



Mental Health Services in the Criminal Justice System:

A Description of Montgomery County Services And Promising Practices from Other Jurisdictions

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Executive Summary

Research indicates that a combination of de-institutionalization and lack of community mental health services has increased the number of people with mental illness involved in criminal justice systems nationwide. This population often has multiple problems in addition to mental illness (e.g., substance abuse, unemployment, homelessness), requiring coordination among multiple service providers. The number of people with mental illness involved in criminal justice systems, and their multiple service needs, places increasing demands on the limited mental health resources of court systems, jails, and human service agencies.

Montgomery County provides a range of services throughout the criminal justice system for individuals with mental illness, and for individuals with co-occurring mental health and substance abuse problems. The types of services currently provided through various County programs include: diversion; screening, assessment and classification; crisis intervention; treatment; case management; and discharge planning. The Department of Correction and Rehabilitation, Department of Health and Human Services, and Montgomery County Police Department work together to provide the services, with a shared goal to address the mental health needs of County residents from entry to the criminal justice system through release from incarceration.

In sum, Montgomery County Police Department (MCPD) officers help to identify non-violent, misdemeanor offenders who need mental health services, and work with the Department of Health and Human Services to divert them to appropriate care. Staff expect MCPD to divert more people to community-based services after implementation of the MCPD Crisis Intervention Team.

Some Department of Health and Human Services (DHHS) staff assess needs and refer individuals involved in the criminal justice system to mental health, substance abuse, and other treatment resources. Other DHHS staff provide crisis intervention, treatment, and case management services directly. The DHHS staff work with people diverted from the criminal justice system to community-based services, people incarcerated in Montgomery County, and people re-entering the community after release from incarceration.

Department of Correction and Rehabilitation (DOCR) staff conduct screening, assessment and classification services within the Montgomery County Detention Center. The Department also provides medication management, crisis intervention, and limited case management and discharge planning for all inmates. Inmates housed in the Crisis Intervention Unit receive additional services, including development of a treatment plan, limited therapy, and more extensive case management and discharge planning.

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Introduction

I. Authority, Methodology and Acknowledgements

A. Authority

Council Resolution No. 14-607, FY 2001 Work Program of the Office of Legislative Oversight, adopted August 1, 2000.

B. Methodology

Jennifer Kimball, Legislative Analyst, and Leslie McDowell, Research Assistant in the Office of Legislative Oversight conducted this project. OLO collected information about the services in Montgomery County from the Department of Correction and Rehabilitation, the Department of Health and Human Services, and the Montgomery County Police Department. General information about incarcerating people with mental illness and promising practices from other jurisdictions came from sources produced by the U.S. Department of Justice and other organizations noted throughout this report.

C. Acknowledgements

The Office of Legislative Oversight appreciates the assistance of staff in the Department of Correction and Rehabilitation, the Department of Health and Human Services, and the Montgomery County Police Department. OLO thanks Art Wallenstein, Robert Green, W.L. Smith, Patricia Sollack, Claire Gunster-Kirby, Susan Wiant, Shelley Caplan, and Renee Parcover from the Department of Correction and Rehabilitation. OLO thanks Mildred Holmes Williams, Corinne Stevens, Dudley Warner, Catherine McAlpine, Athena Morrow, and Larry Wilson from the Department of Health and Human Services. OLO thanks Chief Charles Moose and Officer Joan Logan in the Montgomery County Police Department.

II. Scope and Organization of the Report

A. Scope

This OLO report describes mental health services for people involved in Montgomery County's criminal justice system. The report does not evaluate the effectiveness or results of the current array of mental health services, but serves as a guide to the services provided by different departments and at different points in the criminal justice system.

The report addresses services for individuals with serious mental illness defined as:

- Mood disorders (e.g., depression, bi-polar disorder),
- Psychotic disorders (e.g., schizophrenia, delusional disorder),
- Personality disorders (e.g., borderline personality disorder), and
- Anxiety disorders (e.g., panic disorder, social phobia).

The report also addresses services for individuals with co-occurring disorders, defined as individuals with mental illness and substance abuse problems. The scope does not include description of mental health services for youthful offenders or services provided through the State Office of Parole and Probation.

Finally, the report describes some promising practices identified during our research. OLO did not evaluate the effectiveness or results of the promising practices, but presents them to illustrate different approaches to providing mental health services within a criminal justice system.

B. Organization

The report is organized into four parts:

National Trends in Incarcerating People with Mental Illness provides general background information, including problems associated with incarcerating people with mental illness and characteristics of people with mental illness involved in the criminal justice system.

Mental Health Services in Montgomery County's Criminal Justice System describes the specific mental health services provided in Montgomery County in six categories:

- Diversion,
- Screening, Assessment and Classification,
- Crisis Intervention,
- Treatment,
- Case Management, and
- Discharge Planning.

Promising Practices describes interesting approaches used by other jurisdictions to provide mental health services for individuals involved in the criminal justice system.

Summary of Findings provides a summary of the mental health services available in Montgomery County's criminal justice system and presents OLO's general observations.

National Trends in Incarcerating People with Mental Illness

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National Trends in Incarcerating People with Mental Illness

I. Background

Services for people with mental illness have evolved over the past 150 years. In the mid-19th century most people with serious mental illness were housed in prisons or jails, where they received little or no mental health care. Reformers lobbied state legislatures for more humane medical treatment of people with mental illness, and by 1880 states throughout the country were establishing mental institutions to house people with mental illness.

The development of psychotropic drugs in the 1950s and 1960s, combined with litigation over poor conditions and abuses in the institutions, led states to de-institutionalize large numbers of patients. The number of patients in state mental institutions declined from 560,000 in 1955 to 70,000 in 1995.¹

The goal of de-institutionalization was to provide more humane treatment and housing alternatives in the local community. However, in the 1970s and 1980s, most states fell short of providing the number of clinics, halfway houses and other services in the community needed to care for and house the mentally ill. Exacerbating these problems were health insurance coverage restrictions, reluctance of for-profit hospitals to care for people with mental illness, new civil liberty laws that made it more difficult to commit people to mental hospitals involuntarily, and lack of housing for people with mental illness.

While the number of people released from mental institutions grew, the nation's incarcerated population also increased. From 1983 to 1993, the nation's jail population doubled, from 96 to 188 inmates per 100,000 U.S. residents, according to the Bureau of Justice Statistics. Factors contributing to this increase over the last 20 years include 'truth in sentencing' legislation, abolition of parole in 14 states, incarceration related to the war on drugs, and federal and state mandatory sentences.²

Research indicates that insufficient community mental health services contributes to the increase in the incarcerated population. Lack of community resources prompts law enforcement to incarcerate people with mental illness who commit crimes, making the jail the 'institution of last resort'. A 1999 Bureau of Justice Statistics (BJS) report estimated that there were nearly 284,000 people with serious mental illness incarcerated in the nation's prisons and jails in 1999, four times more than in America's mental hospitals. The Bureau of Justice Statistics (BJS) also reported that just over 1 in 6

¹ "Resident Patients in State and County Mental Hospitals", U.S. Department of Health and Human Services, Center for Mental Health Services, Rockville, MD, 1995.

² "The Nation's Jails Hold Record 490,442 Inmates", Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice, 1995.

inmates in prisons and jails has a mental illness.³ According to a National Institute of Justice report, the rate of schizophrenia and major affective disorder is two to three times higher among jail inmates than in the general U.S. population.⁴

II. Characteristics of Incarcerated People with Mental Illness

Many of the crimes committed by people with mental illness are non-violent and are a result of their mental illness. Examples include vagrancy, trespassing, petty burglary, destruction of property, and drug use. According to the Bureau of Justice Statistics, 70% of all local jail inmates with a mental illness were incarcerated as a result of a non-violent offense.³

People with mental illness who are involved in the criminal justice system typically have multiple problems. They often live in poverty, are unemployed and homeless, lack access to appropriate mental health treatment, have experienced some kind of trauma, and suffer from a co-occurring substance abuse disorder. The 1999 BJS reported the following data about people with mental illness who are involved in the criminal justice system:

- Forty seven percent of inmates with a mental illness were unemployed compared with 33% of other inmates;
- Jail inmates with mental illness were nearly twice as likely as other inmates to have been homeless during the year prior to their arrest;
- Nearly 7 in 10 female jail inmates with mental illness reported physical or sexual abuse in their lifetimes, compared to 4 in 10 other female inmates;
- Men with a mental health condition in jail reported abuse in their lifetimes 3 times as often as other male inmates; and
- More than 6 in 10 offenders with mental illness reported that they were under the influence of alcohol or drugs at the time of their current offense.³

III. Problems Associated with Incarcerating People with Mental Illness

Research from jails and prisons across the country indicates several problems associated with incarcerating people with mental illness. In sum, jails and prisons often do not provide adequate mental health services and incarceration can exacerbate symptoms of mental illness. As a result, inmates leave incarceration in the same or worse mental state and often continue to commit crimes. This prolongs a costly cycle of criminal recidivism, both in terms of threats to public safety and taxpayer expense.

³ Ditton, Paula M., "Mental Health and Treatment of Inmates and Probationers", Bureau of Justice Statistics Special Report, NCJ# 174463, U.S. Department of Justice, July 1999, pg. 1

⁴ "Jail Diversion for the Mentally Ill, Breaking through the Barriers", National Institute of Corrections, U.S. Department of Justice, 1990

A. Symptoms of Mental Illness

Multiple factors associated with incarceration exacerbate symptoms of mental illness. Research indicates that mentally ill offenders have a greater risk of abuse and victimization by other inmates while incarcerated. The mentally ill are nearly twice as likely as other inmates to have been involved in a fight, or hit or punched.⁵ Inmates with mental illness have difficulty coping with the inmate prison code – which requires showing no weakness or fear to other inmates and appearing ready to fight when challenged. Many find hiding their fears and illness impossible. Inmates with mental illness are also disproportionately represented among rape victims inside jail, and are over-represented among inmates in lock-up and administrative segregation units. Finally, they are especially vulnerable to the negative repercussions of lack of visits from loved ones.⁶

B. Inadequate Mental Health Services

Research indicates that most jails and prisons throughout the country lack adequate mental health services, despite federal litigation and mental health requirements for correctional institutions in the Americans with Disabilities Act. A 1997 National Institute of Justice (NIJ) research study found that approximately 43% of U.S. jails provide some kind of mental health crisis intervention, 42% provide psychiatric medication, and 27% provide therapy or counseling. Only one in five jails studied linked inmates with community-based mental health and other services upon release.⁷

Access to mental health treatment in prison and jail is complicated by Medicaid policy. Under federal law, jurisdictions cannot use Medicaid funds to pay providers for health care costs of individuals housed in public institutions, including prisons and jails. Therefore, individuals without private health insurance cannot continue previous mental health treatment while incarcerated. Although not required by federal law, many states and localities also terminate Medicaid benefit eligibility upon incarceration, forcing inmates to reapply for benefits upon release.

