



STATE OF WASHINGTON

DEPARTMENT OF CORRECTIONS

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August 1, 2007

The Honorable Christine Gregoire, Governor  
Post Office Box 40400  
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The Honorable Tom Hoemann, Secretary of the Senate  
Post Office Box 40002  
Olympia WA 98504-0002

The Honorable Rich Nafziger,  
Chief Clerk of the House  
Legislative Building – 338B  
Olympia WA 98504

The Honorable James Hargrove, Chair  
Senate Human Services & Corrections Committee  
Post Office Box 40424  
Olympia WA 98504-0424

On behalf of the Statewide Council on Mentally Ill Offenders the enclosed report is respectfully submitted. This council was formed pursuant to a budget proviso signed by Governor Gregoire calling on the Department of Corrections to create a statewide council on mentally ill offenders. The Council was established in September of 2006 and has been meeting monthly since that time.

Should you have any questions or need any additional information regarding the report, please let me know.

Sincerely,

Thomas Saltrup, Ph.D  
Director of Behavioral Health

TS:sc

cc: Harold Clarke, Secretary  
Marc Stern, MD, MPH, Health Services Director

## **A Report to the Governor**



**Respectfully Submitted**

**by**

**The Department of Corrections**

**on behalf of**

**The Statewide Council on Mentally Ill Offenders**

**Promoting Public Safety and Reducing Incarceration of Persons with Mental Illness**

**June 30, 2007**

## STATEWIDE COUNCIL ON MENTALLY ILL OFFENDERS

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Washington State Department of Corrections  
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Peter Lukevich, Executive Director  
Partners in Crisis

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Peter Casey, Executive Director  
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Report prepared, under contract with the Department of Corrections, by  
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## Executive Summary

The Statewide Council on Mentally Ill Offenders was established by budget proviso in response to proposed legislation “to investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders or who have a history of offending.”

This is by no means the first initiative devoted to reducing the use of incarceration for persons with mental illness. In spite of efforts at the federal, state, and local levels, the status quo is characterized by partial successes:

- Effective programs are limited to particular localities, narrowly-defined populations, or late stages of intervention.
- These are not sufficient to counter a widespread perception—by consumers of mental health services, their families, and professionals in mental health agencies, police, jails, courts, and prisons—that “the system is not working.”

*After years of talking about what is needed, with partial and limited successes, we now have two choices:*

1. Develop a business plan with timelines for implementing a comprehensive, statewide approach to the appropriate use of criminal justice agencies and to identification, diversion, treatment, and community services at every stage of criminal justice involvement by persons with mental illness;
2. Acknowledge that jails, courts, and prisons will continue to serve as the default warehouses and providers of services for large and growing numbers of people with mental illness.

Taking the first course, this report outlines a comprehensive strategy:

- Diverse approaches at various stages of criminal justice involvement are organized by the widely-used strategic intercept model of intervention;
- Earlier intervention is emphasized, before people are adjudicated and sentenced;
- A ten-year timeline incorporates strategic decision-making, forming a business plan, and pursuing strategic objectives;
- Statewide implementation of best practices at each stage of criminal justice involvement is planned by 2017.

## PROMOTING PUBLIC SAFETY AND REDUCING INCARCERATION OF PERSONS WITH MENTAL ILLNESS

### **Introduction: A Fork in the Road**

The Statewide Council on Mentally Ill Offenders was established by budget proviso in response to proposed legislation “to investigate and promote cost-effective approaches to meeting the long-term needs of adults and juveniles with mental disorders who are likely to become offenders or who have a history of offending.” In its first year of operation, the Council has narrowed its focus to adults with mental illness who have come into contact with the criminal justice system. For this purpose, mental illness is defined as a substantial disorder of thought or mood which significantly impairs judgment, behavior, and capacity to recognize reality or cope with the ordinary demands of life; is manifested by substantial pain or disability; and requires continuing treatment to prevent deterioration or social dislocation.

This is by no means the first initiative devoted to reducing the use of incarceration for persons with mental illness:

- In Washington, Community Action for Mentally Ill Offenders (CAMIO) was formed in the mid 1980’s; some of its members went on to form the National Coalition on the Mentally Ill in the Criminal Justice System. Its 1990 report, with contributions from many scholars, served in the early 1990’s as a principal source of policy information.
- The University of Washington-Department of Corrections (DOC) collaboration convened a stakeholder group in the mid-1990’s that produced several policy reforms, including agreements among Regional Support Networks (RSNs) and DOC on enrollment procedures for persons with mental illness leaving prison.
- Many counties have instituted mental health courts for nonviolent offenders, which have been shown, in the few available outcome studies, to reduce the number and severity of re-arrests for offenders with mental illness. The larger county jails also run programs to divert and link persons with mental illness to community mental health agencies.
- In the late 90’s, the Washington State legislature created two programs to reduce recidivism among persons with mental illness after release from prison: the Mentally Ill Offender Community Transition Program (1998), based in Seattle, and the statewide Dangerous Mentally Ill Offender Program (1999), also referred to as the Community Integration Assistance Program. These programs were praised by Human Rights Watch in an otherwise scathing national report on mental illness and corrections (Ill-Equipped, 2003).

