



# **Nebraska Justice Mental Health Initiative**

## **Literature Review**

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## **Executive Summary**

It is estimated that approximately 50% of individuals lodged in U.S. prisons and jails have mental health concerns (BJS, 2006). A body of scholarly research has developed over the past few years aimed at investigating the issue and developing potential solutions. This review of the literature follows the Sequential Intercept Model developed by Munetz and Griffin (2006). The Sequential Intercept Model consists of five different intercepts, or critical points in the criminal justice process, where criminal justice and mental health systems can collaborate to meet the needs of individuals with mental illness involved in the criminal justice system: 1) involvement with law enforcement, 2) post arrest procedures, 3) post initial hearing procedures including incarceration in jails and prisons, 4) re-entry into the community, and 5) community corrections including parole and probation. The following conclusions are a result of the literature review:

### **Intercept One:**

1. Crisis Intervention Team (CIT) training has substantial research support and consists of specially trained law enforcement officers who develop the skills to effectively interact with mentally ill individuals and refer to appropriate services.

2. To be effective, Crisis Intervention Teams require access to emergency mental health services. Critical elements include high visibility of location, a single entry point, a no-refusal policy, streamlined and efficient intake procedures for police officers, established legal authority and policies for detaining mentally ill individuals, extensive and intensive cross-training and, procedures for linking mentally ill individuals with community services.

3. Other Intercept One interventions such as community based specialized mental health response and police based mental health response have limited empirical support and can be considered emerging practices.

### **Intercepts Two and Three**

4. There is preliminary empirical evidence supporting mental health diversion programs, which may be considered a promising practice. Research indicates that individuals in diversion programs spend less time incarcerated and receive more treatment than non-diverted persons.

5. Preliminary evidence indicate pre-booking diversion programs may be more effective than post-booking diversion programs.

6. Critical elements to ensure effective diversion programs include 1) screening groups of detainees for mental illness, 2) evaluation by mental health professionals of those identified during screening, and 3) collaboration among diversion personnel, defense attorneys, prosecutors and judges.

7. There is preliminary empirical evidence for the efficacy of mental health courts; however, unlike drug courts, there is not a uniform model for mental health courts. Mental health courts can be considered an emerging practice.

### **Intercepts Four and Five**

8. Critical Time Intervention (CTI) is a promising practice designed to strengthen the individual's ties to services, build problem-solving skills, and provide support during transition back to the community. This approach has been demonstrated to reduce days in psychiatric institutions, homeless nights, drug use, and negative symptoms of psychopathology.

9. Other interventions such as Forensic Assertive Community Treatment (FACT) and Assess Plan Identity Coordinate (APIC) have some preliminary empirical support and can be considered emerging practices. FACT promotes stability and independent community living through comprehensive mental health treatment for justice involved individuals. APIC focuses on transition planning based on accurate assessment of needs, planning for services to address needs across multiple domains (e.g., mental health, substance abuse, housing, healthcare, employment, income support), identifying effective services, and coordination of efforts across systems.

10. Guidelines for re-entry services include 1) forming partnerships to coordinate mental health and other support services (e.g., housing, employment), 2) integration of service delivery for co-occurring disorders, 3) involvement of community members and families in service planning and delivery, 4) use of evidence based treatment practices, and 5) ensuring culturally appropriate mental health services for racial, cultural and ethnic minorities.

## **Nebraska Justice Mental Health Initiative: Literature Review**

An estimated 50% of persons in United States correctional facilities have mental health concerns (BJS, 2006). In addition, the number of jailed individuals with mental illness continues to increase (Teplin, 1990; Teplin, Abram, & McClelland, 1996; Steadman et al., 1999). As a result, mental health and criminal justice experts have been advocating for increased attention to and implementation of programs that would identify mentally ill individuals involved in the justice system and improve the processes of connecting mentally ill individuals with appropriate community based treatments (Steadman et al., 1999)

Munetz and Griffin (2006) developed a conceptual framework, called the Sequential Intercept Model, for understanding the complex relationship between criminal justice and mental health systems. The model was developed as a method to address concerns regarding “the criminalization of people with mental illness” (p. 544). The model stresses the importance of considering various points in the criminal justice process where individuals with mental health concerns can be identified and receive the appropriate interventions. The model focuses on the creation and maintenance of a strong interface between mental health and criminal justice systems with a shared goal of “preventing individuals with mental illness from entering or penetrating deeper into the criminal justice system” (p. 544). The model describes five different points in the criminal justice process as the most logical and appropriate points for intercepting an individual with mental illness. The ultimate goal is to identify individuals with mental illness at the earliest stages of the process throughout the multiple intercepts that span from the time of arrest to the time of reentry into the community following incarceration (including probation and monitoring).

The first intercept occurs at the point where a person with a mental illness comes into contact with a law enforcement official and includes efforts that divert individuals pre-arrest. The goal is for officers to have tools, skills and programs available to divert individuals with mental illness into intervention programs that can address their mental health needs without arresting them and/or placing them in jail.

The second intercept occurs after an individual with a mental illness has been arrested and may be appropriate for diversion into a treatment setting as opposed to jail or prosecution. Based on the nature of the model, the types of programs and their utilization rate at this level can be largely determined by the interventions at intercept one. In other words, “if there is no prearrest or police level of diversion, people who commit less serious crimes will be candidates for postarrest diversion at intercept 2. In communities with strong intercept 1 programs, postarrest diversion candidates are likely to be charged with more serious acts (Munetz & Griffin, 2006, p. 546). In general intercept 2 interventions tend to include the screening of individuals by mental health workers at police departments, jails, and courts with the goal of avoiding incarceration.

The third intercept focuses on those individuals with mental illness who end up incarcerated. Typically court related and/or corrections related interventions are the focus of this intervention. Interventions such as screening for mental illness within the corrections placement and connecting the offender with services are typical. In addition, mental health courts are intercept 3 interventions and are separate court dockets that process offenders who would otherwise go through a traditional criminal court docket. The goal and focus of mental health courts is to “limit punishment and instead focus on problem-solving strategies and linkage to community treatment to avoid further involvement in the criminal justice system” (p. 547).

Intercept four is focused on the offender's reentry into the community after serving time in jails, prisons or hospitals including issues of monitoring and parole. The overall premise of this intercepts is to focus on continuity of care between corrections and mental health agencies during the transition. Muentz and Griffin (2006) emphasized that historically this has been an area where agencies have been particularly lacking in interventions and collaboration with one another. Interventions within these intercepts focus on the importance of agency collaboration and communication in the form of formalized programs. Examples include programs such as specialized probation officers and transitional day programs that offenders participate in immediately following release.

Intercept five is focused on some of the same issues as intercept four, however it also includes those individuals who were not incarcerated but were required to participate in probation type programs. Intercept five focuses on the need for a streamlined interface between probation services and mental health services. Mental health services are frequently a condition of probation for an offender and therefore it is important that the two systems work efficiently and effectively together to meet both the criminal justice and mental health needs and requirements of the offender.