C. Recidivism

A high rate of recidivism is another problem associated with incarcerating people with mental illness. According to the 1999 Bureau of Justice Statistics report, more than 75% of inmates with mental illness had been sentenced to prison, jail or probation at least once prior to their current sentence. Fifty four percent of inmates with mental illness

⁵ Ditton, Paula M., “*Mental Health and Treatment of Inmates and Probationers*”, Bureau of Justice Statistics Special Report, NCJ# 174463, U.S. Department of Justice, July 1999, pg. 9.

⁶ , Kupers, Terry A., M.D, *Prison Madness: The Mental Health Crisis Behind Bars, and What We Must Do About It*, Jossey-Bass Publishers, San Francisco, 1999, pg. xvii.

⁷ Steadman, Henry J., Ph.D., Veysey, Bonita M., Ph.D., “*Providing Services for Jail Inmates with Mental Disorders*”, National Institute of Justice, U.S. Department of Justice, January 1997, pg. 3.

reported three or more prior sentences, compared to 42% of other jail inmates.⁸ Researchers conclude that many people with mental illness continue to commit crimes after release because incarceration exacerbated the symptoms of their mental illness, the illness was not adequately treated during incarceration, and they did not receive adequate discharge planning or connection to community mental health treatment upon release.

D. Cost

The high cost of multiple incarcerations of people with mental illness impacts the resources of law enforcement, the court system, jails and prisons, and parole and probation offices. To keep up with growing inmate populations, U.S. public spending on jails and prisons alone increased from under \$5 billion in 1980 to \$30 billion in 1996.⁹

IV. Federal Legislation Related to Mental Health Services in the Criminal Justice System

Federal legislation adopted in October 2000 is designed to reduce the incarceration of people with mental illness and increase their access to public mental health treatment.¹⁰ The legislation creates block grants for states, localities, and non-profit organizations to provide a variety of mental health services. Table 1 on page 9 lists the key mental health provisions included in the legislation. One provision establishes grants for states and localities that divert individuals with mental illness from the criminal justice system to community-based services. Although the federal government passed the legislation creating the block grants with specified funding amounts, it did not appropriate funds in FY 2001. Funds may be appropriated in FY 2002.

The federal government also created legislation last October to establish mental health courts for non-violent offenders with severe mental illness. America's Law Enforcement and Mental Health Project provides \$10 million per year for up to 100 grants to state and local government to establish mental health courts (see page 54 for more information on mental health courts). Funds were not appropriated in FY 2001, and may be appropriated in FY 2002.

⁸ Ditton, Paula M., "Mental Health and Treatment of Inmates and Probationers", Bureau of Justice Statistics Special Report, NCJ# 174463, U.S. Department of Justice, July 1999, pg. 5.

⁹ Zedlewski, Edwin, Office of Development and Communication, National Institute of Justice, U.S. Department of Justice, July 2000.

¹⁰ The legislation signed in October, titled the Children's Health Act of 2000, includes provisions from former Senate Bill 2639 - Mental Health Early Intervention, Treatment and Prevention Act.

Table 1: Mental Health Provisions in the Children’s Health Act of 2000

Jail Diversion	Provides up to 125 grants to state and local governments and non-profit organizations, totaling \$10 million the first year, to develop and implement programs to divert individuals with a mental illness from the criminal justice system to community-based services.
Integrated Treatment for Co-occurring Disorders	Provides grants to state and local governments and non-profit organizations, totaling \$40 million per year, to provide fully integrated treatment services to persons with co-occurring mental health and substance abuse disorders.
Emergency Services	Provides grants to state and local governments, totaling \$25 million per year, to establish emergency mental health centers, including mobile crisis intervention teams.
Treatment Services for the Homeless	Provides grants to public mental health agencies and non-profit organizations, totaling \$50 million per year, to expand mental health treatment services to homeless individuals, including those with co-occurring disorders.
Awareness Training	Provides grants to state and local governments, totaling \$25 million per year, for teacher and emergency personnel mental illness awareness training.
Suicide Prevention	Provides federal financial assistance for programs that reduce suicide deaths, with particular focus on populations that experience high rates of suicide.
Coordination of Child Welfare and Mental Health Services	Provides federal financial assistance for programs that integrate child welfare and mental health services by providing a single point of access for coordinated services.
Treatment Compliance Initiative	Provides federal funds for National Institute of Mental Health research on medication non-compliance among people with mental illness, and on non-coercive methods to enhance compliance.

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Mental Health Services in Montgomery County's Criminal Justice System

I. Overview

This overview describes six generic categories of mental health services typically provided in criminal justice systems. It also includes tables that summarize the specific services available in Montgomery County.

A. Categories of Mental Health Services

Diversion - Diversion programs redirect people with mental illness who have committed a non-violent crime from the criminal justice system into mental health treatment and other social services.

Screening, Assessment and Classification - Screening involves initial identification of people that may suffer from a mental illness. Assessment refers to a more in-depth review of a person's mental state to verify that a mental illness exists and to identify the type of mental illness. Classification involves determining the next steps in the individual's mental health care or triaging the individual to the appropriate services and providers.

Crisis Intervention - Crisis intervention is an immediate response to a mental health crisis situation. During incarceration, crisis intervention usually involves removing the individual from the general inmate population, putting the individual on suicide watch, and/or prescribing medication.

Treatment - Individuals involved in the criminal justice system may receive mental health treatment from community-based providers or from jail/prison staff. Treatment typically involves prescribing and managing psychotropic medication, developing treatment plans, and providing group and/or individual therapy. Mental health treatment may be combined with substance abuse treatment.

Case Management - In general, case management in the criminal justice system involves identifying an inmate's service needs, accessing appropriate services, monitoring progress, and providing on-going support and assistance.

Discharge Planning - Discharge planning prepares inmates for release from incarceration and reintegration into the community. It involves activities that will help inmates function in the community (e.g., basic life skills training, job search assistance), and referral to services upon release (e.g., mental health and substance abuse treatment).

B. Summary of Montgomery County Programs and Services

Categories of Services - Table 2, on page 13, lists the mental health programs/services available in Montgomery County by the six categories described above. The County operates multiple programs or services within each category. For example, four County services/programs provide discharge planning for different clients in the criminal justice system. In addition, a single County program can provide more than one category of mental health service. For example, the Detention Center Mental Health Services program provides screening, assessment, and classification; crisis intervention; and treatment services.

Service Providers - Table 3, beginning on page 14, presents the mental health programs/services by the department providing the service. The Montgomery County Police Department (MCPD), the Department of Health and Human Services (DHHS), and the Department of Correction and Rehabilitation (DOCR) each play an important role in providing services to individuals with mental illness who are involved with the criminal justice system.

In general, MCPD officers help to identify individuals who need mental health services and work with DHHS to divert them to appropriate care. DHHS staff screen and assess people for mental health problems, and refer them to appropriate services. DHHS staff also provide treatment and case management services directly. DOCR staff work with individuals on a pre-trial basis and during incarceration. They screen and assess mental health, refer to appropriate services, and provide some mental health treatment, case management, and discharge planning services.

Context in the Criminal Justice System - To place the County mental health services described in this report in context, the flow charts attached at ©1 - ©4 map the sequence of events in a generic criminal justice system. The flow charts break the criminal justice system into the following four phases: entry into the system; prosecution and pre-trial services; adjudication and sentencing; and corrections. The charts indicate which mental health services Montgomery County provides at each phase of the system.

Montgomery County programs that divert individuals from the criminal justice system to community-based mental health services appear in all four phases of the system. Screening, assessment, and classification takes place at entry to the criminal justice system, during the pre-trial phase, and when individuals enter the Montgomery County Detention Center. Programs that provide treatment and case management also appear in those three phases of the Montgomery County criminal justice system. Discharge planning services only take place during the corrections phase, as inmates leave incarceration.

Table 2: Mental Health Services by Category

Type of Service	Montgomery County Department	Montgomery County Program/Service
Diversion	Department of Correction and Rehabilitation	Daily Supervision Services Program
		Intervention Program for Substance Abusers
	Department of Health and Human Services	Clinical Assessment and Triage Services Unit (located in the Detention Center)
		Crisis Center
		Mobile Crisis Team
Montgomery County Police Department	Emergency Evaluation Petition ¹¹	
Screening, Assessment and Classification	Department of Correction and Rehabilitation	Central Processing Unit
		Detention Center Intake Unit
		Detention Center Medical Unit
		Detention Center Mental Health Services
	Pre-Trial Services Unit, Assessment Section	
Department of Health and Human Services	Clinical Assessment and Triage Services Unit (located in the Detention Center)	
Crisis Intervention	Department of Correction and Rehabilitation	Detention Center Mental Health Services
	Department of Health and Human Services	Crisis Center
		Mobile Crisis Team
Treatment	Department of Correction and Rehabilitation	Detention Center Mental Health Services
	Department of Health and Human Services	Assertive Community Treatment Team
		Addiction Services Coordination/Outpatient Addiction Services
		Jail Addiction Services
Case Management ¹²	Department of Correction and Rehabilitation	Detention Center Correctional Specialist
		Pre-Trial Services Unit, Supervision Section
Discharge Planning	Department of Correction and Rehabilitation	Community Accountability, Reintegration and Treatment
		Detention Center Correctional Specialists
		Pre-Release Center
	Department of Health and Human Services	Community Re-Entry Services

¹¹ Police officers, Crisis Center/Mobile Crisis Team staff, psychologists, physicians, and selected DHHS designees (DHHS practitioners and MCPS social workers) can complete non-judicial EEPs. Judges issue judicial EEPs at the request of family members.

¹² Other programs/services provide some case management related functions, in particular, the Assertive Community Treatment Team, Community Re-Entry Services, the Pre-Release Center, and Community Accountability, Reintegration and Treatment.

Table 3: Mental Health Services By Department

Montgomery County Program/Facility/Staff	Function	Type of Mental Health Service
Department of Correction and Rehabilitation (DOCR), Detention Services		
Central Processing Unit (CPU)	Books individuals arrested in Montgomery County and brings them before a District Court Commissioner, and screens detained individuals for mental health problems.	Screening, Assessment, Classification
Detention Center Correctional Specialists	Provide case management for inmates in the MCDC general population, including housing classification, counseling, and discharge planning.	Case Management; Discharge Planning
Detention Center Intake Unit	Processes all inmates entering the Montgomery County Detention Center, including screening for mental illness.	Screening, Assessment, Classification
Detention Center Medical Unit	Screens new inmates for medical and mental health needs and address the medical needs of all MCDC inmates.	Screening, Assessment, Classification
Detention Center Mental Health Services	Provides mental health services for all MCDC inmates.	Screening, Assessment, Classification; Crisis Intervention; Treatment
Department of Correction and Rehabilitation (DOCR), Pre-Release Services		
Community Reintegration, Accountability and Treatment (CART)	Provides intensive pre-release services to help inmates reintegrate into the community. Clients live at home, monitored by caseworker visits and electronic monitoring equipment.	Discharge Planning
Pre-Release Center (PRC)	Provides close supervision and monitoring in a DOCR facility in the community, and access to programs and services on-site and in the community to help inmates reintegrate into the community.	Discharge Planning
Department of Correction and Rehabilitation (DOCR), Pre-Trial Services Unit (PTSU)		
Daily Supervision Services Program (DSSP) ¹³	Diverts homeless, male, substance abusers from jail to shelter housing and treatment between their arrest and trial date.	Diversion
Intervention Program for Substance Abusers (IPSA)	Diverts first time drug possession offenders from jail to education and treatment programs.	Diversion
PTSU Assessment Section	Assesses all detainees before their bond hearing to recommend whether the defendants should participate in DOCR's pre-trial supervision program.	Screening, Assessment, Classification
PTSU Supervision Section	Provides community monitoring and supervision of all defendants referred by the court supervision between their bond hearing and trial date.	Case Management

¹³ Due to eligibility restrictions, DOCR only diverted three people to the program in the last three years.