- Washington’s federally-funded Mental Health Transformation Project has adopted, as one of its three top priorities, a “decreased number of people with mental illness entering into the criminal justice system.”
- In 2004, the President signed the Mentally Ill Offender Treatment and Crime Reduction Act, which provides funds for mental health courts and other collaborative programs seeking to encourage the use of treatment alternatives to incarceration for nonviolent offenders with mental illness.

In spite of efforts at the federal, state, and local levels, participants in a joint conference organized in September, 2006 by the Washington Council of Sheriffs and Police Chiefs (WASPC) and the National Alliance on Mental Illness (NAMI) described policy, program, and funding patterns that continue to channel people with mental illness into jails, courts, and prisons. The status quo, in short, is characterized by partial successes:

- Effective programs are limited to particular localities, narrowly-defined populations, or late stages of intervention.
- These are not sufficient to counter a widespread perception—by consumers of mental health services, their families, and professionals in mental health agencies, police, jails, courts, and prisons—that “the system is not working.”

*After years of talking about what is needed, with partial and limited successes, we now have two choices:*

1. Develop a business plan with timelines for implementing a comprehensive, statewide approach to the appropriate use of criminal justice agencies and to identification, diversion, treatment, and community services at every stage of criminal justice involvement by persons with mental illness (see Appendix A for the elements of such a plan). A well-documented business plan is required to assure legislators and taxpayers that new initiatives are affordable and effective. Several types of approaches should be considered:
  - Construction of facilities designed for assessment, safe detention, and treatment of persons with mental illness who have been arrested or sentenced;
  - Policies and programs to use existing resources more effectively to promote community safety and the welfare of persons with mental illness;
  - Development of technologies and data sharing to improve collaboration and planning between criminal justice and social service agencies.
2. Acknowledge that jails, courts, and prisons will continue to serve as the default warehouses and providers of services for large and growing numbers of people with mental illness.

The following outline of a comprehensive strategy is offered on the assumption that Washington will choose the first course.

## **Scope of Problem**

Mental illness should not give rise to the pain and suffering of arrest and imprisonment, nor the associated loss of social participation and support, if these harms can be prevented by less coercive responses or by providing access to clinical care. People with mental illness, however, are disproportionately subjected to arrest, detention, sentencing and incarceration, posing barriers to appropriate treatment and placing undue stress on police, jails, courts, and prisons.

- A study in New York found that men involved in the public mental health system over a five-year period were four times as likely to be incarcerated as men in the general population; women were six times as likely.
- Using a narrow standard of diagnosed severe mental illness, it is estimated that 8% of jail admissions (1 million annually) represent people with schizophrenia, chronic major affective disorders, delusional disorders, and psychosis NOS.
- Los Angeles County jail and Rikers Island (New York City) each hold more people with mental illness than any psychiatric facility in the United States. A study of the Fairfax County, Virginia jail found that pretrial male detainees charged with misdemeanors and identified as psychotic stayed in jail 6.5 times as long as average jail inmates.
- Estimates of the percentage of the prison population with serious mental illness average approximately 15%, indicating that our state and federal prisons are holding approximately 300,000 mentally ill persons.

Because courts have accepted that corrections agencies have a duty to protect wards of the state from harm, prisons and jails are at risk when a case can be made that they have been deliberately indifferent to this obligation.

- Because funding for mental health staff is often insufficient and prisons and jails are organized to serve custodial rather than clinical purposes, distressing incidents involving abuse of inmates or failure to act to prevent harm are common.
- Reliable data about the clinical profile of persons arrested or detained are needed to support program planning by police, jails, courts, and social service agencies.

Fortunately, review of research and model programs in Washington and elsewhere in the U.S. indicates that much can be done to remedy these problems.

## **A Ten-Year Comprehensive Strategy**

The comprehensive strategy outlined here has three principal components:

1. Application of the widely-used strategic intercept model of intervention to organize diverse strategies appropriate to various stages of criminal justice involvement;
2. Emphasis on earlier intervention, acknowledging that most of our successes have occurred at later stages;
3. Establishing a ten-year timeline that incorporates strategic decision-making, forming a business plan, and pursuing strategic objectives along four tracks:
  - Building a political constituency;
  - Securing funding;
  - Changing laws and policies to facilitate program success;
  - Implementing programs with procedures for evaluation, and expansion.

### Sequential Model of Intervention

The sequential intercept model of intervention usefully identifies five stages of criminal justice system involvement at which programmatic initiatives and reforms in procedures may reduce the use of incarceration for people with mental illness:

1. *Law enforcement and emergency services.* Provide crisis intervention training to first responders, and provide police with alternatives such as diverting these individuals to treatment facilities in lieu of arresting and detaining people whose behavior reflects mental disturbance.
2. *Initial hearings and detention.* At initial hearings and arraignments, jail staff or mental health counselors may arrange for partial confinement in lieu of jail, referral to mental health services, and other community dispositions. In some cases, decisions about filing of charges may be postponed pending successful completion of diversion programs.
3. *Jails and courts.* Interventions at this stage include access to treatment in jail, linkage with community mental health providers, and mental health courts that typically provide alternative dispositions involving assertive community treatment on a deferred-prosecution basis.
4. *Re-entry from jails and prisons.* Here the focus is on ensuring that when offenders leave confinement, they have a safe place to live, and adequate support in terms of

income, medical benefits and medication, and timely access to treatment with community providers—including assignment to collaborative case management teams. Because short stays in jails create a different set of transition issues from those of prisons, we provide separate discussions of Intercepts IVA (jails) and IVB (prisons).