Finally, in addition to the five intercepts discussed above, the authors stress the importance of a strong community mental health system which they refer to as "the ultimate intercept" (p. 545). At the same time the authors stress that "even the most underfunded mental health systems can work to improve services to individuals with the greatest need, including the group of people with serious and persistent mental disorders who have frequent interaction with the criminal justice system" (p. 547).

A Similar intervention model has been developed to specifically address the concerns regarding youth with mental health concerns who are involved in the justice system (Skowyra & Coccozza, 2006). The Comprehensive Model identifies seven critical intervention points “from intake to re-entry where opportunities exist to make better decisions about mental health needs and treatment” (Skowyra & Coccozza, 2006, p. 7). The model is based on the general belief that whenever possible juveniles with mental health needs should be placed in treatment rather than the justice system and for those juveniles who do require involvement of the justice system they should have access to evidence-based treatment. In addition, the model stresses the importance of collaboration across community systems in order to best meet the needs of those youth involved in the juvenile justice system. The intervention points in the Comprehensive model are similar to those in the Sequential Intercept Model however they are specifically concerned with juveniles. The intervention points include; 1) initial intake and referral, 2) intake, 3) detention, 4) judicial processing, 5) secure placement, 6) probation supervision, and 7) re-entry. At each intervention point the goal is to identify youth that are in need of mental health services, divert them from the justice system if possible, and if not to properly and adequately address their mental health needs while in the system (Skowyra & Coccozza, 2006). Both the Comprehensive model and the Sequential Intercept Model provide a helpful framework for understanding the complexity involved in the multiple systems involved when an individual with mental health needs is also involved in the justice system.

The Sequential Intercept Model is an important framework and tool for understanding the multiple issues and concerns related to the criminalization of individuals with mental illness. The following sections will provide a review of the relevant literature regarding efforts aimed at

addressing the relevant issues associated with individuals with mental illness in the justice system. The review will be organized according to the format of the Sequential Intercept Model.

### **Intercept 1: Law enforcement**

As reviewed above, Munetz and Griffin (2006) describe intercept one as including efforts and programs that focus on minimizing the number of individuals with mental illness who are arrested. Police officers play a central role in intercept 1 intervention efforts as they are often the first to respond to emergency calls involving mentally ill individuals (Compton, 2006; Hails & Borum, 2003; Lamb, Weinberger, & DeCuir, 2002; Shah, 1989; Teplin & Pruett, 1992).

Increasingly law enforcement agencies have responded to the call for increased attention to the issues of mentally ill individuals in the justice system by revising policies and procedures, often with input from and collaboration with mental health agencies, which improve interactions with mentally ill individuals and incorporate the use of diversion programs (Reuland & Cheney, 2005). As a result of this collaboration with mental health agencies, intercept 1 type programs are structured either within, or closely aligned with police departments. The general focus of these programs is on improving police response to situations involving mentally ill individuals.

Programs that fall under the intercept one definition are generally categorized into three major models (Borum, Dean, Steadman, & Morrissey, 1998). Deane and colleagues (1999) collected survey data from 174 police departments in cities in the United States with populations of 100,000 with the purpose of identifying and analyzing the different ways in which city police departments handle interactions with mentally ill individuals. The surveys revealed that 96 of the departments did not have specialized programs in place, while 78 of the departments reported specific programs in use. Deane and colleagues (1999) used the information reported by the police departments with specialized programs to outline and define three general types of

program organization. The three types of programs are described as 1) mental health based specialized mental health response, 2) police based specialized mental health response, and 3) police based specialized response.

The first type of program organization identified by Deane and colleagues (1999) is known as mental health based specialized mental health response. This type of program can be described as a more traditional model for police interaction with mentally ill individuals. In this type of program, police departments develop partnerships with mental health crisis teams that exist within the community mental health system and operate independently from the justice system (police departments, courts, etc.). In the mental health based system, police contact and request assistance from mental health professionals, who often report to the scene at the officer's request in order to assist them with mentally ill individuals (Cordner, 2006). An example of this type of program is Knoxville's mobile mental health crisis unit. For the Knoxville program, crisis teams based in the mental health system coordinate with the police department to handle incidents involving mentally ill individuals (Borum, 1998).

The second type of program organization is the police based specialized mental health response (Deane et al., 1999; Reuland & Cheney, 2005). This type of program is characterized by police departments that employ mental health professionals to provide telephone consultations to officers interacting with mentally ill individuals. An example of this program is the Birmingham's Community Service Officer (CSO) program. For this program the Birmingham police department employees and houses social workers on staff who handle incidents involving mentally ill individuals (Steadman et al., 1999; Borum et al., 1998).

The third type of program, police based specialized response, often called Crisis Intervention Teams (CIT), has received considerable attention in the literature. CITs are

characterized by utilization of police officers who have received special training in issues of mental health and crisis intervention (Cordner, 2006; Law Enforcement News 2000; Reuland & Cheney, 2005). These officers serve as the “first line of response” to dispatch calls involving mentally ill individuals. In addition, these specially trained officers serve as liaisons between the police department, the community and the mental health system. The purpose of the CIT programs is to intercept mentally ill individuals prior to entrance into the justice system (jails, courts, etc.) and to either handle the situation on scene (without further processing) or to divert the mentally ill individual into the mental health system for evaluation (Cordner, 2006; U.S. Department of Justice, 2000).

Perhaps the most widely cited and highly regarded example of this type of program is the Memphis Crisis Intervention Team (CIT; e.g. Compton, et al., 2006; Borum et al., 1998; Law Enforcement News, 2000; Munetz, et al., 2006). The Memphis CIT was established in 1988 as a collaborative effort between the police department, city administration, family members/advocates of individuals with a mental illness, mentally ill individuals, and mental health agencies following a police shooting of a young man diagnosed with a mental illness (Memphis Police Department, 2007). The principles and practices of the Memphis CIT have led to development of the “Memphis Model”, which has since been replicated in precincts across the country (Crisis Intervention Team Resource Center, 2007; U.S. Department of Justice, 2000). In addition, the National Alliance on Mental Illness (NAMI) has named the Memphis Model/CIT program as a best practice and has developed a resource center dedicated to CIT related program development and implementation (Crisis Intervention Team Resource Center, 2007). The Memphis CIT relies on volunteer officers who complete a 40 hour training curriculum provided by mental health professionals, legal experts, and family advocates from the community (Law

Enforcement news, 2000). The volunteer program is a competitive one that requires application and additional background checks. The officers perform the same duties as their non-CIT trained co-workers; however they are intentionally dispatched to calls involving mentally ill individuals. Approximately 10% of the police departments' uniformed police officers are part of the CIT. The department staffs a minimum of one specialist for each shift in each precinct. A special dispatch protocol has been established to efficiently and effectively divert specialists from other precincts when necessary (Memphis Police Department, 2007).