Table 3 Cont.: Mental Health Services in the Montgomery County Criminal Justice System By Department

Department of Health and Human Services (DHHS), Adult Mental Health and Substance Abuse Services		
Addiction Services Coordination (ASC)/ Outpatient Addiction Services (OAS)	Screens, assesses, and refers clients to appropriate substance abuse treatment services, including clients who need substance abuse and mental health treatment. Provides intensive outpatient treatment to substance abusers and individuals with both a mental illness and a substance abuse problem.	Treatment
Clinical Assessment and Triage Services Unit (CATS)	Assesses new inmates for mental illnesses at intake to the Detention Center, and tries to divert detainees out of the criminal justice system and into community mental health services.	Division; Screening, Assessment and Classification
Community Re-Entry Services (CRES)	Provides discharge planning and case management services for inmates in the Jail Addiction Services Program, inmates housed in the Crisis Intervention Unit, and youthful Moral Recognition Therapy offenders.	Discharge Planning
Jail Addiction Services (JAS)	Provides substance abuse treatment for MCDC inmates that volunteer to participate, including education, self-help groups, and referral to community-based treatment services.	Treatment
Department of Health and Human Services (DHHS), Crisis, Income and Victim Services		
Assertive Community Treatment Team (ACT)	Provides comprehensive treatment, case management, and support services to people who have not successfully responded to traditional mental health treatment programs.	Treatment; Case Management
Crisis Center	Provides 24-hour/7 day per week telephone and walk-in crisis stabilization, referral, and short-term residential services to persons experiencing situational, emotional, or mental health crisis.	Diversion; Crisis Intervention
Mobile Crisis Team (MCT)	Serves as the Crisis Center's mobile unit, providing emergency mental health services to individuals in the community.	Diversion; Crisis Intervention
Montgomery County Police Department (MCPD)		
Emergency Evaluation Petition (EEP) ¹⁴	Provides the authority to transport an individual against his or her will to a hospital emergency room for a mental health evaluation.	Diversion

¹⁴ Police officers, Crisis Center/Mobile Crisis Team staff, psychologists, physicians, and selected DHHS designees (DHHS practitioners and MCPS social workers) can complete non-judicial EEPs. Judges issue judicial EEPs at the request of family members.

The remainder of this part of the report provides a detailed description of mental health services for people involved in the Montgomery County criminal justice system, based on the six categories of services described above. Each description begins with an overview of the category and information on standards and guidelines for providing that type of mental health service. The standards and guidelines were developed by the National Commission on Correctional Health Care (NCCHC) and the American Psychiatric Association (APA).¹⁵

II. Diversion

What is Diversion?

Diversion programs redirect people with mental illness who have committed a non-violent crime from the criminal justice system into mental health and other services. Diversion places these mentally ill offenders in community-based treatment programs to address the problems that led to their committing a crime. Research indicates that addressing the illness is usually more effective at preventing future crimes than incarceration. These kinds of programs rely on effective cooperation between police and community mental health services.

Diversion programs come into play at any of the four phases of the criminal justice system. Pre-booking diversion programs divert people at entry to the system. Post-booking diversion programs divert people during the other three phases of the criminal justice system.

Pre-Booking Diversion - Pre-booking diversion takes place either before a person is arrested, or after they are arrested but before charged with a crime. Law enforcement officers usually initiate pre-booking diversion by connecting the person to mental health services. Typically, an officer takes the individual to a designated “drop off center”, such as a mental hospital, clinic, or crisis center. The drop-off center staff evaluate and monitor the individual and identify appropriate services, allowing the officer to quickly return to his or her patrol.

Post-Booking Diversion - Post-booking diversion, the more common form of diversion, occurs after arrest. Post-booking diversion programs divert individuals with a mental illness during prosecution/pre-trial services, adjudication/sentencing, or the correction phase of the criminal justice system.

Post-booking diversion involves negotiating with judges, prosecutors, public defenders, attorneys, corrections staff, and community-based treatment providers to develop a plan to divert the person from the criminal justice system to community-based

¹⁵ The National Commission on Correctional Health Care (NCCHC), founded by the American Medication Association, is the primary accreditation body for correctional health care programs in the United States. NCCHC also operates a national certification program for correctional health professionals, and sponsors education, training and research activities.

services. A judge may order participation in a diversion program as a condition of a reduction in charges, in lieu of prosecution, or to defer prosecution. Failure to follow the diversion plan can result in renewal of charges and/or incarceration.

What Diversion Services are Available in Montgomery County?

Pre-Booking Diversion

Montgomery County Police Department officers frequently initiate formal and informal pre-booking diversion from the criminal justice system to community mental health services. Informal diversion takes place when officers provide individuals with information about community mental health services. Officers only use this strategy if they believe that the individual is not in danger of hurting themselves or others, and is able to seek help for their mental illness on their own. This informal diversion does not directly connect a person with services.

This part of the report describes ways that MCPD officers can formally divert individuals who commit non-violent crimes, including:

- Complete an emergency evaluation petition and transport the individual to a hospital emergency room;
- Contact the Mobile Crisis Team; and/or
- Transport the individual to the Crisis Center.

Use of diversion varies across MCPD officers. No MCPD directives instruct officers on how to address situations that involve an individual with a mental illness, and the Police Training Academy curriculum includes only limited training on this subject.¹⁶ The Department expects diversion to increase with implementation of the MCPD Crisis Intervention Teams. Part of the FY 2001 Corrections Behavioral Health Initiative (formerly called the Mental Health and Criminal Justice Initiative), the program dispatches trained officers to handle all incidents involving individuals with a mental illness. The CIT officer training teaches officers about characteristics of different mental illnesses, de-escalation techniques, and mental health services available in the County. The Crisis Intervention Team training provides the information necessary to take greater advantage of the County's diversion opportunities.

A. Emergency Evaluation Petitions

An emergency evaluation petition (EEP) provides the authority to transport an individual against their will to a hospital emergency room for a mental health evaluation. To qualify for an EEP, the individual must be a threat to themselves or others and unable to access help for their illness on their own. An emergency evaluation petition is attached at ©5-6. Police officers, Crisis Center/Mobile Crisis Team staff, psychologists,

¹⁶ Between April and September 2000, Crisis Center staff provided four hours of training in handling behavioral health emergencies for all MCPD patrol officers.

physicians, and selected DHHS designees (DHHS practitioners and MCPS social workers) can complete non-judicial EEPs.¹⁷ Judges issue judicial EEPs at the request of family members.

Police officers with an emergency evaluation petition transport the individual to the closest emergency room and return to their patrol. Hospital personnel have up to six hours to complete a mental health evaluation and decide whether to release the individual or commit them to the State's Springfield Mental Hospital for further observation. If they are not sent to Springfield, they are released on their own recognizance with no formal follow-up.

All five hospital emergency rooms in Montgomery County accept EEP patients.¹⁸ Montgomery General and Suburban hospitals have a mental health crisis teams available to evaluate EEP patients. The Washington Adventist Hospital also has psychiatric staff. Department of Health and Human Services Crisis Center mental health professionals see individuals brought to Shady Grove's emergency room for a mental health evaluation. Holy Cross does not have psychiatric staff assigned to the emergency room.

B. Crisis Center

The Department of Health and Human Services' Crisis Center provides 24-hour/7 day per week telephone and walk-in crisis stabilization services to persons experiencing situational, emotional, or mental health crisis. Police officers can divert to the Crisis Center individuals who do not qualify for an emergency evaluation petition and are willing to access mental health services voluntarily. Crisis Center staff do not track the number of clients brought to the Center by MCPD officers, but expect to receive more referrals from MCPD with the advent of the MCPD Crisis Intervention Teams (CIT).

When officers transport someone to the Crisis Center, staff stabilize the person, assess their mental health needs, and refer them to community mental health services. Individuals that already have a mental health provider typically use the Center for crisis intervention when their doctor is unavailable on the weekends and evenings. Individuals that do not have a mental health provider can receive short term counseling at the Center (up to four sessions) and/or referral to a community mental health provider. The Crisis Center also provides short term residential services to help avoid hospitalization. Up to seven people can stay at the Center for 72 hours for crisis intervention and short term counseling services.

The Department of Health and Human Services, Department of Correction and Rehabilitation, and Montgomery County Police Department are developing an additional pilot diversion program as part of the FY 2001 Corrections Behavioral Health Initiative. The pilot will allow officers to accompany a person who is eligible for diversion and needs a mental health evaluation to the MCPD Rockville District Station. Crisis Center

¹⁷ Montgomery is the only County in the state that designates DHHS staff that can complete EEPs.

¹⁸ Some local governments designate one diversion 'drop-off' location to create consistency and help police officers develop relationships with hospital psychiatric staff.

staff will meet the officer at the District Station, evaluate the person with the mental illness, determine whether they have a mental health provider, and connect them to a provider.

C. Mobile Crisis Team

The Mobile Crisis Team (MCT) is the Crisis Center's mobile outreach service, providing emergency mental health services to individuals in the community.¹⁹ The Mobile Crisis Team responds to calls for assistance from police officers, family members, friends, neighbors, and school personnel who observe someone with unusual or disturbing behavior. Approximately 50% of MCT visits respond to police requests for assistance.

Police officers can call the Mobile Crisis Team (MCT) to the scene when an individual appears to need mental health services, will not voluntarily go to the Crisis Center, and do not qualify for an emergency evaluation petition. The Mobile Crisis Team expects to receive more calls for service after the MCPD Crisis Intervention Teams are in place. The CIT officers will be first on the scene, maintain safety at the scene, begin to assess individuals for mental illness, and contact the Mobile Crisis Team, as necessary.

Two Mobile Crisis Team therapists respond to officer requests for assistance. They de-escalate the situation, stabilize the individual, evaluate and address the behavior or problem, and help the officers/family/neighbors understand the mental health problem. If the individual has a mental health provider, the Mobile Crisis Team staff contact the provider. If the individual does not have a provider, the Team refers the person to an appropriate mental health provider in the community. As a last resort, the Mobile Crisis Team completes an emergency evaluation petition and accompanies the individual to the hospital for an evaluation. Mobile Crisis Team staff follow-up with clients, as necessary, by providing short-term counseling after a crisis and maintaining contact with a client until they receive a long term mental health provider.