5. *Community corrections and support services.* Renewed offending and incarceration may be prevented if case managers from correctional and social service agencies work together to minimize risks, maintain stable housing, and encourage the client’s continuing participation in appropriate clinical services.

A Washington study, the largest yet conducted in the U.S. of people with mental illness after release from prison, indicates that jails represent a strategic missed opportunity for intervention:

- Of 219 subjects released from their first prison term, there were 164 (75%) with previous offenses, ranging from one up to 28 in number with an average of 5.5
- After release from prison, 63% of those who eventually committed another felony were arrested meanwhile for misdemeanor offenses, averaging 3.4 “harbinger arrests” apiece.

#### Emphasis on earlier intervention

From the premise of mitigating harm to persons with disability and reducing social costs associated with untreated mental illness, it follows that, wherever possible, earlier intervention is better than later.

Once persons with mental illness have arrived in prison: (1) a substantial investment has already been made in prosecution, sentencing, and incarceration; (2) the continuity of their lives and relationships has been severely disrupted; and (3) they face the prospect of coping for months or years in an environment ill-suited to clinical care. They pose management challenges for prisons, and are likely to be released with diminished coping capacities and a poor prognosis for community reintegration.

- Court-directed programs have connected persons to treatment who otherwise would have been missed because they might not have sought or may not have met eligibility criteria for voluntary treatment, but are costly because once charges are filed, the administrative machinery of due process and disposition of charges must proceed.

An outline of a comprehensive strategy is presented below, followed by a timeline. This outline will remain hypothetical unless details are filled in by an expanded group of concerned citizens and professionals ranging from local consumer groups to the Governor’s office. Following the outline and timeline, further information is presented about problems, solutions, and issues at each stage of intervention.

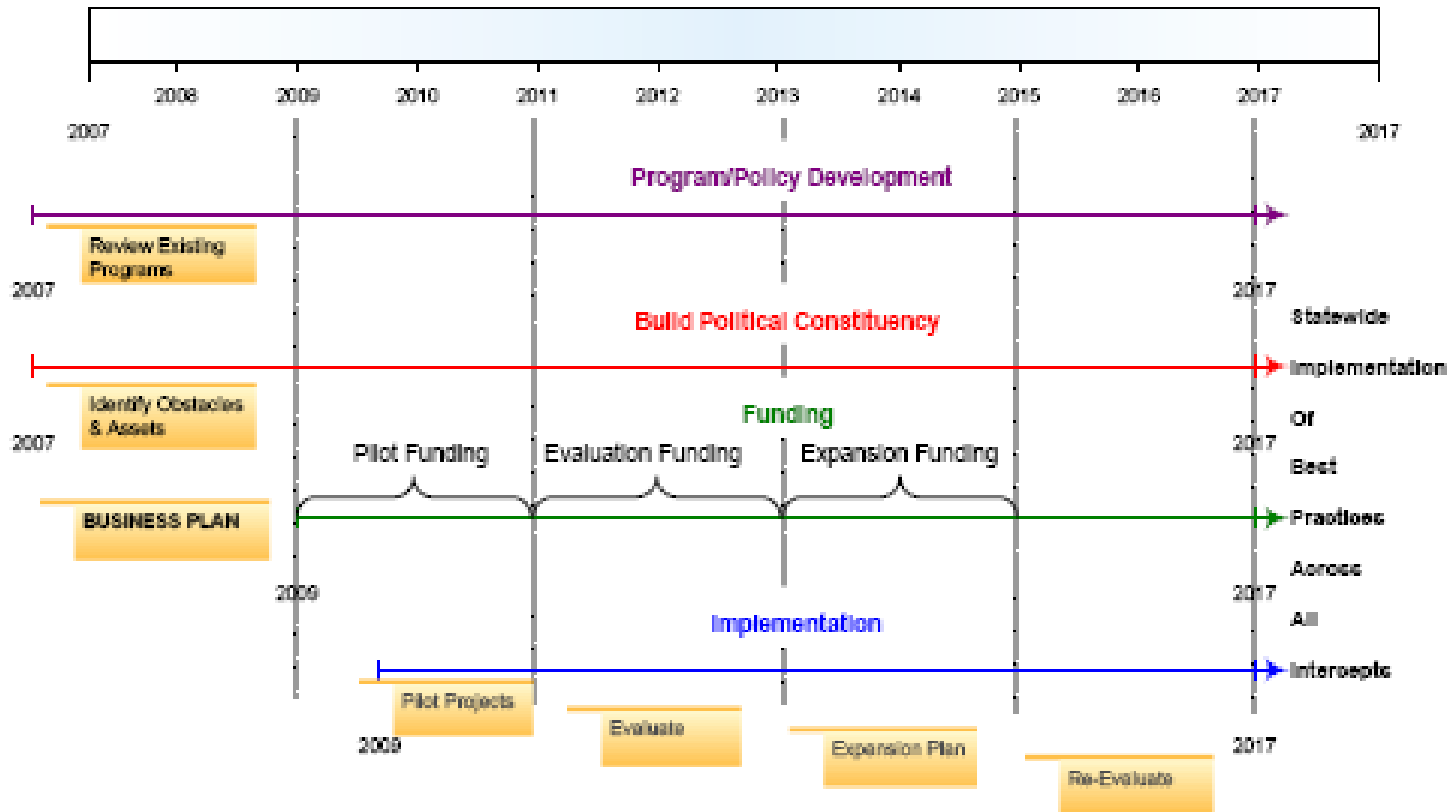
## Sequential Intercept Planning Outline