In addition to the training the officers receive, a key component of the Memphis model is the availability of a 24/7 no refusal psychiatric emergency room in which officers can take individuals for monitoring and evaluation (Steadman et al. 2001). This component of the Memphis model has been identified as vital for the success of the program because it allows the officer to easily and quickly connect an individual with mental illness to community services (Borum et al., 1998; Law Enforcement News, 2000; Steadman et al., 2001). Another component of CIT is minimizing the bureaucratic obstacles and time constraints officers face when working with mentally ill individuals. Often officers in police departments across the country who encounter mentally ill individuals are faced with the difficulty of making multiple contacts and waiting several hours with the individual in custody before they are able (and sometimes unable) to admit them into the mental health system. The time and effort required from officers in this type of a system can be daunting and frustrating and may lead to officers choosing the more streamlined administrative option of arrest and incarceration, which results in increased numbers of mentally ill individuals in jails (Borum et al., 1998; Steadman et al., 2001; Taft, 1980). As a result of experiences like these across the country, the CIT recognizes the importance of officers having simplified and direct access to mental health services. As Major Cochran, co-founder

and current Coordinator for the Memphis CIT program describes, “easy access to mental health facilities is crucial in keeping the mentally ill out of county jails...the prospect of a five or six hour wait before the person who is in crisis can be received by the [mental health] system could make the officers decide to deliver the individual to jail...” (Law enforcement news, 2000, n.p.). Steadman and colleagues (2001) have identified several important principles for successful operation of psychiatric emergency programs. The principles include high visibility of location, a single entry point, a no-refusal policy, streamlined and efficient intake procedures for police officers, established legal authority and policies for detaining mentally ill individuals, extensive and intensive cross-training and, procedures for linking mentally ill individuals with community services (Steadman et al., 2001).

There are few empirical outcome studies focusing on intercept 1 type intervention programs (GAINS/TAPA, 2004). The studies that have been conducted are typically on a small scale, utilized different methodologies, and investigated different variables. As a result, limited outcome data is available regarding the various programs, in part due to the difficulty associated with real-world settings of diversion programs and ethical and practical limitations associated with conducting rigorous outcome data studies (Steadman et. al., 1999). In general the outcome type studies fit into one of two categories, 1) they consist of case studies that focus on one type of program at one location and may or may not provide pre and post measures of outcomes, or 2) they compare outcomes of several different types of programs at different locations.

A study conducted by Bower and Pettit (2001) is an example of the first type of study category, as it focuses on one program (CIT) at one location (Albuquerque). The Albuquerque Police Department began a CIT program based on the Memphis Model in 1997 and according to departmental findings the program has produced positive results (Bower & Pettit, 2001). The

departments findings indicate that in 1999 the CIT team responded to 3,257 calls, 48% of the calls resulted in transporting persons to mental health facilities, while less than 10% of the calls resulted in arrest or protective custody (Bower & Pettit, 2001). The department also reported that since the implementation of the CIT program deployment of special weapons and tactics teams (SWAT) had decreased by 58%. In addition, despite the fact that the population of Albuquerque has grown substantially, the number of crisis related police shootings decreased from six individuals (from 1994-1996) to 4 individuals (from 1997-1999).

Another study (Lamb et al., 1995) focused on one type of program (police-based specialized mental health response) in one location (Los Angeles.) Lamb and colleagues (1995) investigated the number of consecutive referrals made to the Los Angeles SMART emergency outreach teams resulting in arrest. Out of 101 consecutive referrals, only 2 were jailed while 80 were transported to a hospital, and 69 were placed in an inpatient setting under a 72-hour mental health hold. Limited conclusions can be drawn from this information gained in the study due to methodological constraints; never-the-less the findings indicate that emergency outreach teams can be effective in minimizing arrests of persons with mental illness.

Steadman and colleagues (2000) conducted a study that compared three different programs models of police responses to individuals with mental illness at three different locations: Birmingham Alabama (community service officers), Knoxville Tennessee (traditional mobile mental health crisis team), and Memphis Tennessee (Crisis Intervention Team). The authors reviewed records of police dispatch calls, and incident reports to determine the frequency of response team calls and the proportion of incidents ending in arrest and incarceration. The findings regarding the frequency of the response team being called to the scene varied across programs: Knoxville's mobile crisis unit reporting to 40% of the calls involving a individual with

mental illness; in Birmingham 28% of the mental disturbance calls received a specialized response: and in Memphis the CIT was used in 95% of the calls reporting a mental health disturbance. The authors concluded the large differences found across the three sites in the percentage of calls receiving a specialized response, were related to differing staffing patterns and program structure. The researchers concluded that understaffing and a large catchment area of responsibility (5 counties) for the Knoxville program resulted in “lengthy response times [which] posed a significant barrier to the use of the service by police” (Steadman et al., 2000, p. 647). Steadman and colleagues further observed “police often expressed frustration and concern about delays and frequently made disposition decisions to jail individuals, transport them to services, or drop them off ‘somewhere’ without calling the unit” (Steadman et al., 2000, p. 647).

In Birmingham the authors believed that understaffing was responsible for the low percentage of mental health disturbance calls receiving the specialized response. According to the authors only 6 officers (out of 921) from the Birmingham police department had received specialty training as community officers and of those six none were on duty during the evening or weekend shifts (although 1 was on call). The percentage (95%) of specialized responses to mental disturbance calls was significantly higher for the Memphis program who had 130 (out of 1,354) officers on the intervention team. The authors concluded that the availability of an emergency psychiatric facility with a no refusal policy was likely a significant factor in the Memphis findings because it allowed for officers to quickly and effectively connect mentally ill individuals with services. Being able to do so quickly prevented the officers from being tied up for hours working on the one incident and instead allowed them to be available to respond to other calls for assistance.

The second part of the analysis from the Steadman and colleagues (2000) investigation focused on the outcomes of the calls involving the specialized response teams across the three departments. Results indicated that 35% of the mental health incidents for the total sample were resolved on scene with no further processing, while 13% of the incidents resulted in referrals to mental health professionals, 46% were immediately transported to a treatment facility (psychiatric, detox, general), and finally only 7% of the total incidents resulted in arrest. Memphis had the lowest percentages of arrests at 2%, while Knoxville had 5% and Birmingham had an arrest rate of 13%. Based on their findings, the authors concluded that the existence of a psychiatric triage or drop off center and the “centrality of community partnerships” were the programs key factors for success (Steadman, et al., 2000, p. 649). Overall the authors concluded “Our data strongly suggest that collaborations between the criminal justice system, the mental health system and the advocacy community, when they are combined with essential elements in the organization of services...may reduce the inappropriate use of U.S. jails to house persons with acute symptoms of mental illness” (Steadman, et al., 2000, p. 649).