Post-Booking Diversion

The Department of Correction and Rehabilitation, Department of Health and Human Services, Montgomery County Police Department, and State's Attorney Office staff initiate most post-booking diversion. This part of the report describes the Clinical Assessment and Triage Services Unit, the Intervention Program for Substance Abusers, and the Daily Supervision Services Program.

A. Clinical Assessment and Triage Services (CATS)

The FY 2001 Corrections Behavioral Health Initiative includes \$137,850 in the Department of Health and Human Services' budget for a Clinical Assessment and Triage

¹⁹ The FY 2001 Corrections Behavioral Health Initiative included \$83,000 for two Mobile Crisis Team positions, providing coverage from noon to midnight seven days per week.

Services Unit (CATS). The Unit, housed at the Montgomery County Detention Center, will include three mental health therapists and a clinical supervisor.

CATS Unit staff will screen and assess new MCDC inmates for mental illnesses at intake to the Detention Center. They will also try to divert detainees out of the criminal justice system and into community mental health services. They will work with DHHS' Community Re-Entry Services to identify appropriate mental health, substance abuse, and other services in the community. If they identify appropriate services, Pre-Trial Services Unit Assessment staff will recommend the diversion plan to the bond hearing judge as a condition of release on bond. Additional information about the mental health screening function of the Clinical Assessment and Triage Services Unit begins on page 28.

B. Intervention Program for Substance Abusers

Diversion to the Department of Correction and Rehabilitation's Intervention Program for Substance Abusers (IPSA) takes place after arrest, at the defendant's first trial appearance. The program diverts first-time drug possession offenders from jail to education and treatment programs. The State's Attorney Office and Montgomery County Police Department jointly refer people to the program. If the defendant successfully completes the program their criminal record is expunged. DOCR staff estimates that 72% of FY 2000 IPSA participants successfully completed the program.

A portion of the drug offenders in the IPSA program also have a mental illness. As of February 2001, PTSU staff estimates that 5% of the IPSA participants had a diagnosed serious mental illness in addition to their substance abuse problem. They estimate that another 15% to 20% suffer from both depression and a substance abuse problem.

Defendants assessed as recreational, non-addicted drug users participate in the IPSA education track for at least 16 weeks. This track requires participants to attend classes about substance abuse, submit to urinalysis and breathalyzer testing twice per week, attend at least one Alcoholics or Narcotics Anonymous meeting, and perform community service. IPSA assigns approximately 90% of the participants to the education track.

Individuals assessed as chronic drug abusers and those with co-occurring mental health and substance abuse problems participate in the IPSA treatment track. The treatment track lasts at least 26 weeks and includes mental health and/or substance abuse treatment from private providers, DHHS' Outpatient Addiction Services, or public mental health system providers. Clients also attend weekly Alcoholics or Narcotics Anonymous meetings, submit to urinalysis and breathalyzer testing, and perform community service.

C. Daily Supervision Services Program

The Department of Correction and Rehabilitation's Daily Supervision Services Program (DSSP) was designed as a diversion program for homeless, male, substance abusers. However, due to eligibility restrictions, PTSU has only referred three people to the program in the last two years.

The program diverts individuals from jail to treatment programs between their arrest and trial. DSSP participants live at the Chase Partnership House for an unlimited period of time, and must attend three to six months of daily addiction treatment at the Department of Health and Human Services' Outpatient Addiction Services. All participants stand trial for their crime, however successful completion of the Daily Supervision Services Program results in significantly reduced sentences.

The DOCR's Pre-Trial Services Unit staff recommend clients for the program. Due to limited resources at the Chase shelter, the program includes eligibility restrictions that limit the number of participants. To be eligible, clients must:

- Be willing to work on their substance abuse problem;
- Have stable mental health;
- Have no drug or alcohol abuse relapses while housed at the shelter; and
- Attend Outpatient Addiction Services treatment daily (participants cannot be employed); and
- Have been a Montgomery County resident before becoming homeless.

PTSU reports difficulty identifying clients that meet these requirements. In particular, it is difficult to find homeless, substance abusers involved in the criminal justice system who have stable mental health. In addition, after PTSU identifies an eligible participant, the shelter often must remove them from the program because they have a drug or alcohol relapse.

III. Screening, Assessment and Classification

What is Screening, Assessment and Classification?

Screening involves identifying people that may suffer from a mental illness and require mental health services. Assessment refers to a more in-depth review of a person's mental state to verify that a mental illness exists and to identify the type of mental illness. Classification involves determining the next steps in the individual's mental health care or triaging the individual to the appropriate services and providers. To screen, assess and classify individuals, criminal justice system staff:

- Observe for signs of mental illness;
- Review mental health history;
- Interview the individual about his or her mental health;
- Talk with others familiar with the individual's mental health; and
- Diagnose a mental illness and refer the individual to appropriate care.

Screening, assessment and classification takes place at all four phases of the criminal justice system. Screening can begin at entry into the system, by law enforcement officers at the scene of a crime or incident. Formal screening, assessment, and classification takes place when individuals enter incarceration. Additional screening, assessment and classification takes place throughout an inmate's jail sentence as his or her mental status and service needs change. Mental health professionals may also screen, assess and classify individuals in preparation for release from incarceration.

The American Psychiatric Association's (APA) Task Force on Psychiatric Services in Jails and Prisons recommends three stages of screening and assessment at entry to incarceration:

1. An initial screening of all inmates at the time they are booked into the detention facility to assess suicide potential, mental health history, and current medications;
2. A second screening of all inmates within 24 hours of booking, that is more thorough and structured, and is performed by a mental health professional; and
3. A comprehensive mental health evaluation of inmates suspected of having a mental illness or who offer information about their mental illness. The evaluation should be completed by a trained mental health professional, within 24 hours of referral.

What Screening, Assessment and Classification Services are Available in Montgomery County?

As recommended by the APA, multiple criminal justice system staff in Montgomery County screen individuals for serious mental illnesses. At entry to the system, law enforcement officers rely on observations and conversation with the individual to informally screen for mental illness. The Montgomery County Police Department's Crisis Intervention Team training will help officers screen for mental illness in a more consistent and standardized manner. Crisis Center and Mobile Crisis Team staff also screen clients for mental illness as they address crises. This section of the report describes the screening, assessment and classification that takes place during processing at the Central Processing unit, at intake to the Montgomery County Detention Center (MCDC), and during incarceration.

A. Central Processing Unit

Introduction

Mental health screening begins at the DOCR Central Processing Unit (CPU). To maintain safety, staff observe all individuals at the CPU for signs of health problems, mental illness, and suicide risk. They also conduct a formal mental health screening for individuals detained at the Montgomery County Detention Center after booking.

According to CPU staff, law enforcement officers transport approximately 15,000 people to the CPU for booking annually. If an individual arrives at the CPU in a mental health or medical crisis that requires immediate attention, the law enforcement agency transports the individual to Shady Grove Hospital. Once stabilized, the law enforcement agency transports the individual back to the CPU for booking. Booking involves fingerprinting, photographing, and verifying identification, prior arrests, and outstanding warrants.

District Court Commissioner

After booking, the District Court Commissioner at the CPU decides whether:

- To charge an individual with a crime,
- To release an individual charged with a crime on their own recognizance until trial, or
- To require payment of bond and conditions of bond for individuals charged with a crime and released until trial.

Individuals not charged with a crime are released and receive no formal mental health screening or services. This accounts for approximately 1% of the individuals that appear before a District Court Commissioner annually.

Approximately 35% of the 15,000 individuals brought to the CPU annually are charged with a crime and released until trial. They do not receive a formal mental health screening or any mental health services. These individuals may have a mental illness that contributes to their criminal behavior, but no opportunities currently exist in the system to identify the problem. For approximately 3% of the 15,000 individuals brought to the CPU annually, the District Court Commissioner charges them with a crime and releases them on bond with the condition that they participate in pre-trial supervision. PTSU staff screen those individuals for mental health problems in the course of pre-trial supervision and refer them to appropriate services.

District Court Commissioners charge the remaining 60% of the individuals brought to the CPU annually and detain them at the Montgomery County Detention Center. This includes individuals that commit crimes that make them not eligible for pre-trial release, individuals that cannot afford the bond set by the District Court Commissioner, and individuals that the District Court Commissioner requires appear for a bond hearing.

Mental Health Screening

CPU staff screen everyone detained at MCDC by a District Court Commissioner by completing a Suicide Screening Form. The Suicide Screening Form lists seven questions regarding mental health, which CPU staff ask to identify suicidal tendencies and mental illness. A Suicide Screening Form is attached at ©7-8. CPU staff put everyone that appears suicidal on 15-minute watch (checked every 15 minutes by correctional officers). They house inmates on 15-minute watch where there are no items they could use to hurt themselves.

The CPU correctional officers have no formal clinical or medical training. According to CPU staff, they rely on observation, information provided by the arresting law enforcement officer, and information that the individual shares about his or her mental health. At any time during the booking and intake process, correctional staff that suspect a serious mental health problem refer a detainee to MCDC mental health staff for a mental health assessment. DOCR staff also refer all detainees whose Suicide Screening Form indicates use of psychotropic medication, suicidal tendencies, or a potential mental illness.

B. Detention Center Intake Unit

Individuals detained at the Montgomery County Detention Center (MCDC) begin the intake process at the MCDC Intake Unit. Intake Unit staff complete a Risk Assessment to determine appropriate housing assignments, complete the Suicide Screening Form, and ask the following questions about mental health:

- Have you ever been in a mental institution? When? Where? and Why?
- Have you ever taken medication for mental illness?
- Do you feel you will have any emotional and/or mental problems while incarcerated?
- Have you ever attempted suicide? When?
- Do you feel suicidal at this time?

Intake Unit staff are not mental health professionals. Like the CPU staff, if Intake Staff suspect a serious mental health problem, they can refer an inmate to MCDC mental health staff for a mental health assessment at any time.

C. Detention Center Medical Unit

All new inmates proceed to the Medical Unit for a medical screening. Medical Unit staff observe inmates for alertness and orientation, signs of abnormal or harmful behavior, and signs of alcohol or drug withdrawal. They complete the Suicide Screening Form and ask the inmate the following mental health questions:

- Have you ever had a psychiatric disorder?
- Have you attempted suicide in the past?
- Are you having suicidal thoughts presently?

Medical Unit nurses are not mental health professionals. If they suspect a serious mental health problem, they can also refer an inmate to MCDC mental health staff for a mental health assessment at any time.

D. Detention Center Mental Health Services

Introduction

Mental health staff at the Montgomery County Detention Center (MCDC) provide a variety of mental health services to all MCDC inmates. The MCDC mental health staff includes a full-time therapeutic program manager, three full-time therapists, and a correctional specialist (shared with another MCDC department). A part-time consultant psychiatrist works between four and five hours per week, and a part-time administrative aide provides clerical support 20 hours per week. The full-time mental health staff are on duty weekdays and are on call during evenings and weekends.