Intercept	Problems	Possible Solutions	Issues to be Resolved
I: Law Enforcement & Emergency Svcs	<ul style="list-style-type: none"> <li>• Erratic behavior evokes police response</li> <li>• Police feel unprepared</li> <li>• Emergency rooms take time, return offender quickly to streets</li> </ul>	<ul style="list-style-type: none"> <li>• Specialized &amp; trained response teams</li> <li>• Specialized crisis response sites</li> </ul> <p>[This section should, but does not, match the corresponding narrative above about sequential intercepts on page 7, item #1]</p>	<ul style="list-style-type: none"> <li>• Ability of specialized response teams to respond over large geographic areas on a 7/24 basis</li> <li>• Legal constraints on no-refusal and commitment authority of crisis stabilization centers</li> <li>• Expense of constructing and staffing secure facilities, duplication of nearby jail operations</li> </ul>
II: Pre-Booking Diversion	<ul style="list-style-type: none"> <li>• High flow of detainees with short stays requiring individualized responses</li> <li>• Stress on jail intake systems, e.g. restraint &amp; suicide issues</li> </ul>	<ul style="list-style-type: none"> <li>• MH screening &amp; diversion</li> <li>• Partial confinement pre-trial</li> <li>• Collaboration, jails &amp; social service/mh providers</li> </ul>	<ul style="list-style-type: none"> <li>• Consent &amp; privacy issues re information sharing between jail and mh agencies</li> <li>• Jail staff resources, training, and cultural resistance to incorporating clinical need into decisions</li> </ul>
III: Jails & Courts	<ul style="list-style-type: none"> <li>• Same as above, plus: standard sentences lack deterrent value</li> </ul>	<ul style="list-style-type: none"> <li>• Crisis intervention training for correctional staff</li> <li>• Mental health courts</li> <li>• Mental health professionals advise regular courts</li> </ul> <p>[This section should, but does not, match the corresponding narrative above about sequential intercepts on page 7, item #3]</p>	<ul style="list-style-type: none"> <li>• Interaction of public safety, accountability, and clinical needs</li> <li>• Use of court orders to circumvent restrictions on community treatment or hospital admission</li> <li>• Post-adjudication sentencing alternatives for felonies/ violent offenses</li> </ul>
IVA: Transition from Jails	<ul style="list-style-type: none"> <li>• Short stays + high traffic→ pre-release planning↓</li> <li>• Laws &amp; agency policies restricting service eligibility upon release</li> </ul>	<ul style="list-style-type: none"> <li>• Interagency collaborative planning begins @ intake</li> <li>• Expedited eligibility programs &amp; policies</li> </ul>	<ul style="list-style-type: none"> <li>• Policy vs. resource issues affecting eligibility &amp; transition planning</li> <li>• Federal vs. state rules &amp; regulations</li> </ul>
IVB: Transition from	<ul style="list-style-type: none"> <li>• Delays &amp; low intensity of svc,</li> </ul>	<ul style="list-style-type: none"> <li>• Funding for pre-release</li> </ul>	<ul style="list-style-type: none"> <li>• Expense of intensive treatment &amp; housing for persons with</li> </ul>

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Prisons	limited housing options <ul style="list-style-type: none"> <li>Restrictive Medicaid eligibility rules</li> <li>Walls between prison &amp; comm. mh staff</li> </ul>	planning & engagement <ul style="list-style-type: none"> <li>Medicaid eligibility waiting period waivers</li> <li>Interagency collaboration</li> </ul>	mental health stigma, extensive or violent records <ul style="list-style-type: none"> <li>Prison staffing &amp; administrative resources for assessment, treatment, &amp; pre-release planning</li> </ul>
V: Community Services & Supervision	<ul style="list-style-type: none"> <li>Incentives to preserve resources for existing clientele</li> <li>correctional vs. social service methods</li> </ul>	<ul style="list-style-type: none"> <li>Collaboration policies, local staff relationships</li> </ul>	<ul style="list-style-type: none"> <li>Distinct authority &amp; practices of correctional, social services, statewide and local agencies</li> </ul>

## Mental Health/Criminal Justice Reform Timelines



## Intercept I: Law Enforcement, Emergency Services

**Problem:** Incidents involving mental illness, or erratic behavior stemming from other causes such as intoxication, present officers with the complex task of achieving an appropriate disposition in the face of difficult situations and limited disposition options. The challenges facing police officers may have increased since the 1960's due to closure of 90% of state hospital psychiatric beds, combined with gaps in community mental health services.