Similar to Steadman and colleagues’ research, Borum and colleagues (1998) conducted a comparison of three different types of intercept one intervention programs. The authors compared one police based specialized mental health response program located in Birmingham Alabama which uses a community service officer program, the CIT program located in Memphis Tennessee and one mental health based specialized response program at in Knoxville Tennessee. The Knoxville department was used as the comparison site. The authors conducted surveys with patrol officers at all three locations, 452 officers responded. The surveys collected data on the officers perceptions of the role of mental illness in their jobs, the rate of their personal encounters with individuals with mental illness while on the job, self-perception of their

preparedness for interacting with mentally ill individuals on the job, perceptions of helpfulness of the mental health system, and perceived effectiveness of the department program in place. The findings indicated a high number of police reported encounters with individuals with mental illness, on average, across the three sites the officers reported 6 encounters in the past month. Ninety-two percent of the sample reported at least one encounter in the past month and 84% reported more than one. No significant differences were found across departments in terms of the officers perceptions of the degree of the problem that individuals with mental illness present for the department (approximately ½ of the officers at each site reported it as a moderate or big problem). When asked about preparedness, over half of the officers in each jurisdiction reported feeling well prepared to handle calls involving mentally ill individuals. However, within the Memphis department, those officers trained as CIT officers reported feeling significantly more prepared than non-CIT trained officers. As for the officer's perceptions regarding the mental health and emergency room systems, the Memphis officers tended to give the highest ratings of approval. In contrast, Knoxville gave the lowest ratings of the mental health system (85% did not view it as helpful). Finally, the officers were asked about their perceptions of the effectiveness of their respective programs. The Memphis CIT officers reported the highest rankings, while Knoxville and Birmingham had lower but similar rankings.

Based on the officers' responses, the authors concluded that minimizing the time involved for officers working on calls involving mentally ill individuals, and the availability of a psychiatric drop off was a very important element of program success. Overall, the authors concluded "Indeed, although each of these departments operate these programs as part of their community policing initiatives, mental health and social service infrastructures in each of these cities are somewhat different...this would appear to be a key operational consideration for law

enforcement agencies. The infrastructure of other services will affect the conceptualization of problem-solving approaches to mental disturbance calls and it most certainly affects the nature of the partnerships that need to be cultivated and developed to make the programs successful” (Borum et al., 1998, p. 403).

In 2003 the Police Executive Research Forum (PERF) conducted a survey and follow up interviews with 28 law enforcement agencies identified as utilizing specialized programs to respond to individuals with mental illness in police settings. In 2004 PERF performed follow-up interviews with 12 of the 28 agencies (Reuland & Cheney, 2005). Part of the interview data was focused on identifying common outcome goals across the various departments. Reuland and Cheney (2005) concluded that the four outcome goals common across the departments were; increased officer and civilian safety, increased officer understanding of mental illness, reduced numbers of individuals with mental illness being jailed, and improved relationships with the community (particularly mental health professionals, people with mental illness, and family members). According to the self-report interview data from the different departments, many of the departments reported improvements in these areas.

In conclusion, several different pre-arrest policies and programs are being implemented across the country to address the needs of individuals with mental health concerns who come into contact with the justice system. Some of these programs have received more attention and have been subjected to more rigorous empirical investigations than others. The CIT program has received substantial attention and is therefore is considered a promising practice for intercept one interventions. One of the key factors contributing to the success of intercept one programs is collaboration among criminal justice based agencies and mental health based agencies.

## **Intercepts Two and Three**

Munetz and Griffin (2006) describe Intercept 2 as occurring “postarrest” and Intercept 3 as occurring “post-initial hearings”. Intercept 2 is described as including postarrest diversion programs which target individuals with mental illness who have been arrested and may be appropriate for diversion at the time of initial detention and/or initial hearing, into treatment as opposed to jail and/or further judicial involvement (prosecution). Intercept 3 is described as targeting individuals with mental illness who were not diverted at the time of initial detention/hearing and therefore continue involvement in the criminal justice system, including admission into jails and prisons. Although intercepts 2 and 3 are clearly defined by Munetz and Griffin (2006) as distinct categories of intervention, the literature that falls under this purview is often not as distinctly defined as fitting into one or the other intercept. Therefore, the following section will discuss interventions that fall under the conditions described as Intercept 2 and/or Intercept 3.

Steadman and colleagues (1994) identified three core elements for both formal and informally based postarrest diversion programs (postarrest diversion programs generally fit the definition of Munetz & Griffin’s intercept 2). The elements include 1) screening defined groups of detainees for mental illness, 2) evaluation by mental health professionals of those identified during screening, and 3) collaboration among diversion personnel, defense attorneys, prosecutors and judges to consider the role of individuals with mental illness in the decision making process. Possible decisions may include, discontinuing further prosecution, a reduction of charges or community supervision under the condition of mental health service participation (Steadman, Barbera, & Dennis, 1994). According to these criteria Steadman and colleagues estimated that in 1994 approximately 50 formal jail based diversion programs existed in the United States (based

on a survey of 760 U.S. jails). Furthermore, the authors concluded that most of the formal programs served non-violent offenders, while a few included services for certain violent felonies, and most of the programs were based out of mental health centers.

One example of a postarrest diversion program is in Montgomery County Pennsylvania (Draine & Solomon, 1999). Bourm (1999) described the Montgomery County postarrest diversion practices as a model program. The county recognizes the need to identify relevant mental health information about individuals who have recently been arrested. The county has developed a plan to address the issue by providing corrections officers with specialty training, and implementing regular mental health screenings in the jail. Some of the corrections officers receive specialized training on how to recognize signs and symptoms of mental illness and how to properly refer those identified for further screening. An emergency services clinician conducts mental health screenings at the jail on a weekly basis. If a jail detainee is identified as having a mental illness, the mental health clinician works with the court to determine the most appropriate intervention including transferring the detainee to a secure emergency facility, a conditional release of the detainee with the detainee's assurance that he/she will follow-up with mental health services, or dropping the charges if it is determined that the individual may benefit from mental health based services as opposed to further involvement with the criminal justice system (Draine & Solomon, 1999).

Another example of a postarrest diversion program can be found in Summit County Ohio which uses a three-tiered approach that involves 1) screening of all detainees (not just those suspected of having mental health needs) during initial booking into the jail, 2) a cognitive functioning examination conducted by a mental health worker, and an evaluation conducted by a clinical psychologist (Council of State Governments, 2002).