Services provided by MCDC mental health staff include:

- Mental health assessments – Conduct mental health assessments of all inmates suspected of having a mental illness and triage to appropriate follow-up services;
- Medication management – Evaluate medication needs, prescribe medication, and provide on-going medication management;
- Crisis intervention – Address all mental health crises in the Detention Center;
- Therapy – Develop treatment plans, provide limited therapy, and follow the progress of all inmates housed in the Crisis Intervention Unit;
- Classification and housing recommendations – Make recommendations regarding classification and housing for inmates with mental illness or psychiatric history;
- Transfer to state mental hospitals – Assess need for hospitalization and coordinate transfers to State mental hospitals;
- Behavior management plans – Develop behavior management plans for disruptive inmates with mental illness who pose a threat to other inmates and staff;
- Juvenile offender assessments – Assess the mental health of all juvenile offenders incarcerated at MCDC.

The remainder of this section describes the mental health assessment and classification services provided by the MCDC mental health staff. Information about crisis intervention and treatment services provided by MCDC mental health staff begins on page 31 and page 35 respectively.

Assessment

DOCR staff can refer any inmate to mental health staff for a mental health assessments during intake to MCDC or at any time during incarceration. Mental health staff assess inmates:

- Referred from the Central Processing Unit, Intake Unit, or Medical Unit;
- Referred by correctional officers observing inmates in the general population;
- Referred by family members, attorneys, or outside physicians; or
- Inmates whose Suicide Screening Form indicates use of psychotropic medication, a potential mental illness, or risk of suicide or self-destructive behavior.

According to the MCDC mental health staff, the majority of the referrals comes from correctional officers observing inmates in the general population. A copy of a form for referring inmates to mental health services is attached at ©9.

MCDC mental health staff respond to referrals as quickly as possible. Crisis or emergency assessments take place immediately and most non-emergency assessments take place within an hour of referral. If an inmate is in a mental health crisis during the evening or weekend, DOCR staff either call mental health staff into the Detention Center or put the inmate on suicide watch until mental health services are on duty.

The mental health assessment is a basic review of mental status, rather than a comprehensive psychological evaluation. It includes an interview to assess orientation, memory, insight, judgement, and psycho-social background. Staff rely on self-reported information and observations, because they do not always have information about an inmates' mental health history.

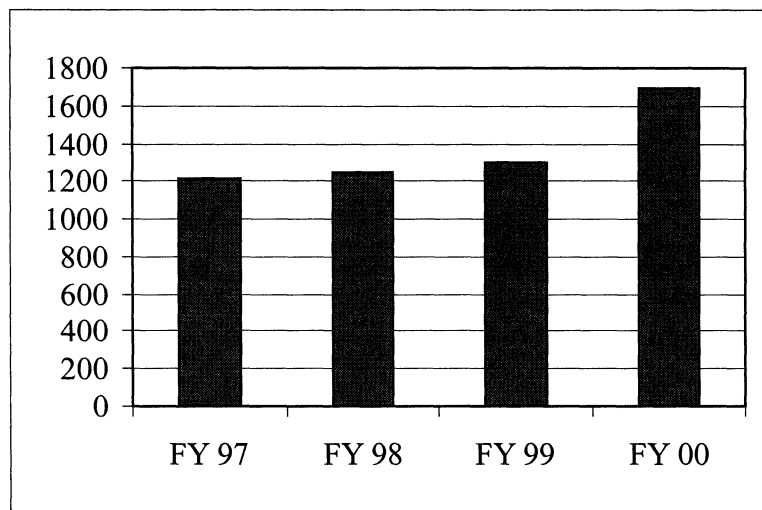
Mental health staff make a diagnostic impression, or overall assessment of mental status, based on the American Psychiatric Association's DSM IV mental health assessment model.²⁰ According to DOCR staff, the types of serious mental illness found among Detention Center inmates varies. Common illnesses include schizophrenia, dementia, depression, and bi-polar disorder. Many inmates also have co-occurring disorders (mental health and substance abuse problems) and have a long history of mental illness.

Mental health staff estimate that they dedicate approximately 70% of their time to mental health assessments. DOCR staff refer 141 inmates on average per month for mental health assessments. Graph 1 illustrates the increase in the number of referrals to MCDC mental health staff for assessments annually between FY 1997 and FY 2000. The annual number of referrals increased from 1,209 in FY 1997 to 1,695 in FY 2000.

²⁰ The APA's Diagnostic and Statistical Manual for Mental Disorders (DSM IV) is the standard diagnostic tool of mental disorders for clinicians and other professionals in the psychology and psychiatry fields. The manual provides categorical classifications of mental disorders that divide disorders into types.

Mental health staff believe that the current system identifies all of the individuals entering the Detention Center with a mental illness. In fact, staff believe there may be over-referrals for mental health assessments from correctional staff in the general population. According to mental health staff, correctional officers err on the side of caution in referring inmates for assessments. As a result, mental health staff spend the majority of their time on assessments rather than other mental health services, such as developing and monitoring treatment plans or providing therapy. Mental health staff report that, ideally, not more than 50% of mental health staff time would be spent on assessments.

Graph 1 – Number of Referrals to MCDC Mental Health Services Staff for Assessments



Classification

The mental health assessment generally results in one of three classifications:

- Clearance to return the inmate to the general population with no further mental health services;
- Clearance to return the inmate to the general population with a referral to the contract psychiatrist for evaluation and medication prescription; or
- Transfer to the Crisis Intervention Unit (CIU) for further observation and treatment.

Information about crisis intervention and treatment services provided by MCDC mental health staff begins on page 31 and page 35 respectively.

E. Clinical Assessment and Triage Services

Introduction

To alleviate some of the demand for assessments on MCDC mental health staff, the FY 2001 Corrections Behavioral Health Initiative includes funds in the Department of Health and Human Services budget for a Clinical Assessment and Triage Services (CATS) Unit. The CATS Unit will assess new inmates suspected of having a mental illness at intake, and try to divert them out of the criminal justice system and into community mental health treatment.

The CATS staff will include a full-time clinical supervisor, three full-time therapists, and two part-time psychiatrists. The therapists will assess clients and identify diversion opportunities. One of the part-time psychiatrists will spend 80% of the time at the CATS Unit assessing and triaging inmates with mental illness. The second part-time psychiatrist will spend 20% of the time providing mental health services to the Spanish speaking inmates at MCDC.²¹

Screening & Assessment

When CATS is fully implemented, Central Processing, Intake, and Medical Unit staff will continue to screen for mental illness by completing the Suicide Screening Form and asking questions regarding mental health and suicide risk. Intake and Medical Unit staff will refer individuals that they suspect have a mental illness to DHHS' Clinical Assessment and Triage Services for a mental health assessment.

The CATS therapists will conduct a psycho-social clinical interview and a brief symptom inventory, and gather basic information from the individual about their mental health and substance abuse history. They will contact family members and physicians for information about an individual's mental health. CATS staff may also review DHHS records for information about the individuals' mental health and substance abuse history. CATS staff will document information about the individuals' history of mental illness, substance abuse, and incarceration for data collection and analysis. The data sheet that CATS therapists will complete is attached at ©10.

CATS will also serve as the State Department of Health and Mental Hygiene's official designee to conduct treatment readiness evaluations and to identify the appropriate level of treatment referral, at the request of judges and lawyers. They expect to complete three to five of these evaluations per week.

²¹ DHHS will use the remaining 20% of the first psychiatrist's time in Outpatient Addiction Services, addressing the mental health needs of individuals discharged from MCDC, until they get an appointment with a psychiatrist in the community. DHHS will use the remaining 80% of the second psychiatrist's time to provide mental health care at the Multicultural Clinic.

Classification

In terms of diversion, CATS staff will also try to identify an appropriate community-based mental health treatment provider for new inmates, and recommend a diversion plan to the court. If an inmate is not eligible for diversion or staff cannot locate an appropriate community-based treatment program, CATS staff will classify or triage assessed inmates as follows:

- Admit inmates with no mental health care needs to the general population;
- Refer inmates that need psychotropic medication to the MCDC contract psychiatrist for medication prescription and/or management; or
- Transfer inmates with immediate and serious mental health needs to the Crisis Intervention Unit for observation and mental health services.

F. Pre-Trial Services Unit, Assessment Section

The DOCR Pre-Trial Services Unit (PTSU), Assessment Section staff assess all detainees before their bond hearing.²² PTSU staff use the assessment information to recommend to the bond hearing judge for or against PTSU supervision until trial.²³ PTSU staff estimate that approximately 20% of PTSU assessments indicate some kind of mental health problem.

To recommend whether a defendant should participate in the pre-trial supervision program, PTSU Assessment Section staff verify the defendant's criminal history, interview the defendant, and speak to family members of the defendant.²⁴ PTSU staff consider job and residency status, whether the defendant is a threat to themselves or others, the likelihood that the defendant will fail to appear at trial, and the defendant's mental health. The recommendation regarding PTSU supervision must remain charge blind (not consider the alleged crime or statement of charges for the current arrest).

Regarding mental health concerns, PTSU staff ask if the defendant has been treated and/or hospitalized for a mental illness, taken psychotropic medication, or attempted to commit suicide. They also rely on information from the jail intake record and the criminal record (which describes previous MCDC mental health assessments), and observations of arresting officers, MCDC staff, and family members. Many defendants have already been assessed by the MCDC mental health staff when they get to PTSU.

²² People detained by the District Court Commissioner appear before a bond hearing judge within 24 hours of arrest (except on weekends) via closed circuit television from the Detention Center.

²³ PTSU guidelines stipulate that PTSU does not make a recommendation regarding pre-trial supervision for the following defendants: 1) Individuals arrested for a violent crime, as defined by the state, 2) Individuals arrested for a violent crime or for drug distribution while out on bond following arrest for a violent crime or for drug distribution.

²⁴ Offenders can decline an interview with PTSU staff. In practice, PTSU staff interview two-thirds to three-quarters of all pre-trial offenders.

If PTSU staff believe that an individual may not be competent to appear for a bond hearing due to a mental illness, they ask MCDC mental health staff to complete a brief mental health assessment and recommend whether the individual should have a competency evaluation. Based on that recommendation, the judge decides whether to order the competency evaluation before holding a bond hearing. Between November 2000 and January 2001, judges recommended a competency evaluation for approximately 1% of the people appearing for a bond hearing.

A Court Diagnostic Team completes competency evaluations at the bond hearing judge's request, and may recommend sending the defendant to Springfield Hospital for a full mental health evaluation. The Court Diagnostic Team members are state employees from Springfield Hospital. The competency evaluation assesses an individual's ability to appear at a hearing, but is not a complete mental health evaluation.

IV. Crisis Intervention

What is Crisis Intervention?