- In addition to the time required to work with hospital staff, officers are also frustrated when admission is refused or potential detainees are quickly returned to the streets with no improvement in circumstances or behavior.
- Officers often feel unprepared to handle incidents involving apparent mental disturbance.

**Possible Solutions:** Two principal tactics have been applied in Washington and elsewhere.

1. Training of police officers or civilian staff, both throughout law enforcement departments and in specialized units—Crisis Intervention Teams (CIT)—on methods of

responding to highly agitated citizens and use of dispositions other than arrest or detention.

The Memphis, Tennessee CIT & Crisis Center combination is seen as a model program:

- It combines both street-level police teams and alternatives to jail detention, developed through an extended process of inter-agency collaboration;
- The Crisis Response Center has a no-refusal policy;
- It has the highest rate of mental disturbance incidents ending at a treatment location (75%), and the lowest rate ending in arrest (5%).

The Birmingham, Alabama program is slimmed down and inexpensive compared to Memphis; it produces a higher rate of arrests (13%), much less use of a treatment location (20%), and a much higher proportion of incidents resolved on the scene (64% vs. 23%).

2. Development of specialized crisis response sites (“triage” centers) that temporarily detain and assess detainees, after which they may proceed into the criminal justice system or be diverted into appropriate mental health, substance abuse, or dual diagnosis programs.

Whether Washington state law provides the authority for a no-refusal policy on the part of crisis response centers, seen as critical to some programs such as that in Memphis, is a matter of contention. Furthermore, for jurisdictions with fewer mental disturbance incidents, construction and staffing of a facility separate from a jail may not be cost-effective. Co-

locating facilities with jails can achieve some cost savings.

Given the demonstrated promise of interventions at this stage, a ten-year plan will need to begin with assessing where the use of crisis response centers is appropriate, the advantages of the different CIT models applied in Memphis, Birmingham, and other jurisdictions, and obstacles to more widespread use of any of these tactics.

## **Intercept II: Jail Diversion**

**Problem:** Up to 40% of adults with mental illness will come into contact with law enforcement and are often jailed for nonviolent, victimless crimes.

- The high flow of detainees into and out of jails, in combination with low mental health staffing levels, works against individualized responses and attention to the clinical needs of detainees.
- Urban jails are crowded, and substantial cost savings may be realized by diverting arrestees.

- A model program in Bexar County, Texas shares arrest data with an outside mental health agency, which screens detainees for likely mental illness before they are booked and makes recommendations on placement and the need for treatment.
- In King County correctional facilities, jail staff and administrators recommend placement for arrestees on partial confinement status through the Community Center for Alternative Programs. Substantial effort is devoted to assessing arrestees and channeling them into appropriate substance abuse or mental health treatment programs.
- In Pierce County, special funding arrangements have allowed community mental health caseworkers to work within the jail. As mental health agency staff, they have access to clinical information about arrestees and can readily make referrals.

**Possible Solutions:** The principal option at this stage requires jail intake staff to review arrestees to determine whether the nature of the incident and other information about the arrestee warrant release from continuing detention or transfer to partial confinement, accompanied by referrals to appropriate community social service agencies.

Systematic implementation of jail-based diversion programs requires attention to the following issues:

- Systematic sharing of data between correctional and social service agencies is hampered by issues of consent and protection of medical information.
- Approaching detention decisions from a clinical standpoint along with custodial risk factors is a cultural shift for many jail staff, involving issues of education and the

availability of time to make individualized assessments in a high-traffic administrative environment.

- Building staff-level collaborative relationships between correctional and mental health providers can increase the efficiency of diversion.

### **Intercept III: Jails and Courts**

**Problem:** Because of short stays and heavy traffic in jails, many of the problems, solutions, and issues apparent at Intercept II also apply at this stage, but there are further problems:

- Clinically adequate, constitutionally required levels of screening for mental illness upon intake, and care for persons with mental illness during confinement, are hampered by shortages of trained staff, limited programming and living quarter options, lack of historical information about people recently arrived at jail, and short stays before detainees move on.
- For individuals whose offending behavior reflects mental illness, standard sentencing options (fines, time in jail) may prove either harmful or lacking in deterrent value.

Mental health courts typically operate on a deferred-prosecution, pre-adjudication basis. Defendants stipulate to the facts alleged in the filed charges, prosecution is deferred, and return to jail and reinstatement of criminal charges are used as sanctions to comply with treatment and supervision conditions.

- Eligibility conditions include the severity of mental illness and the severity of charges. Felons are typically excluded from the mental health court process because judicial discretion is more limited for most felonies considerations of clinical need.
- A team approach is applied in which prosecutors, defense attorneys, mental health providers, probation officers, and the defendant agree upon alternatives and referral to a community mental health treatment program.
- In the few outcome studies conducted so far, mental health courts have reduced the number and severity of re-arrests among mentally ill offenders.

sentences.