A third example of a postarrest diversion program exists in Miami-Dade County Florida (Munetz & Griffin, 2006). The program in Miami-Dade County diverts misdemeanor defendants with a mental illness into community health services within 24 to 48 hours after arrest (Perez, Liefman, & Estrada, 2003). The process begins with a jail psychiatrist evaluating the detainee within 24 hours of arrest and determining if the individual meets requirements for involuntary hospitalization. Based on the psychiatrist's evaluation, the defendant's case may be moved to a diversion judge who will determine if the individual needs a secure mental health center. If the decision is made to move the individual, the State's Attorney considers the individual's criminal and mental health history and the current charges, when working with defense counsel to determine whether charges against the individual should be dismissed upon the client's stabilization or if further court involvement is warranted. If it is determined that further involvement is necessary, once stabilization is established the defendant is returned to the court where decisions are made regarding appropriate conditions of release. If the charges are dropped, the defendant is referred to a community treatment center for ongoing treatment. Perez and colleagues (2003) report that for misdemeanors, this process is the typical manner of adjudication. According to the Perez and colleagues the program utilized by Miami-Dade county has been successful in connecting defendants with necessary treatment and reducing costs from the previous protocol which often involved mentally ill individuals staying in jail for approximately 10 days waiting for costly evaluations and then being released from jail without treatment services (Perez et al., 2003).

One intervention that occurs at the post-initial hearings stage (Intercept 3) is that of mental health courts. Mental health courts fall under the general category of "problem-solving courts" which also includes other specialty courts such as drug courts and community courts

(Denckla & Berman, 2001). The focus of these problem solving courts has been to “move beyond standard case processing to address the underlying problems that bring people to court...in the process they seek to shift the focus of the courtroom from weighing past facts to changing the future behavior of defendants” (Denckla & Berman, 2001, p. 7). The first drug court opened in 1997 in Broward County Florida with a goal of reducing recidivism by providing court monitored treatment to defendants with mental illness. Since the Broward County mental health court opened several other jurisdictions have opened similar programs across the country (Redlich et al., 2005). Although jurisdictions have different procedures, in general defendants enter mental health courts after a series of mental health screenings and evaluations. As a condition of their participation in drug court the charges may be dismissed or prosecution is held over on the condition that the defendant successfully participates in and completes the court mandated treatment. Typically the type, level and requirements of treatment are determined on an individual basis according to the mental health status of the defendant and the nature of their criminal history and current charges (Denckla & Berman, 2001).

In 2000 Goldkamp and Irons-Guynn (2000) conducted a review of the first four mental health courts functioning in the United States; Broward County (Florida), King County (Seattle), San Bernardino, and Anchorage. As a result of the review the authors identified a set of eleven common factors across the different courts typifying the general mental health court approach.

1. Mental health courts address a specific issue (mentally ill defendants) and using innovated approaches combined with a court setting to address the often cyclical nature of the issue within the justice system.
2. Mental health courts focus on addressing issues of public trust and confidence related to mentally ill individuals in the justice system. In fact, several mental health courts have

been initiated in part as a response to a community tragedy involving a mentally ill individual.

3. Mental health court includes therapeutic jurisprudence, focusing on the role of mental health courts utilizing the law as a “therapeutic agent” (Denckla & Berman, 2001).
4. Mental health courts focus on accurately identifying individuals with mental health needs.
5. Mental health courts target individuals with mental health problems and emphasize the importance of early identification of individuals in the system, who may be appropriate for mental health courts, and of establishing eligibility criteria that target the appropriate defendants for participation.
6. Mental health courts have dedicated staff to work through the court procedures who are specially trained.
7. Mental health court staff have non-traditional roles Specifically the authors noted that the role of a dedicated judge and specialized staff was paramount to the success of the mental health courts and in order to make it work the staff had to be willing and capable of moving beyond the traditional, more adversarial approach in typical court rooms to a more collaborative team effort.
8. The eighth factor, voluntariness, highlighted the importance of mental health court participants choosing or volunteering to participate in the specialty court as opposed to the traditional judicial procedures.
9. Plea structure, acknowledged the importance of the different ways that pleas are handled as a part of the mental health courts. Two different plea options are typically used in the mental health court; a plea is accepted and later dropped or reduced after treatment is

successfully completed, or the charges are held over, and later dismissed after successful treatment completion.

10. Judicial monitoring, highlights the importance of regular meetings between the defendant and the mental health court judge who monitors and responds to progress.

11. System integration, highlights the role of collaboration and partnership across community systems (mental health, court, drug treatment, etc.) in a concerted effort to address the needs of the offenders and the community.

Cosden and colleagues (2005) conducted a randomized experiment comparing two groups of offenders, one group (MHTC group) participated in a mental health court while the other group was processed through the criminal justice system in the traditional manner (treatment as usual group, TAU). The differences between the conditions of treatment for the two groups were substantial. The study followed and assessed the participants, the majority of whom had dual diagnosis, for a two year period, collecting data at intake and every six months up to the 24<sup>th</sup> month. The measurements used at every data collection interval included; 1) the Global Assessment of Functioning, 2) the Lehman Quality of Life Scale—Short Form, 3) the Behavior and Symptom Identification Scale-32, and 4) the Addiction Severity Index. The authors hypothesized that compared to the TAU offenders the MHTC offenders would have reduced levels of criminal activity, alcohol and drug problems, and psychological distress while also demonstrating improvement in independent functioning and life satisfaction.

Findings from the study indicated that generally the first hypothesis was not supported, as the group of offenders in the MHTC group had higher levels of jail/prison time than they had before participation in the program. However, the authors noted because a subset of offenders accounted for approximately 54% of the total post-program jail days which resulted in the

number of average jail days across all participants did not “portray a typical response pattern” (p. 206). The authors then conducted a series of analysis that excluded the subset. Once that group of offenders (approximately 20% of the total) was removed from the analysis “the remaining participants averaged fewer jail days after entering treatment than before, with a greater reduction in jail days noted for participants in the MHTC than TAU” (Cosden et al., 2005, p. 207).

The authors hypothesis regarding improvements in psychological functioning were partially supported as both the MHTC and TAU participants demonstrated improvements. However, the MHTC group demonstrated a greater improvement in life quality than TAU participants while also demonstrating a more significant reduction in problems with drugs and psychological distress. The authors conclude that “treatment bleeding” may have effected the findings indicating improvements for the TAU group. Further analysis revealed that both groups were utilizing treatment from community sources throughout the study. The two groups had rates of treatment during the 6 months prior to starting the program and at the time of the 24 month follow-up. However, the MHTC group was engaged in significantly more hours of treatment during the six, twelve, and 18 month data collections. They conclude that the TAU group was receiving services although not of the same caliber or quantity as the MHTC group.

McNiel and Binder (2007) conducted an evaluation of mental health court effectiveness by using a “retrospective observational design” which matched 170 defendants who participated in a mental health court with offenders who did not participate in mental health court but were arrested during the same time period. Based on the results from a propensity-weighted Cox regression analysis which controlled for various demographic, clinical and criminal variables, the authors concluded that individuals who participated in the mental health court demonstrated

longer time periods without new criminal charges. In addition, individuals who successfully completed the program were less likely to recidivate when no longer under the supervision of the mental health court (McNiel & Binder, 2007).