Crisis intervention is the most common mental health service provided in U.S. jails. It is an immediate response by mental health staff to a mental health crisis situation, e.g., suicide attempts, violent incidents due to symptoms of mental illness. Crisis intervention usually involves removing the individual from the general inmate population, putting the individual on suicide watch, and/or prescribing medication. It does not usually involve extended individual or group therapy. While crisis intervention can take place at any point in the criminal justice system, this report focuses on crisis intervention provided during incarceration.

The American Psychiatric Association (APA) recommends that crisis intervention in jails and prisons include:

- Correctional staff training to recognize mental health crisis situations;
- Twenty-four hour availability of psychiatrists and other mental health professionals to complete mental health evaluations and prescribe emergency medication; and
- A special housing area for those requiring mental health supervision.

For inmates with mental illness who are violent, APA recommends specialized programs that provide the security necessary to prevent violence, as well as treatment needed to address the mental illness. The APA recommends placing violent inmates with mental illness in a psychiatric unit instead of isolation, because isolation can exacerbate the symptoms of the mental illness and result in more violent behavior.

Preventing and handling suicide attempts are important components of crisis intervention because all inmates, with or without a mental illness, are at high risk of attempting suicide. Table 4 lists key components of a suicide prevention program recommended by the National Commission on Correctional Health Care (NCCHC).

Table 4: NCCHC Recommendations to Prevent Suicide

Training	Jail administrators provide training for correction staff in recognizing potential suicide cues.
Identification	Suicide screening forms contain observation and interview items designed to gauge an inmate’s potential suicide risk.
Monitoring	Staff provide regular and documented supervision, supplemented by closed circuit TV or inmate watchers.
Referral	Jail administrators develop procedures for referring potentially suicidal inmates and inmates that attempt suicide to mental health care providers.
Evaluation	Qualified mental health professionals conduct mental health evaluations.
Housing	Correction staff provide constant supervision in jail housing units.
Communication	Jail administrators develop procedures for clear and timely communication between health care and correctional staff.
Intervention	Jail administrators develop plans for handling a suicide in progress.
Notification	Jail administrators develop procedures for notifying jail administrators, outside authorities, and family members of attempted and successful suicides.
Reporting	Jail administrators develop procedures for documenting potential, attempted, or completed suicides.

What Crisis Intervention Services are Available in Montgomery County?

This section of the report describes crisis intervention services available for Montgomery County Detention Center inmates, but a person can experience a mental health crisis at any point during their involvement with the Montgomery County criminal justice system. In some cases, County hospital emergency rooms and State mental hospitals care for people in crisis. The DHHS Crisis Center and Mobile Crisis Team provide mental health crisis intervention in the community 24-hours a day, 7 days per week (see page 18). Between arrest and trial, DOCR’s Pre-Trial Services Unit staff may help address the mental health crisis of an individual under PTSU supervision (see page 42).

A. Detention Center Mental Health Services

MCDC defines a mental health crisis as any action resulting from a mental illness that creates disruption or jeopardizes safety in the Detention Center. MCDC mental health staff respond to all mental health crisis at the Detention Center. They assess and stabilize all inmates referred by DOCR staff as quickly as possible. If a mental health crisis occurs during non-business hours, mental health staff are called in or the inmate is put under suicide watch until mental health staff are available.

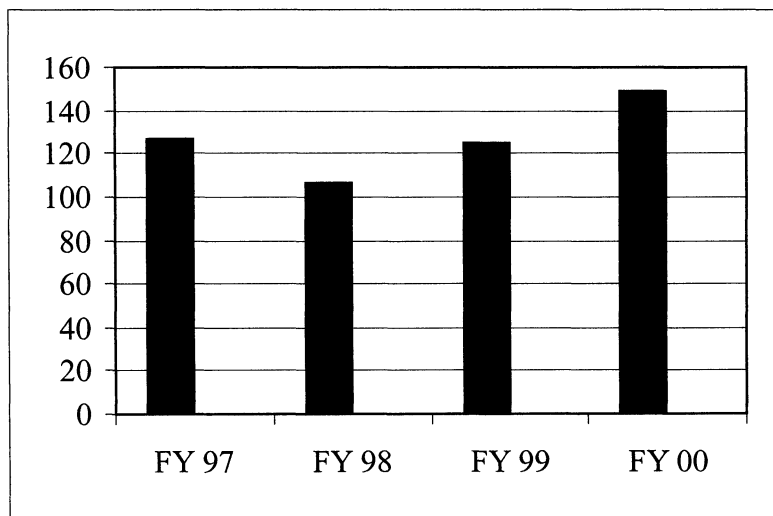
Mental health staff may transfer the inmate in crisis to the Crisis Intervention Unit (CIU) for observation, stabilization, medication, and counseling. The length of stay in the CIU depends on the inmate’s mental health status. Some inmates stabilize and return to the general population in a few days or weeks. Others do not attain enough mental stability to return to the general population for the rest of their incarceration.

The Crisis Intervention Unit houses up to 28 male inmates and 4 female inmates. The average number of inmates housed in the CIU monthly ranged from 20 in FY 1997 to 26 in FY 2000. DOCR staff indicated that the number of inmates admitted to the CIU is limited by the number of available beds and may not reflect the total number of inmates that need special housing due to a mental health problem. If space is not available in the CIU, DOCR houses inmates needing special mental health attention in the general population under 15 minute watch.

Suicide Prevention

DOCR follows National Commission on Correctional Health Care standards concerning suicide prevention. First, DOCR trains all correctional staff that have contact with inmates to recognize potential suicide clues. In addition, correctional staff from the Central Processing, Intake, and Medical Units assess all new inmates at intake for suicide risk. If at any time during incarceration inmates show signs of suicide risk, DOCR staff refer them to the mental health staff for a mental health assessment. DOCR staff place all inmates that exhibit self-destructive behavior on 15-minute watch and/or transfer them to the Crisis Intervention Unit for observation. Graph 2 illustrates the number of inmates placed on 15-minute watch annually between FY 1997 and FY 2000.

Graph 2 – Number of MCDC Inmates Placed on 15 Minute Watch



DOCR made additional procedural changes over the past year to prevent suicides. In the case management filing system, all inmates assessed as a potential suicide risk have red files, to bring them to the attention of correctional specialists. DOCR requires the correctional specialists to meet with those inmates at least once per week to check on their stability. DOCR staff report that, due to large correctional specialist caseloads, the weekly checks are very brief. DOCR has also improved communication among MCDC staff to further prevent suicides. For example, MCDC records department staff keep reports of all attempted suicides and inmates who exhibit suicidal tendencies. They monitor internal communications to make sure shift commanders are forwarding this information to relevant MCDC staff daily.

DOCR also placed posters and pamphlets in the lobby and visiting areas to increase visitor awareness of potential suicidal behaviors. They instruct visitors to notify DOCR staff of any inmate behavioral changes which may indicate a mental health problem or suicide risk.

V. Treatment

What is Treatment?

Mental health treatment in criminal justice systems typically includes:

- Development of a treatment plan,
- Prescription and management of psychotropic medication, and
- Therapy.

Individuals may receive mental health treatment services through diversion programs, while awaiting trial, during incarceration, or following release from incarceration.

Treatment Plan - According to the National Commission on Correctional Health Care (NCCHC), a treatment plan is a series of written statements specifying a particular course of therapy and the roles of the qualified health care personnel in implementing the plan. It is an individualized, multidisciplinary statement of short and long-term goals, and the methods used to pursue the goals. The treatment plan outlines the pharmaceutical, supportive, and rehabilitative services that the inmate will receive during incarceration. The treatment plan is updated as the inmate's clinical conditions change.

Psychotropic Medication - People with mental illness may receive psychotropic or behavior-modifying medication while incarcerated. NCCHC guidelines stress the importance of prescribing psychotropic medication only when clinically indicated and not for disciplinary reasons. Dispensing psychotropic medication requires careful management and frequent review by a psychiatrist to make sure that the medication continues to meet a patient's needs. Special care must be taken in prescribing psychotropic medication to substance abusers. This group presents challenges in the accurate diagnosis and treatment of complaints that may be associated with a drug addiction.

Therapy - Therapy involves individual or group counseling. The basic philosophy underlying the APA and NCCHC standards is that the mental health therapy provided in correctional institutions should be equivalent to that available in the community. Relatively short sentences and limited resources in local jails restrict the effectiveness and availability of therapy. Therefore, treatment in jail is often restricted to the prescription and management of psychotropic medication and crisis intervention.

What Treatment Services are Available in Montgomery County?

Most County programs refer individuals with mental illness involved in the criminal justice system to appropriate mental health and substance abuse treatment. For example, the DHHS Crisis Center and Mobile Crisis Team staff provide short-term counseling and refer clients to appropriate long-term mental health treatment. PTSU staff refer clients to treatment providers during pre-trial supervision. A few County programs/services provide treatment directly, including DHHS' Outpatient Addiction Services, the Detention Center mental health services, DHHS' Jail Addiction Services, and DHHS' Assertive Community Treatment Team.

A. Addiction Services Coordination and Outpatient Addiction Services

Addiction Services Coordination

As the entry point into substance abuse services in the County, DHHS' Addiction Services Coordination (ASC) staff screen, assess, and refer County residents to appropriate substance abuse treatment services.²⁵ ASC staff also screen and refer individuals who have a mental illness and substance abuse problem, called co-occurring disorders.

ASC reports that approximately 50% of their clients come from the criminal justice system, including the Pre-Trial Services Unit, the Intervention Program for Substance Abusers, Community Re-Entry Services, the Pre-Release Center, and the Community Accountability, Reintegration and Treatment (CART) program. Referral to ASC occurs when:

- A judge orders substance abuse or co-occurring disorder treatment as part of the conditions of pre-trial release;
- A judge orders treatment for substance abuse or co-occurring disorder as part of a defendant's sentence;
- An individual is enrolled in the Intervention Program for Substance Abusers;
- An individual's Pre-Release Center or CART treatment plan includes treatment for substance abuse or a co-occurring disorder; or
- An inmate's jail discharge or diversion plan includes treatment for substance abuse or a co-occurring disorder.

Addiction Services Coordination refers a large proportion of their clients from the criminal justice system, particularly those with co-occurring disorders, to DHHS' Outpatient Addiction Services for treatment. Other clients receive outpatient treatment from DHHS contractors. A small proportion of clients from the criminal justice system require inpatient residential treatment. Addiction Services Coordination refers those

²⁵ Addiction Services staff report that only 40 percent of the people referred to substance abuse treatment enroll in a treatment program within 30 days of referral. This is typical behavior for people suffering from severe alcohol or drug addiction, who frequently have relapses even after periods of abstinence.

clients to DHHS contractors who provide residential substance abuse treatment services e.g., Avery Road Treatment Center. A typical residential substance abuse program includes a one to five day detoxification program, plus 21 days of inpatient care.