**Possible Solutions:** County and municipal programs that provide resources and incentives for collaboration between correctional and social service providers, especially mental health and dual diagnosis treatment programs, are a common feature of many promising programs that have emerged in recent years.

*Mental health courts* have proliferated: a survey published in 2006 covers 90 courts in 34 states. These specialized courts are designed to take advantage of flexibility accorded to judges, particularly over the disposition of less serious cases, to move people into community treatment programs in lieu of standard

- The general issues that attend attempts to intervene at the intersection of mental health and criminal justice are prominently displayed in controversies over mental health courts: Do restrictive eligibility conditions limit effectiveness? Are judges equipped to assess continuing need for treatment?
- It is sometimes argued that the administrative machinery, formal team process, and eligibility determinations characteristic of specialized courts can be obviated simply by bringing mental health professionals into the court process whenever mental illness is a factor: “any courtroom in which a mental health professional provides input to the judge is a mental health court.”
- Depending on who pays, there is a risk that court process may be used as a way of providing access to treatment for people who would otherwise not meet eligibility conditions, providing perverse incentives. Some of these may be addressed by SB5533 (2007), which reduces requirements for further processing of misdemeanants with impaired competency.
- If mental health courts take on felony cases, all but the lowest-level felonies (those statutorily eligible for deferred prosecution) require post- rather than pre-adjudication programs: a Mentally Ill Offender Sentencing Alternative (like SSOSA and DOSA).

A ten-year plan for Intercept III intervention requires careful attention to the interaction between public safety and accountability requirements, mental health court eligibility conditions, and community mental health policies.

### **Intercept IVA: Transition from Jails**

**Problem:** Because of the short-term, high-traffic orientation of jails, transition of people with mental illness from jail to the community often occurs without pre-release planning and linkage to services, housing, or income support. In addition to well-established issues of coordination between agencies with different missions and procedures, policy wrinkles concerning eligibility for benefits are widely seen as enforcing gaps in care and inefficiencies in the use of resources.

- Eligibility for public assistance programs, both income support and medical benefits, is taken as a de facto requirement for public community mental health services, even though some state-only funding is available for non-Medicaid eligible clients.
- RCW 74.08.025(c) excludes benefits for inmates of public institutions, leading to loss of eligibility for some persons jailed on supervision violations as well as misdemeanor charges; other rules about the timing of applications delay eligibility upon release.

- Proposals to amend RCW’s run afoul of the requirement of RCW 74.04.050 that the Department administer public assistance consistently with regulations of the federal government which contributes a share to benefit programs.

**Possible Solutions:** The GAINS Center and its branch, the TAPA Center for Jail Diversion, have identified and described promising programs in many jurisdictions.

- Interagency agreements, joint transition planning teams, and collaborative case management for people under post-release supervision are common features of programs now under development across the country.

The Bazelon Center for Mental Health Law provides a handbook on how state and local initiatives can take “advantage of the flexibility in federal rules to ensure that individuals with mental illnesses are expeditiously connected to health and mental health care coverage.”

- In Maryland, Medicaid participants remain on the enrollment list, even if incarcerated longer than 30 days. The state notes the incarceration in its information system to prevent unauthorized claims payments.
- Findings in King, Kitsap, Snohomish and Thurston Counties indicate that 71% of previously covered DSHS clients do not lose eligibility when jailed. Among those jailed more than 45 days with a break in coverage, the percentage who resumed coverage has risen from 44% to 55% since E2SHB 1290.

In Pierce County, DOC created a Transition Options Partnership. This program coordinates efforts with the Department of Adult Detention and a network of treatment, housing, and employment services to identify persons under DOC supervision when they are re-arrested and intervene upon their admission to jail. Post-release planning begins at that point, and community partners have collaborated to facilitate housing, supported employment, and treatment upon release.

- In Washington, the passage of E2SHB1290 in 2005 spurred “expedited eligibility” programs in which DSHS-MHD, the Economic Services Administration, WASPC, and RSN’s have collaborated in an interagency task force to conduct speedy medical eligibility determinations for persons with mental disorders being released from jail or prisons
- Findings indicate that in jails, there remains substantial room for improvement through better targeting of candidates for expedited review and more timely collection of relevant data.

• Further analysis is needed to assess the extent to which improvements in linkage to services for jailed offenders depend upon legislation, administrative policy changes, or resources for jail or community mental health services.

## **Intercept IVB: Transition from Prisons**

**Problem:** A Washington study of offenders with mental illness released in 1996 and 1997 found systematic gaps in treatment planning, linkage between systems, and post-release services.

- Although almost three-quarters of subjects eventually obtained access to social services, only 16% received steady social services in the first year after release.
- Hours of service per service month typically ranged from 2-5 hours, far from enough for people facing the multiple challenges of mental illness, drug abuse, and recent incarceration.
- Only 32% received mental health services within three months; average time to first contact was six months.
- Only 5% received services reported under DASA's TARGET system, although an intensive chronological study of 48 participants found that 60% were actively and seriously abusing chemicals after release (cocaine, methamphetamine, opiates, or repeated urinalysis failures).

