evaluation of results at six month intervals for two groups: one receiving “enhanced treatment” pursuant to the MIOCRG program and the other, a randomly selected control group, receiving “treatment as usual.” Early reports indicated that while enrolled in the program the enhanced treatment group had:

- A significantly greater number of participants with no involvement with the criminal justice system.
- A significantly lower number of jail bookings and fewer days in jail.
- Significantly fewer self-reported substance abuse problems.
- More economically self-sufficient participants.

A contributing factor for the favorable result was felt to be the increased amount of contact given by treatment providers and probation staff to the enhanced treatment group.

The latest information from the MIOCRG program presents an overview of quantitative findings from their evaluation project. As indicated earlier the enhanced treatment group enrolled in the MIOCRG program (ET) is compared with a control group receiving treatment as usual (TAU). The results presented include eight criminal justice and six quality of life outcomes. These are shown on Table 9. The ET group showed statistically significant positive results (compared to the TAU group) in 10 categories, positive results approaching statistical significance in two, and negative results (not statistically significant) in only two categories.

Table 9 – MIOCRG Outcomes (ET vs TAU)

<u>Criminal Justice</u>		<u>Quality of Life</u>	
1. Any booking	++	9. Drug problems	++
2. Mean bookings	-	10. Alcohol problem	++
3. Booking offense-felony	++	11. GAF* score improved	++
4. Any conviction	++	12. Homeless	++
5. Mean convictions	+	13. Unemployed	-
6. Felony convictions	++	14. Economic self-sufficiency	++
7. Any jail time	+		
8. Mean jail days	++	GAF* = Global Assessment Functioning	

Key

- ++ Statistically significant positive effects
- + Positive effects approaching statistical significance
- Negative effects, not statistically significant

The overview report will be followed by a more comprehensive analysis that is awaiting release as of June 2, 2005.

The County Collaborative Jail Linkage Project (CJLP) also reported some notable effectiveness information (McCoy 2004). The results of a study of outcomes for the group first admitted to the program indicated that all 24 (100%) remained in treatment for 24 months. The group showed impressive reduction in hospitalizations and justice system involvement.

When the group's experience for one year prior to program participation was compared to that for one year after participation, the following improvements were found:

- Hospitalizations were reduced from an average of 0.88 per person to 0.21 per person.
- Hospital days were reduced from an average of 64.6 days per person to 7.0 days per person.
- Arrests were reduced from 3.1 per person to 0.83 per person.
- Days in jail or prison were reduced from 107.1 days per person to 7.8 days per person.

Using what are believed to be conservative estimates for the cost for confinement of mentally ill persons in hospital per day (\$500) or prison per day (\$70 per day), the cost avoided for 24 people would be \$691,200 for hospitalization and \$166,800 for jail or prison confinement.

Cost-Effectiveness

The study identified little cost data that would support a cost-effectiveness discussion. However it is interesting to note that the MIOCRG program cost \$86 million and served 7,700 mentally ill persons (\$11,200 per person) to provide intensive care and over-sight needed to connect the client with services supplied by cooperating organizations. Information on additional costs incurred that were not covered by the MIOCRG is not available.

The more definitive information for the outcomes for the CJLP program combined with assumptions made above avoided cost, indicate a total avoided cost of \$858,000. This amounts to about \$35,750 per person or about \$98/person/day.

Linkage and the Difficult-to-Treat

About 90,000 mentally ill inmates are being discharged annually from prisons and jails. An estimated 75% (67,000) will be dually diagnosed with substance abuse problems. The population appears to be a primary source of difficult-to-treat individuals that would be candidates for treatment.

Closing Thoughts

The Need for Reform

Decades of piecemeal reforms have allowed our system of caring for mentally ill individuals in the community to evolve into a highly imperfect system. The need for change is widely accepted. The President's New Freedom Commission on Mental Health (President's Commission 2003) said:

“...for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic, the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.”

No rebuttal to this statement has been found in the literature. One negative criticism of the commission's work indicated that it “fails to consider the sickest silent minority that is languishing in back bedrooms, jail cells, and homeless shelters” (Satel 2003). Others have seen the report as presenting “an important opportunity for advocates and consumers” (Hogan 2003). Representatives of NAMI, the Association of State Mental Health Directors, the National Mental Health Association, Brazelton Center for Mental Health Law, the American Psychiatric Association, and United Behavioral Health have presented their ideas (Druss 2003). Responses are variable but none denies the need for reform.

The Capability for Improvement

There seems to be little question that we have the present capability for effective management of mental health disorders. The Surgeon General's report on mental health (U.S. Public Health Service 1999) claimed that a review of research supports two main findings:

- The efficacy of mental health treatments is well-documented, and
- A range of treatments exists for most mental disorders.

It was suggested six years ago that “the outlines of a reasonable new mental health system have quietly begun to take shape” (Torrey 1999b). The article goes on to describe successful programs that need to be replicated and suggests appropriate federal, state, and local government roles to stimulate progress. The activity described in the present report suggests movement since 1999 is in directions suggested by Torrey, but whether it is adequate to slow growth in the population of difficult-to-treat individuals is debatable. Work reviewed for this report indicates that we may be developing momentum that will sustain a level of activity needed for meaningful reform.