Outpatient Addiction Services

DHHS' Outpatient Addiction Services (OAS) provides intensive outpatient treatment to substance abusers and individuals with co-occurring disorders (mental health and substance abuse problem). OAS targets people with multiple service needs, e.g., substance abuse, mental illness, disability, homelessness, unemployment. OAS provides between 9 and 30 hours of treatment per week, regular urinalysis testing, and attendance at Alcoholics Anonymous or Narcotics Anonymous meetings.

Outpatient Addiction Services staff develop an Individual Treatment Plan for all new clients. Treatment involves weekly group programs on topics such as how drugs work, myths about addiction, medical aspects of addiction, addiction and the family, and anger management. The OAS program also provides individual counseling, General Education Diploma (GED) education, vocational counseling, primary health care, meals for breakfast and lunch, and bus tokens. Some clients participate in specialized DHHS treatment programs, such as the Methadone to Abstinence program. Individuals with co-occurring disorders supplement the OAS substance abuse programs with regular meetings with a psychiatrist. OAS contracts with two psychiatrists for a total of 25 hours per week of psychiatric services.

As a client's condition improves over time, they reduce the number of hours per week spent in OAS treatment. Participants complete treatment when they achieve their treatment goals and are alcohol and drug free for six months. The OAS treatment process usually lasts at least six months.

B. Detention Center Mental Health Services

Introduction

DOCR staff house most inmates with mental illness in MCDC's general population. Due to limited mental health resources, treatment for inmates in the general population is limited to prescription and management of psychotropic medication. During FY 2001, to facilitate medication distribution, DOCR began housing inmates in the general population that take psychotropic medication in two designated housing units.²⁶

DOCR staff house inmates with chronic mental illnesses and inmates in a mental health crisis in the Detention Center's Crisis Intervention Unit (CIU). According to DOCR, these inmates pose serious jail management and security problems and need assistance in most areas of functioning (e.g., basic hygiene, medication compliance, social interaction). Mental health staff develop treatment plans, provide limited therapy, and distribute medication for CIU inmates.

²⁶ Medicated inmates participating in special programs that require other housing arrangements (e.g., Jail Addiction Services), do not live in the two units designated for inmates on psychotropic medication.

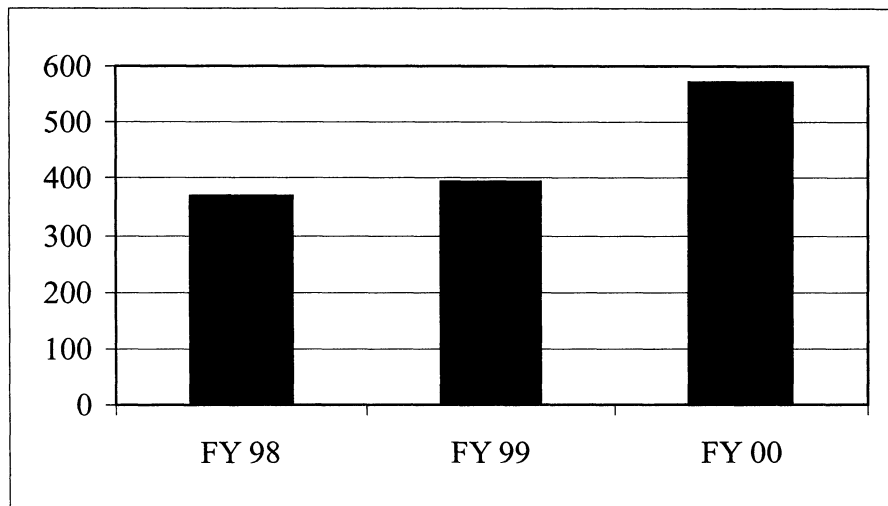
MCDC mental health staff attempt to transfer to State mental hospitals inmates that pose an imminent danger to themselves or others and do not respond to MCDC services. DOCR transfers inmates with or without mental illnesses to administrative segregation or isolation units within MCDC in response to disciplinary problems.

Psychotropic Medication Management

Medication management at MCDC includes an evaluation to determine medication needs, prescription and administration of medication, and on-going medication management. According to DOCR, 18% to 20% of the total MCDC inmate population currently receives psychotropic medication. Almost all of the MCDC inmates on medication have a history of using psychotropic medication before incarceration.

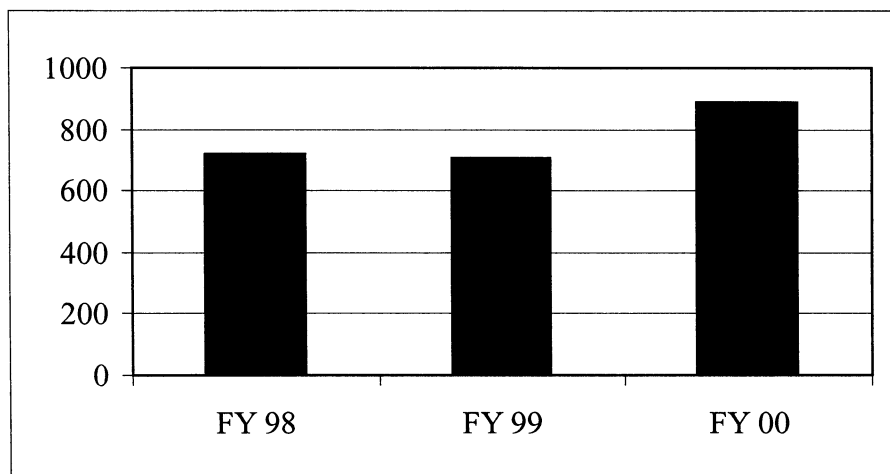
MCDC mental health staff conduct mental health screenings for all inmates referred by DOCR staff. Mental health staff refer approximately one third of the screened inmates to the DOCR contract psychiatrist for medication prescription and management. Graph 3 illustrates the increase in the number of inmates referred each year to the contract psychiatrist for an initial evaluation and medication prescription between FY 1998 and FY 2000.

Graph 3 – Number of Inmates Referred to the Psychiatrist for an Initial Assessment – FY 98 – FY 00



The psychiatrist, on contract with DOCR for five hours per week, evaluates inmates referred by CIU therapists, assesses the inmates' needs for medication, and prescribes medication. The psychiatrist then meets regularly with the inmates to assess the effectiveness and appropriateness of their medication. The MCDC mental health staff coordinate the periodic follow-up visits with the psychiatrist. Graph 4 illustrates the number of follow-up medication consultations with the psychiatrist between FY 1998 and FY 2000. The psychiatrist evaluates, on average, 25-30 inmates during the five-hour period at MCDC each week. Detention Center mental health staff report that, ideally, the psychiatrist would see approximately half that many inmates per week.

Graph 4 – Number of Inmates Referred to the Psychiatrist for Follow-Up Medication Management – FY 98 – FY 00



Through FY 2000, most of the inmates prescribed psychotropic medication were housed in the general inmate population and received their medication from MCDC Medical Unit nurses without psychiatric training.²⁷ The FY 2001 Corrections Behavioral Health Initiative includes \$155,020 in DOCR's budget for three psychiatric nurses to:

- Administer prescribed psychotropic medication;
- Monitor mental health symptoms and medication compliance;
- Prevent suicide attempts within the general population by supplementing correctional officer monitoring of inmates; and
- Educate inmates and help coordinate a plan for continuing services after release.

DOCR also began housing all inmates taking psychotropic medication in two designated housing units to facilitate mental health care from the new psychiatric nurses. DOCR will schedule the new positions in staggered shifts to provide 24-hour coverage seven days per week.

Treatment Plan

MCDC mental health services staff usually house inmates with a serious mental illness or inmates in mental health crisis in the Crisis Intervention Unit. Due to limited staff resources, only inmates housed in the CIU receive a treatment plan and limited mental health therapy.

²⁷ DOCR cannot force an inmate to take medication. If an inmate refuses to take his or her medication and mental health staff believe the inmate is dangerous to him or herself, they take steps to admit the inmate to a State mental hospital.

Mental health staff develop a confidential treatment plan for each inmate housed in the Crisis Intervention Unit. The treatment plan identifies goals and objective for the inmate's time in the Unit, which varies from a few days to an inmate's entire sentence. Mental health staff indicate that it can be difficult to evaluate an inmate's mental health and develop a treatment plan because staff frequently do not have information about the inmate's mental health history. They rely solely on self-reported information and observations by DOCR staff.

Mental health staff also develop management plans for inmates leaving the Crisis Intervention Unit, to share with the correctional officers that oversee the inmate in the general population. Mental health staff develop special management plans for inmates who are psychotic, hostile, assaultive, or suicidal. The special management plans may specify, for example, that a correctional specialist check in weekly with an inmate who has a history of self-destructive behavior.

Therapy

Mental health staff meet individually with the inmates housed in the CIU at least once per week, to provide some therapy and to assess their status. The mental health staff meet weekly to discuss the progress of all of the CIU inmates. Mental health staff do not provide therapy for inmates in the general population or for CIU inmates after they return to the general population. Mental health staff report that they stopped providing individual and group therapy to inmates in the general population in the mid-1990s, due to staff attrition and hiring freezes.

Currently, professional mental health staff at MCDC include a full-time therapeutic program manager, three full-time therapists, and a part-time consultant psychiatrist (four to five hours per week). In 1999, DOCR requested that the U.S. Department of Justice, National Institute of Corrections (NIC) complete a study of the suicide prevention practices and mental health services at MCDC. The NIC report recommended a minimum of seven full-time mental health staff for a facility the size of MCDC. The findings and recommendations of the NIC report are attached at ©11.

Transfer to State Mental Hospitals

Mental health staff attempt to transfer inmates with serious mental illnesses who pose an imminent danger to themselves or others. Inmates charged with misdemeanors are transferred to the Springfield State Mental Hospital. Inmates charged with felonies are transferred to the Perkins State Mental Hospital. Transfer requires involuntary commitments signed by two physicians, approval by the State public mental health system (for inmates who do not have private health insurance), and acceptance by the State hospital.

MCDC mental health staff indicate that these requirements make it difficult to get inmates admitted to the State mental hospitals. In addition, the 1999 National Institute of Corrections report (see Attachment 6 at ©11) noted that the hospitals resist accepting

inmates who are a danger to themselves or others and may require longer term hospital care. NIC reported that hospital access is only readily available to inmates requiring short-term inpatient competency or insanity evaluations. MCDC mental health staff observe that the hospitals often discharge admitted inmates after a brief stay, and that they return to MCDC still exhibiting symptoms of a serious mental illness.

C. Jail Addiction Services

The DHHS Jail Addiction Services (JAS) program provides substance abuse treatment services for MCDC inmates who volunteer to participate in the program. JAS focuses on inmates who will return to the community relatively soon. JAS provides treatment during incarceration and referral to continued treatment after release. JAS treats addiction as a disease and gives participants tools that they can use to address the addiction their entire lives.

The program serves an average of 60 inmates at MCDC (50 men and 10 women), and has an 80 inmate capacity.²⁸ Most of the JAS program participants committed minor crimes and have multiple problems in addition to substance abuse, such as mental illness, homelessness, and unemployment.²⁹ JAS staff report that the number of JAS participants with co-occurring disorders is increasing. They estimate that 30% of the JAS participants take psychotropic medication, and an additional 30% have some form of mental illness not currently treated with medication. JAS clients with substance abuse and mental health problems do not receive any additional treatment to specifically address their mental illness.