**Possible Solutions:** Here, Washington is ahead of the rest of the country both in developing interventions and in providing outcome and process evaluations from which substantial guidance can be derived:

- The Mentally Ill Offender Community Transition Program (MIOCTP) began operations in 1998. This small program is based in Seattle, with a strong residential component and high representation of women and drug offenders. Its results are impressive: participants showed a two-year felony recidivism rate of 19%, vs. 42% for matched controls.
- The statewide DMIO program has undergone a series of evaluations by WSIPP that found substantial increases in the timing and extent of services and reductions in recidivism.

The MIOCTP and DMIO programs are successful, and there is every reason to think that the methods applied in these specialized programs could be extended to all people with mental illness leaving prison.

Four pillars of the DMIO Program:

- *Additional funding* of up to 10,000 per year per participant was provided to support extra services (especially collaborative transition planning), specialized clinical services such as sex offender treatment after release, and housing.
- *Legislatively-established collaboration* brought together the principal statewide agencies (DOC, MHD, DASA, DDD) to coordinate eligibility determinations, treatment planning, and subsequent monitoring for program integrity. Collaborative methods and relationships spread through the network of local offices of statewide agencies and affiliated service providers.
- *Pre-release coordination*, using special transitional funding, brought mental health caseworkers into the prisons to meet with prospective participants, assess their needs, and encourage engagement in treatment *before* release.
- *Medicaid eligibility waivers*. Administrators at DSHS-MHD worked with the Economic Services Administration to waive the 90-day waiting period normally required for a certification of medical necessity, a key criterion of Medicaid eligibility.

Findings of DMIO Program Evaluations:

- Key participants uniformly reported that constructive working relationships had been built among staff and administrators who began the program with little knowledge of each others' missions, methods, and constraints.
- Three-quarters of DMIO participants were served within a week after release, and three-quarters received steady mental health services during the first year, averaging 9 hours per month.
- Although rates of previous chemical abuse and dependency were substantially lower for the DMIO population, which included few drug offenders because of its focus on prisoners with violent crime, over half of them received some chemical dependency services during the first year after release.
- Rates of recidivism after 2.5 years were substantially lower: 22% vs. 43% for felony recidivism, 40% vs. 65% when misdemeanors are included.

- The primary obstacle is expense. WSIPP's evaluation shows the DMIO program barely breaking even, in terms of program costs vs. reduced costs due to lower victimization and criminal justice system expenditures. MIOCTP is almost twice as expensive per participant.
- Collaborative relationships among correctional and social service providers are vulnerable if institutional incentives shift: for example, if new federal rules about non-Medicaid-eligible consumers lead to territorial conflicts over reduced resources.
- Application of the methods of the MIOCTP and DMIO programs to all people with serious mental illness leaving prison requires more reliable assessments upon prison

entry, tracking offenders into outpatient or residential programs while in prison depending on level of need, preparation of individual release plans for every inmate with mental illness, and establishment of expanded interagency teams to handle an increased volume of referrals.

## **Intercept V: Community Corrections and Support Services**

**Problem:** We have described under Intercept IV some of the problems that have plagued the transition of people with mental illness from jails or prisons to the community. We have also described several transitional programs and policies which, in Washington, flesh out the concept of “assertive community treatment” widely advocated as a method of keeping people with mental illness safe in their communities. Comprehensive plans to sustain community integration must take account of several realities:

- Nationwide, 80% of offenders are supervised after release from prison, and the active community supervision caseload of Washington’s Department of Corrections is half again as large as the number of confined inmates. Many of the people arrested, detained, and released from jail are also under state correctional supervision.
- Despite the overlap in clientele, correctional and community mental health administrators and staff have in the past been unfamiliar with or distrustful of the methods and practices of each other’s agencies.

**Possible Solutions:** Behind the outcome statistics, funding requirements, and policy changes we have used to describe the MIOCTP and DMIO programs, the case documents of agency staff and reports of officials tell an important story.

- Community corrections staff have learned that community mental health staff and services support their public safety mission, and community mental health staff have recognized that offenders with mental illness are legitimate service clientele.
- The statewide agencies and divisions—DOC, MHD, DDD, DASA, and the Economic Services Administration—are capable of translating a legislative requirement to collaborate into effective working relationships among staff in local offices and service providers who work directly with clients.

This report has described the heavy flow of people with mental illness into and out of jails as the critical strategic issue for statewide policy planning. The experience of E2SHB 1290 indicates that implementing expedited eligibility programs for people leaving jails is more difficult than for people leaving prisons. In addition to high traffic and short stays, a further obstacle to statewide planning for local agency collaboration is posed by the need to work with 39 independent correctional agencies with separate lines of funding and authority.

- The Offender Re-Entry Initiative, developed by DOC's funding requests and legislative action (ESSB 6157, 2007), seeks to use the Department of Community Trade and Economic Development to facilitate collaborative groups of agencies within each county.
- While this initiative extends quite broadly to offenders leaving prison, the implementation of this legislation will provide important lessons about frameworks for interagency collaboration at the local level, which may be applied to community services and supervision for people with mental illness after they leave jails.