Despite the recent popularity and attention given mental health courts, there remains much discussion and some criticism within the field regarding their status (Bazelon Center for Mental Health Law, 2003; Seltzer, 2005; Steadman, Davidson, & Brown, 2001; Stefan & Winick, 2005). Criticisms regarding mental health courts range from procedural issues to issues of public policy. For example, the lack of a universal definition for mental health courts and for what the core components of mental health courts are (or should be) is a concern for some (Steadman et al., 2001; Stefan & Winick, 2005). In fact mental health courts have been referred to as “idiosyncratic” in terms of their operations and intervention styles (Steadman et al., 2001; Stefan & Winick, 2005). According to Steadman and colleagues (2001) mental health courts are a concern because “the lack of any common model other than a hybrid of drug court principles and use of existing community-based services for persons with mental illness...unlike drug courts mental health courts have no such infrastructure or model” (p. 457). The lack of empirically rigorous outcome data to demonstrate mental health courts effectiveness has also been a significant criticism (Steadman et al., 2001; Stefan & Winick, 2005). Another criticism of mental health courts is that they result in individuals in the criminal justice system, as opposed to individuals with mental health needs who are not in the system, “ironically receiving priority access to needed mental health services” (Stefan & Winick, 2005). Other criticisms of mental health courts have been raised by advocates for the rights of individuals with mental health needs. Their concerns are that mental health courts create more stigma for individuals, violate their civil rights and, inadvertently divert attention from the underlying systemic problems that

result in individuals with mental illness coming into contact with the justice system in the first place (Seltzer, 2005). In other words, Seltzer believes the presence of mental health courts “makes it more difficult to generate political will to address the root of the problem” (p ?). Seltzer further concludes that “mental health courts fail to address the root causes of the overrepresentation of people with serious mental illnesses in the criminal justice system...communities would be better served by undertaking broad reform of the community mental health system...” (p. 584).

In response to some of the concerns and criticisms regarding mental health courts, alternatives have been forwarded by others in the field. For example, Seltzer (2005) argues that jurisdictions should focus attention and resources on prevention, pre-arrest diversion programs (such as those described in Intercept 1), and postbooking programs that address the issue without specialty mental health courts.

Clark (2004) argues for the implementation of alternative methods instead of mental health courts and proposes a model for such programs. His model focuses on two important decision points within the system; the pretrial release decision, and the decision to deter prosecution. Clark argues that paying special attention to the timing and available options of those decisions can effectively accommodate jurisdictional needs regarding mentally ill individuals within the system. Clark (2004) describes two programs (Connecticut state and Hamilton County Ohio) that exemplify his model. Both programs include mental health screenings of all arrestees by either court or jail based agencies and a follow-up assessment conducted by a mental health practitioner for those identified in screening. The results of the assessment are then presented to the judge at the initial court appearance, in addition, the judge is

also presented with individually tailored (to the offenders needs) options for pretrial release or deferred prosecution.

Clark (2004) argues that this model is a positive alternative to specialized mental health courts because it addresses some of the criticisms aimed at those courts. Specifically Clark believes that the alternative offers a way to address the needs of individuals with mental illness in the justice system without the added stigma associated with mental health courts and by targeting all individuals that may benefit from the services, not just those who meet the criteria for a mental health court.

The Pretrial Services Resource Center (YEAR, PSRC) conducted a survey aimed at identifying programs across the country that fit with Clark's (2004) model, and specifically excluded jurisdictions utilizing mental health courts. From the surveys and follow-up interviews PSRC identified 12 jurisdictions (including the two described by Clark) as programs fitting the criteria. These programs included thorough mental health screenings for all arrestees, assessment by a mental health professional of individuals identified in the screening process within hours of screening, and a streamlined process of getting the assessment information and recommendations to the pretrial judge or prosecutor. The authors concluded that in general the 12 jurisdictions made decisions based on streamlined information, they utilize a variety of community treatment options, most do not automatically exclude defendants charged with felonies, the sizes of the twelve jurisdictions vary widely, and most of the programs were relatively new. The follow-up interviews revealed seven critical elements of successful programs as identified by the jurisdictional representatives. The critical elements include; 1) the involvement of representatives with decision making authority from all key agencies, including a mental health advocate, 2) strong judicial leadership, 3) the ability of mental health specialists to

have easy and quick access for assessment purposes, 4) the availability of adequate mental health resources (including providers willing to take court referrals), 5) providing offenders with assistance in complying with imposed conditions, and 6) the importance of patience with the process, system and various stakeholders involved.

The Consensus Project report (Council of State Governments, 2002) defines ten policy statements/recommendations for addressing the issue of mentally ill individuals within the justice system specifically addressing issues relevant to the post arrest time frame: 1) the importance of defense attorneys being knowledgeable about the mental health status of their clients and of the knowledgeable about community mental health based resources, and knowledgeable about current relevant legislation and case law related to mental health, 2) the importance of consultation with individuals who may have been victimized by an individual with a mental illness, 3) the importance of maximizing the use pretrial diversion programs as opposed to prosecution when appropriate, 4) the importance of modifying pretrial diversion criteria as needed to facilitate defendants with mental illness' success in complying with pretrial diversion conditions, 5) the importance of maximizing the options available for pretrial release for individuals with mental illness, 6) the importance of modifying pretrial release conditions as needed to facilitate defendants with mental illness' success in complying with release conditions, 7) the importance of having screening, crisis intervention, and short-term treatment mechanisms in place in jails and detention centers, 8) the importance of the availability of dispositional alternatives relevant to individuals with mental illness, 9) the role of utilizing various sentencing options as appropriate for individuals with mental illness, and 10) the importance of assisting offenders who receive probation with meeting the conditions of their probation.

In conclusion, intercepts two and three are essential intervention points for identifying and addressing the needs of individuals with mental health needs who are in the criminal justice system. Several different policies, procedures and programs are utilized across the nation to target these individuals. Arguably the intercept 2/3 intervention receiving the most attention is the concept of mental health courts. However, there is some disagreement within the literature on the appropriateness and effectiveness of mental health courts. This issue is sure to continue to be a topic of scholarly inquiry and debate. Regardless of whether or not a specific program is utilized interventions at this point in the intercept model are important and require collaboration amongst criminal justice and mental health agencies in order to be the most successful.

### **Studies that compare programs from Intercepts one, two and three**

Some research examined programs from multiple intercepts within one investigation. For example, the Center for Substance Abuse Treatment and the Center for Mental Health Services both of SAMHSA collaborated on the Jail diversion and Knowledge Development and Application (KDA) project in 1997 with the goal of uncovering information that would lead to improvement of diversion programs (GAINS & TAPA, 2004). The project included several different sites in the investigation (both pre and post booking programs) and included data from a large number of diverse study participants. The pre-booking programs included in the study were Montgomery County Pennsylvania, Memphis Tennessee, Multnomah County Oregon, and Wicomico County Maryland. The study examined outcome data for diverted clients who met eligibility requirements for a serious mental illness and a co-occurring substance use disorder. The investigation utilized a quasi-experimental non-equivalent comparison group design. Participants were interviewed three times (baseline, 3 months and 12 months). Several differences between the diverted and non-diverted groups were found in the baseline analysis;

“diverted participants were more likely to be female; have a primary diagnosis of schizophrenia or a mood disorder with psychotic features; receive Supplemental Security Income or SSDI have higher Colorado Symptom Inventory scores indicating better mental health; and report higher life satisfaction” (GAINS & TAPA, 2004, p. 5). In addition, the non-diverted group was more likely to live with a spouse or partner, have been arrested/spent time in jail previously, and to have substance use problems. However, the two groups were similar on issues such as employment, ethnicity/race, educational experience, age, physical health, previous treatment and previous victimization and violent acts.