Barriers to Overcome

Available information indicates that care for our difficult-to-treat population can be cost-effective

for the taxpayer. But implementation of the most effective models can be retarded by inertia associated with the status quo. Factors that have been cited included:

- the disconnect between economic impacts (community mental health providers bearing the cost of more effective treatment do not benefit from costs avoided by jails and hospitals)
- the reluctance of some mental health providers to work with the difficult-to-treat individuals
- lack of meaningful cooperation between police and mental health professionals
- bureaucratic money management that makes reimbursement for some intense treatment models non-reimbursable
- a strong commitment by mental health providers to a disease maintenance philosophy, with little consideration of recovery goals

The last point above may be the most troublesome barrier to significant progress in dealing more effectively with the difficult-to-treat population. The advances in our ability to treat mental illness with new medications and improved techniques have progressed faster than, and are running ahead of, our ability to deliver them effectively.

Fortunately, starting in the 1990s, enlightened thinkers embraced the notion that an improved quality of life for the difficult-to-treat is possible with the right combination of commitment and resources. For the mentally ill, recovery does not mean the absence of the disease or its symptoms. What it does mean is vastly improved prognosis based on the patient's ability to manage his or her disease through the provision of structured, individualized, restorative treatment (Anthony 2000; Mueser 2002; Frese 2001).

Those working with the mentally ill need to either make or renew a commitment to recovery. And such commitment will manifest itself in various ways. For example, the jail administrator who sees the same mentally ill wards again and again should advocate for services which emphasize the mental illness and not the public order offenses that are merely a symptom of the disease. The case manager who coordinates services for the difficult-to-treat should seek realistic options that approximate a normal lifestyle. And family members who understandably are frustrated and burned out by their experience should try to channel that emotion into advocacy for their loved ones.

Financing New Programs

Money is always a factor in introducing new services. The relatively high cost of intensive treatment for new difficult-to-treat clients will require imaginative financing and a demonstration of beneficial outcomes to justify new programs. Some of the programs discussed here are said to have been started by re-programming funds rather than increasing spending. It has been suggested that too much of the current spending is on care for the "worried well" (Torrey 2003; Shorter 2003) and in Ohio it has been suggested that too little of Ohio Department of Mental Health funding is for treatment of seriously mentally individuals (Russell 2003). Further investigation to identify opportunities for reordering priorities is needed.

Demonstrated Success

A recent report on the first five years of operation under New York State's Assisted Outpatient Treatment (AOT) legislation documents some remarkable progress in care for the difficult-to-treat mentally ill individuals in the community. The law is "to ensure that individuals with mental illness and a history of hospitalizations or violence participate in community-based services appropriate to their needs." As of March 1, 2005, 3,908 individuals had been placed in treatment under the legislation (NY State 2005).

The demonstrated benefits of the program as they are outlined in a briefing document by the Treatment Advocacy Center (TAC 2005) are:

- It helps those who need it most, i.e. people with a high rate of involvement with the criminal justice system, psychiatric hospitals, and homelessness.
- The severest consequences from lack of treatment are reduced; hospitalizations, homelessness, arrests, and incarceration were all reduced from between 74% and 87% of the level experience in the three years prior to program entry.
- Participation reduces costs for the most expensive forms of psychiatric services, e.g., hospitalization days were reduced from an average of 50 days in the six months prior to participation to 13 in the six months after completion of the AOT program.
- Harmful behavior is reduced; suicide attempts, alcohol and drug abuse, damage to property, and incidences of harm (or threats of harm) to others are all reduced from between 43% and 55% for the six months after AOT as compared to the six months before.

It is further noted that medication compliance is substantially increased, and a survey conducted to assess opinions of participants indicated that they strongly believe that their lives have been improved by AOT.

Finally, it is indicated that the state's mental health system has improved its ability to treat all those in need including those who are difficult-to-treat. Factors of importance cited in this connection are increased collaboration between the mental health and the justice systems and increased accountability for results.

Summing Up

Although economic factors have been a prominent consideration in this report, humanitarian and public safety issues are equally important. Untreated mentally ill people can be a threat to themselves or others, but with treatment for their illness they do not represent a special risk in the community. The homeless people who are "living the way they choose" are often suffering from a frightening loss of cognitive ability and may be delusional, hallucinatory, or otherwise suffering mental anguish. They are suffering from a disease and are as deserving of treatment as people suffering from diabetes or other chronic diseases.

A primary purpose of this report is to convey information that will be useful in local applications of the models that have proven successful in other settings. Communities of all sizes have been successful in implementing programs that demonstrate an effective approach to dealing with their difficult-to-treat population. For jurisdictions that have not done so, formation of a task force to address the problem of mental illness in the homeless population and in our jails and prisons is in order. Given the cooperation of law enforcement, the justice system, mental health advocates, and other interested parties, the community can enjoy benefits as described herein.

A Call to Action

One goal of this report is to persuade communities that have not yet adopted programs to deal with their difficult-to-treat population, to do so. There are several compelling reasons why we can no longer sidestep the delivery of services to this underserved group.

One important reason for addressing this problem head-on is the cost of maintaining the status quo. The criminal justice system – law enforcement, prosecution, courts and corrections– has its hands full just processing those who legitimately belong there. Justice functionaries do not need, and should not be burdened with, clients whose needs are best served through structured treatment rather than incarceration.

A second reason for confronting this problem is that it is good for the community. Money that we are spending on the difficult-to-treat for short term care in hospitals, survival assistance in emergency rooms, shelter, soup kitchens, and the like, does little to improve their mental health. We are just propagating conditions that will make the public increasingly uncomfortable in communities that do nothing, or make only cosmetic changes rather than take meaningful action.

The third, but perhaps the most important reason for acting is that it is simply the right thing to do. Mentally ill homeless persons should not have to spend time in jail because the community has failed to provide for them. They should not be repeatedly hospitalized or living in boxes or under bridges because we choose to turn our heads, hoping they somehow will go away. Indeed, they will not, and their fate rests on the community's collective conscience.

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