Can legislative requirements for collaboration between social service and criminal justice agencies be translated into effective programs in all of Washington's counties? This is the critical challenge for Intercept V planning in the coming years.

## **The Road Ahead**

This report began with the observation that reducing the use of incarceration for persons with mental illness has long been a focus of concern for many stakeholders, including family members, agency staff, policymakers, researchers, and most of all the people who are caught up in this system without sufficient resources or alternatives to find a better way of living in the community.

- While we have cited only a few examples of programs and policies that address some of these problems, it is clear that promising alternatives are available.
- One reason that jails and prisons have so many MIO's is that no one has ever really developed a credible business plan that legislators and taxpayers will accept and support: one that would in fact change the status quo in any significant way.

We have proposed a ten-year comprehensive strategy to address policy, programmatic, and funding issues at each stage of intervention. Carrying out this strategy requires rapid progress on a business plan in time for the first stage of funding in 2009. Participation will be required by a broad group including DOC, court officials, prosecutors and defense attorneys, jail administrators, DSHS, WASPC, NAMI, and consumers; the Mental Health Transformation Project may help bring these participants together.

The Statewide Council on Mentally Ill Offenders has two more years of legislative funding. Now is the time for those with a stake in a better way of coping with offenders with mental illness to develop a plan and the political will to reduce costs and stress on our criminal justice system and yield safer and more humane results for our citizens.

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## APPENDIX A: ELEMENTS OF A BUSINESS PLAN<sup>1</sup>

The proposal describes what is to be done, but ordinarily it does not contain details on how it is to be done. The details are the responsibility of operating management, and typically are worked out after the proposal has been approved.

The program proposal should include:

1. A description of the proposed program, and evidence (i.e., references, summary of literature, best practices, and assumptions) it will accomplish the organization's objective. A discussion regarding what population the initiative will target and whether there are existing programs that are also aimed at the population.
2. An estimate of the resources to be devoted to the program over the next several years, divided between investment costs and operating costs. Since the principal purpose of the estimate is to show the approximate magnitude of the effort, the costs are therefore usually offered as "ballpark" amounts. Proposals should also take care to fully address the "Ripple Effect or Downstream Impacts." Detailed cost analysis ordinarily is deferred until after the program has been approved in principle.
3. The benefits expected from the program over the same time period, expressed quantitatively. One purpose of quantifying the benefits is to permit subsequent comparison of actual results with planned results.
4. A discussion of the risks and uncertainties and core issues associated with the program that must be addressed for success.

### **Program Effectiveness Criteria**

Defines an effectively managed program. A set of ideal conditions for program implementation and performance:

1. Goals - The end results that programs pursue, which must be realistic and clearly stated.
2. Objectives - The effects or results to be achieved by the program in pursuing its goals, which must be measurable and achievable. Objectives should also be relevant, responsive, valid, reliable, cost-effective, useful, accessible, comparable, compatible, clear and affordable.

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<sup>1</sup> Adapted from a planning document provided by Steve Thompson

3. Linkage -The program must have sufficient and appropriate activities in place to achieve the objective (result) expected, which means there is evidence that the existing pattern of program activities can produce the expected results.
4. Performance Information - Should be developed which signal to what extent the program is meeting its objectives (achieving the expected results). This information is obtained by measuring the program's actual results, then comparing them with the program's expected results.
5. Acceptable Performance - The program meets or exceeds the expectation objectives set for it, and its actual performance is acceptable to program managers and oversight officials. This recognizes there may be times when a program does not fully achieve its objectives (due to unforeseen and uncontrollable events), but is nevertheless considered to be performing successfully.

### **The Planning Process**

Required goals can be met if the organization proceeds step by step and addresses the following questions:

1. What is the long-range goal?
2. What background factors have prompted the required action?
3. What action is required to reach that goal?
4. What resources will be committed in this action?
5. What will this action accomplish in the long run?
6. When is accomplishment expected to take place?
7. What conditions must be met to achieve the objectives?
8. Are any early indicators of success/failure available?
9. Will corrective action further commit additional organization resources?
10. What impacts will corrective action have on day-to-day operations and on the long-range plan?

### **Decision Criteria**

The below criteria have been used in the past to assess the feasibility of various proposed options:

1. Cost - The estimated cost to implement the option.
2. Time - The estimated amount of time required to implement the option.
3. Scope of Support Required - The different agencies and officials whose support is required to implement the option.
4. Liability Issue - The degree of possibility that an option could endanger the safety of the community.
5. Community Concerns - The degree that the option complies with or is sensitive to a wide ranging set of community concerns including but not limited to safety, security, potential siting issues, costs, etc.
6. Legal Issues - The degree the option is consistent with or complies with applicable laws, ordinances, codes, standards or agreements.
7. "Downstream Impacts - Ripple Effects" - The degree the option effects other units, agencies, or organizations operations.
8. Research - The degree the proposal is supported by documents and well-defined assumptions, references/best practices, and a summary of the literature.