Results demonstrated that non-diverted offenders spent less time in the community during the year following the arrest. In addition, the diverted group participated in significantly more mental health treatment during the study than the non-diverted group. However, both groups had relatively equivalent levels of mental health improvement and additional arrests during the 12 months. As a result of the findings, the authors of the study concluded “Jail diversion ‘works’ in terms of reducing time spent in jail, as evidenced by diverted participants spending an average of two months more in the community (GAINS & TAPA, 2004. p. 7).

Lattimore and colleagues (2003) conducted a study which examined the characteristics of diverted offenders from 8 jurisdictions at the time of baseline. Five of the jurisdictions had post-booking diversion programs while the remaining three had pre-booking diversion programs. The focus of the analysis was to describe and compare the characteristics of offenders in the pre and post booking programs. In general the authors found that postbooking offenders scored worse on indices of social functioning such substance use and criminal involvement histories. However, results also indicated that the pre and post diversion groups were similar in their baseline levels of mental health functioning. In addition, the authors also noted variability between sites (even

those of the same diversion type) in terms of target population, selection criteria, and services available. The authors conclude that perhaps the pre and post booking programs are actually addressing different populations and that because the postdiversion programs seem to be addressing the needs of more seriously impaired individuals, the authors suggest that future studies take this into consideration when comparing pre and post diversion programs. Draine and colleagues (2005) found similar differences between the characteristics of pre and postbooking offenders. Baseline data from their study revealed postbooking diversion offenders to have a criminal history including probation or parole and to have participated in substance abuse treatment as compared to the prebooking offenders whereas offenders in the pre-booking program were more likely to be demonstrating acute symptomology and to be diagnosed with psychosis NOS.

Draine and colleagues conclude that based on the characteristic differences of offenders in the different types of programs future research should be cautious to compare pre and post booking type programs; “the more appropriate research question for comparing and contrasting the outcomes of these program models is who benefits from which program and in what ways...” (Draine et al., 2005, p. 180).

#### **Intercept 4: Reentry from jails, prisons**

As described above, intercept four is focused on the offender’s reentry into the community after serving time in jails, prisons or hospitals including issues of monitoring and parole. The overall premise of this intercepts is to focus on continuity of care between corrections and mental health agencies during the transition. The following segment is a review of the literature on models/interventions related to the transitional planning from institution to community (intercept 4).

Reentry involves reintegration of offenders back to communities after being discharged from prison or jail. It is estimated that about 600,000 adults discharged from jails and prisons return to the communities each year (Petersilia, 2004; Visher & Travis, 2003). It is reported that about 16% of discharged individuals have a serious mental illness (Ditton, 1999) and that this subpopulation is more likely to return to incarceration (Consensus Report, 2002). There are different types of challenges for individuals returning from prison or and individuals returning from jails. Individuals in prison may spend longer periods of separation from their community, and this can make transition more difficult (Draine et al., 2005) as personal and community connections once used to navigate through the community are gone. On the other hand, individuals in jails spend shorter periods of time incarcerated compared to those in prison, however these short episodes in jail can also make the transition from jail to community challenging (Oshner, 2003) with less available time spent on planning reentry.

Individuals with mental health problems discharged from either prison or jail face two risks: the risk of recidivism and the risk of relapse. For people with mental illness leaving prison, discharge planning to coordinate supports with treatment is rare (Draine & Herman, 2007); however, preparation for release, including planning for rehabilitation and treatment, is an essential part of ensuring the care this vulnerable population (The Council of State Governments, 2002).

Once in the community, this subpopulation has multitude needs, including housing, employment, transportation, treatment, and navigation of services, among others. Draine and colleagues (2005) present an interdisciplinary conceptual model to understand community reentry for former prisoners with mental illness- the “shared responsibility and interdependent” model. The goal of this model is to improve on traditional models by focusing on the

interdependence between the community and individual (Draine et al., 2007). At the core of the model is the individual, and surrounding the individual is the community with various domains of support such as housing, jobs, services, and treatment. The challenge is in pulling the community towards the individual and creating a match between the resources/needs of the individual and resources/needs of the community. Essentially, this model of reentry is a social resource exchange process. Current interventions that support transition from jail/prison to community focus on enhancing the integration of resources/services and continuity of care, thus bridging the gap between community and individual. The integration planning requires connecting services in the community at time of discharge for the inmate to reduce the likelihood of entering the cycle of relapse and reentry.

The coordination and provision of community services has been described as an “essential component of community reintegration,” particularly for juvenile offenders as it has been associated with lowered rates of recidivism (Trupin, Tuner, Stewart, & Wood, 2004). One promising model to enhance connections to community resources is the Critical Time Intervention model (CTI; Draine & Herman, 2007). CTI is actually reviewed and listed on SAMHSA’s National Registry of Evidence Based Programs and Practices (NREPP, 2008). The aim of CTI is to strengthen the individual’s ties to services and provide support during transition, in efforts to sustain long term recovery and reintegration. This is done through building problem-solving skills, motivational coaching and advocacy with community agencies (Draine & Herman, 2007). While the evidence base on CTI for former prisoners with mental health problems is limited, it has been shown to be effective in reducing days in institutionalized mental health settings, and drug use among homeless veterans with mental illness discharged from inpatient care settings (Kaspro & Rosenheck, 2007). Additional outcomes include reduction in

homeless nights, reduction in negative symptoms of psychopathology, and it has also been shown to be a cost-effective intervention (NREPP, 2006). Although there are no randomized trials on the impact of CTI on reentry for people with mental illness leaving the criminal justice system, it is posited that CTI may serve as an alternative model in the hope to reduce recidivism and involvement in the criminal justice system.

Another model that has been proposed for this population is the Forensic Assertive Community Treatment (FACT) team. The FACT teams are interdisciplinary, community based treatment teams that provide treatment and support services for individuals with severe mental illness involved in the criminal justice system. The FACT team is an adaptation of the Assertive Community Treatment (ACT) teams that were formed in the early 1970s as a service delivery model that was based in the community, and included representation from psychiatry, nursing, substance abuse treatment, and vocational rehabilitation. The ACT model promotes clinical stability and independent living through a “team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness” ([www.actassociation.org](http://www.actassociation.org)). The goal of the program was to reduce the number of repeated hospitalizations of individuals with severe mental illness. The effectiveness of ACT at reducing the number of days spent in hospitals was demonstrated across several different studies (Morrissey & Meyer, 2005), however studies regarding ACT have found that the program was not consistently effective in reducing arrests/jail time (Bond et al. 2001, Morrissey & Meyer, 2005).

More recently some of the philosophies and components of the ACT program have been adapted and utilized with forensic populations with the goal of preventing arrests and incarcerations for individuals with mental illnesses who have criminal justice histories. FACT

incorporates both community based treatment interventions and criminal justice components. A universal definition and/or understanding of what a FACT intervention includes have not been established at this time. However, Lamberti, Weisman, and Faden (2004) identified 16 different programs that are FACT like, as they target forensic populations, and have similar service and system elements included in the program. No rigorous empirical data is currently available on the effectiveness of FACT programs, however three of the sixteen programs identified by Lamberti and colleagues reported descriptive outcome data. One of the programs, the Arkansas Partnership Project, reported that their first 18 participants in the program remained arrest free for an average of 508 days. Other programs (Threshold Jail Project and Project Link) reported that the number of days spent in jail dropped for their participants during the first year of participation. The Massachusetts forensic transition program is another program serving individuals with mental illness who were involved in the justice system. Among those who received services (n = 233 ), 57% were living in the community and receiving mental health services, while 20% were hospitalized after release, 10% were reincarcerated, and 3% were hospitalized after briefly staying in the community after discharge (Hartwell & Orr, 1999). Although these preliminary results show promise for justice involved persons, further research is required to demonstrate the effectiveness of forensic assertive community treatments (Lamberti, Weisman & Faden, 2004).

Although there is little empirical research on transition planning models, programs like the Assess Plan Identity Coordinate (APIC) model provide a promising strategy to improve reentry. The APIC model emphasizes inmates needs, identifies community and correctional post release programs, and coordinates the transition plan (Osher, Steadman & Barr, 2002). According to the model, planning starts through proper screening and assessment before leaving

jail/prison. The second step includes **P**lanning of the needs, which may include mental health or substance abuse services, housing, healthcare, employment, and income support. The third component includes **I**dentifying how the needs will be addressed and met, when they will be met and by whom. The last component of the model is **C**oordination of assessment and transition planning to meet the multiple needs of the ex inmate (Osher, 2003). The National GAINS center adopted the APIC checklist for reentry as a tool to 1) identify the needs in the community after release, 2) identify the steps taken by jails staff to meet those needs, and 3) identify the detainee's final plan and contact information for referrals.

Another integrated model addressing reentry for adults with mental illness is the Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM; Rotter, McQuiston, Broner, & Steinbacker, 2005). SPECTRM has two components: one for mental health providers and one for consumers. Providers attend workshop training on adaptive behaviors and cultural competency in respect to incarceration. The consumer component consists of the RAP program, a cognitive-behavioral based program that targets social skills training to assist in adaptation to the community. The SPECTRM can be viewed as a therapeutic model to potentially facilitate integration between providers and client; however, further research is needed to evaluate the effectiveness of the model.

It is suggested that one way to address outcomes for individuals with mental illness in the criminal system is through the adaptation of evidence based practices (EBP; Osher & Steadman, 2007). It appears that the integration of systems (i.e justice system and mental health systems), services, and needs is necessary to markedly improve reentry. However, a systematic evaluation of the service strategies being employed by over 58 reentry programs across the United States

revealed that the reentry programs are heavily dominated by the criminal justice system rather than cooperatively with the mental health system (Wilson & Draine, 2006).

In conclusion, research indicates the reentry can be a very difficult transition for individuals with mental health concerns in the criminal justice system. These individuals face many obstacles and the potential for relapse and/or recidivism is a real concern. Various policies and programs have been developed and implemented in an effort to improve the outcomes associated with this transition. It is clear that coordination between criminal justice and mental health agencies in terms of assessments and interventions is crucial to the success of individuals experiencing the transition.

#### **Intercept 5: Community corrections and community support**

The fifth intercept refers to mental health treatment as a mandated condition of parole or probation, both of which are community supervision programs. Over the past 25 years, community supervision has experienced a significant growth (Williams, 2007). It is estimated that about 16% of persons on probation have a diagnosable mental illness (Ditton, P.M, 1999) and that 1 out of 5 mentally ill offender is committed to a mental health center directly from prison as a part of parole (Feder, L., 1991). Evidence on whether mental health services reduce incarceration risk for psychiatric individuals in parole or probation is mixed (Solomon, Draine, & Marcus, 2002). Among those incarcerated for a probation or parole technical violation, higher rates of incarceration is associated with being hospitalized, taking prescribed medication, and receiving intensive case management services. Factors protecting against incarceration included engaging in any form of therapy (Solomon, Draine, & Marcus, 2002). Other research suggests that mentally ill offenders do well with structure and counseling; continuation of medication and vocational training helps their stability in the community (Feder, 1991).

One example of a community diversion program targeting mentally ill individuals on parole and probation is the Maryland Community Criminal Justice Treatment Program (MCCTJP) which features: case management services (crisis intervention, screening, counseling, discharge planning and community follow-up), housing support services, routine planning for criminal justice and treatment professionals, and post booking diversion programs for mentally ill defendants (National Institute of Justice, 1999). According to the Consensus Project (2008), data from 1994 to 1995 for the MCCTJP project indicate some success for the program. Of the 503 clients that received services, 5% returned to state psychiatric hospitals, 20% returned to detention centers and 5% returned to homelessness. In addition, data from the first quarter of 1996 indicate a reduction in recidivism for participants with only 7.4% returning to detention centers.

The Community Supervision Services division of the Court Services and Offender Supervision Agency (CSOSA) suggests that in order to improve offender outcomes, there needs to be a focus on evidence base practices, particularly targeting high-risk mentally ill offenders (Williams, 2007). There is little empirical research regarding what mental health practices work in parole and probation. In efforts to incorporate evidence based practices, the American Probation and Parole Association (APPA) developed a series of training programs (i.e. audio teleconferences, web casts, and CD) for rural and other training-challenged probation and parole officers of which over 5,000 probation and parole officers have participated. Other efforts to incorporate evidence based practices are presented by the Criminal Justice/Mental Health Consensus Project (Council of State Governments, 2002) which describes several policy recommendations, including : 1) promotion of evidence evidence-based practices and promising approaches in mental health treatment services 2) forming partnerships among mental health

services to be provide a full array of accessible services and an overall continuity of care; 3) integration of services for co-occurring mental health and substance abuse disorders; 4) development and enhancement of housing that are linked to appropriate levels of mental health supports and services; 5) involvement of community members and families in mental health planning and service delivery; 6) insurance of appropriate mental health services for racial, cultural, and ethnic minorities.