Education and Treatment Services

DHHS refers to JAS as a modified therapeutic community. Participants live together in a minimum security block at MCDC, providing accountability and support for one another. The program is interactive and participatory, with inmates assigned responsibilities such as serving as peer counselors for new participants and helping to run self-help groups. Participants attend education classes to learn about their disease (e.g., neurological aspects of chemical dependency, the process of recovery), and attend task groups to discuss and complete tasks that help them understand and control their addiction. After completing the education and task phases of the program, inmates attend aftercare groups for counseling on life issues and long term recovery.

JAS clients with co-occurring disorders do not receive any additional treatment to specifically address their mental illness. The staff tries to address participants' mental health problems by noting the problems in the inmates' treatment plan. For example, the treatment plan will indicate that a treatment goal is to stay on prescribed psychotropic medication. The treatment plan may also mention maintaining an awareness of the

²⁸ Since the program is voluntary, it is often not at capacity. The rigorous demands of the program keep many inmates from volunteering to participate.

²⁹ To participate in JAS the individual's mental health must be stable. Inmates accused of or sentenced for committing violent crimes are not eligible to participate.

mental illness (e.g., if a person suffers from depression the treatment plan will indicate that one treatment goal is to observe changes in the inmate's mood). JAS staff report that the psychiatrist funded through the FY 2001 Corrections Behavioral Health Initiative will provide some individual mental health therapy for JAS clients.

Referral to Community-Based Services

Community Re-Entry Services (CRES) staff identify treatment programs outside the jail that are better suited to the needs than incarceration, and recommend placement in the treatment program to the court. CRES also identifies services for JAS participants after release from MCDC. Some JAS clients receive residential substance abuse and mental health services out-of-state. Others receive local residential treatment services, and then transition to outpatient treatment.

CRES reports that the number of providers in the community serving individuals with co-occurring disorders is limited. CRES staff often refer individuals with co-occurring disorders to DHHS' Outpatient Addiction Services for community-based substance abuse and mental health services in the community. Additional information about Community Re-Entry Services program begins on page 46.

D. Assertive Community Treatment Team

The DHHS' Assertive Community Treatment (ACT) Team provides comprehensive treatment, case management, and support services to people who have not successfully responded to traditional mental health treatment programs. Few of the ACT Team clients served to date were referred by the Montgomery County Police Department and Montgomery County Detention Center. Most ACT Team clients served were referred by local hospitals, Springfield Hospital Center, DHHS' Core Service Agency, homeless services providers, advocacy organizations, and relatives.

ACT Team clients have multiple problems in addition to their mental illness (e.g., substance abuse, homelessness) and may have multiple mental illnesses. They typically have difficulty keeping treatment appointments and taking medication as prescribed. To address these difficulties, ACT staff interventions take place in the community and ACT staff members form a multi-disciplinary team that can address the clients' multiple service needs.³⁰ If an ACT Team client is incarcerated, the Team provides services throughout incarceration.

The ACT Team monthly caseload is approximately 30 clients. DHHS expects to increase the caseload to 70 clients by the end of FY 2001. ACT Team clients must meet medical necessity criteria under the public mental health system and cannot receive services from the ACT Team and another outpatient treatment provider simultaneously. To more consistently identify clients that have not responded to traditional mental health

³⁰ The FY 2001 Corrections Behavioral Health Initiative funds one full-time Psychiatric Nurse and two full-time Community Service Aides for the ACT Team. These positions bring the total FY 2001 ACT Team staff to 11 full-time positions.

treatment, DHHS is developing a formal referral system between the ACT Team and mental health providers. When a provider's client is not succeeding in the current treatment program (e.g., does not go to appointments, take medication, or cooperate with the mental health provider), the provider will contact the ACT Team to take over providing services to the client.

DHHS staff are also working to increase the use of ACT Team services for individuals involved in the criminal justice system. That population often needs the type of intervention provided by the ACT Team, to reintegrate successfully into the community and avoid recidivism. DOCR and DHHS staff currently try to connect inmates with the most severe mental health needs to community providers upon release from incarceration. Those inmates are not eligible for ACT Team services because clients cannot receive services from the ACT Team and another provider simultaneously. They would be appropriate ACT Team clients if they do not succeed in the community-based treatment arranged by DOCR and DHHS staff.

VI. Case Management

What is Case Management?

In general, case management in the criminal justice system involves:

- Assessing an individual's service needs;
- Creating a comprehensive case management plan identifying the client's short and long term goals;
- Identifying and linking clients to appropriate service providers both in and outside the jail;
- Monitoring client progress; and
- Providing counseling to clients and their families to help them meet goals.

Case management is an important component of services for individuals in the criminal justice system because they usually have multiple service needs (e.g., mental health, housing, employment) that require assistance from multiple providers. Case managers coordinate these services and provide the support that individuals involved in the criminal justice system need to succeed in treatment, maintain stability, and stay out of the criminal justice system in the future.

Case management can take place in any phase of the criminal justice system. At entry to the system, case management primarily involves coordinating services to divert individuals from incarceration. In the prosecution/pre-trial phase, case managers supervise defendants until trial, assess service needs, refer to service providers, and assure that defendants meet pre-trial release conditions and appear at court.

During the corrections phase of the criminal justice system, case managers provide counseling and coordinate services during incarceration, and refer inmates to community-based providers for services after release. Some inmates also need case

management services after release to maintain stability and succeed in community-based treatment. Research indicates that inmates with mental illness who received case management during and after incarceration were significantly less likely to be re-arrested, or were re-arrested after a longer period of time than were mentally ill inmates who did not receive such services.³¹

What Case Management Services are Available in Montgomery County?

Multiple services for people with mental illness involved in the Montgomery County criminal justice system include some aspects of case management. However, few County programs and services include all of the components of traditional case management or provide case management over the long term. Assessment of needs and referral to service providers is the most common component of case management provided in Montgomery County. Staff from the Montgomery County Police Department, Crisis Center, Mobile Crisis Team, Clinical Assessment and Triage Services, Pre-Trial Services Unit, and Addiction Services Coordination perform this function at different points in the system.

Other programs provide more comprehensive case management. The Assertive Community Treatment (ACT) Team provides case management, treatment and support services. However, the ACT Team currently serves very few individuals involved in the criminal justice system. The Community Re-Entry Services (CRES) staff provide case management services to a subset of MCDC inmates. Inmates participating in the Pre-Release Center and Community Accountability, Reintegration and Treatment (CART) programs receive case management services that support community re-integration. CRES, PRC, and CART case management services end at the end of the individual's sentence. The Assertive Community Treatment (ACT) Team provides case management services for ACT Team clients.

ACT Team services are described in more detail beginning on page 40. The Community Re-Entry Services, Pre-Release Center and Community Accountability, Reintegration and Treatment programs are described under discharge planning, beginning on page 49. This part of the report describes the case management provided by the Pre-Trial Services Unit's Supervision Section and the Montgomery County Detention Center correctional specialists.

A. Pre-Trial Services Unit, Supervision Section

DOCR's Pre-Trial Services Unit (PTSU), Supervision Section staff monitor all pre-trial defendants referred by the court. DOCR data indicate that approximately 1,200 defendants were placed in pre-trial supervision during FY 2000. The average daily caseload in FY 2001 ranges from 300 to 450 pre-trial clients. Each PTSU caseworker carries a caseload of approximately 55 clients. PTSU staff estimate that between 25%

³¹ Ventura, L.A., et al. 1998. "Case Management and Recidivism of Mentally Ill Persons Released From Jail", *Psychiatric Services* 49:1330-1337.

and 30% of their clients have a mental illness.³² PTSU staff also report that the number of pre-trial supervision clients accused of misdemeanors has declined and the number accused of violent crimes has increased.³³

Case management functions of Pre-Trial Services Unit, Supervision Section staff include:

- Assessing client service needs,
- Connecting clients to service providers,
- Monitoring compliance with pre-trial release conditions,
- Checking in with clients regularly by phone and in person,
- Conducting periodic breathalyzer and urine tests for alcohol or drug use, and
- Reminding clients of court appearances.

PTSU caseworkers begin supervision by completing an intake assessment, which includes compiling information about the defendant's criminal record, stability in the community, employment, and substance abuse and mental health history. The caseworker also reviews the statement of charges, and the bond conditions imposed by the judge or District Court Commissioner.³⁴

PTSU staff determine an appropriate level of monitoring for each client, ranging from telephone tracking (one phone call to the PTSU office weekly) to intensive supervision (three face-to-face or telephone contacts each week). Supervision for individuals with mental illness usually includes one or two face-to-face contacts per week. Clients also receive regular breathalyzer and urinalysis testing.

If bond conditions require mental health, substance abuse, or other treatment, PTSU staff identify appropriate providers. They call the providers to make initial appointments for the client (usually occurs within two weeks) and help the client arrange transportation. The caseworkers usually refer clients to one of the following providers for mental health services:

- Crisis Center – when clients are in a mental health crisis (e.g., suicidal);
- Outpatient Addiction Services – when clients have a co-occurring disorder;
- State public mental health system provider – when a client does not have private health insurance and needs psychotropic medication and on-going medication management; or
- Private provider – when the client has private health insurance.

³² PTSU staff report that defendants with a mental illness tend to remain under pre-trial supervision longer than average due to multiple pre-trial interventions by the court and attorneys to find alternatives to incarceration.

³³ Although PTSU guidelines indicates that the PTSU cannot recommend for or against pre-trial supervision for offenders accused of committing a violent crime, the court can require that PTSU supervise individuals accused of a violent crime.

³⁴ If the caseworker determines after the bond hearing that the client needs mental health services, the caseworker can petition the court to modify the bond release conditions to include a requirement for mental health services. If the defendant ever becomes a danger to himself or the community, the caseworker submits a revocation petition to the judge and a bench warrant may be issued by the court.

Defendants sign a Release of Information waiver allowing the PTSU caseworker and treatment providers to exchange information about clients. The caseworker can contact the service provider to monitor treatment attendance, compliance with medication, and other information about the defendant's conditions of release.

B. Detention Center Correctional Specialist

MCDC correctional specialists provide case management services to all inmates in the Detention Center general population, including housing and program classification, counseling, referral to services, crisis intervention, and discharge planning. Six correctional specialists each have a caseload of 100 to 150 inmates in designated jail units. A seventh correctional specialist serves approximately 50 inmates housed in the Youthful Offender Unit.

Due to large caseloads, correctional specialists are not able to provide the in-depth oversight, guidance, and follow-up services commonly associated with case management. For example, correctional specialists do not develop and regularly review comprehensive case management plans for each inmate, which describe program goals during incarceration and after release. Required face-to-face meetings with inmates designated as suicide risks are very brief, usually a few minutes. Correctional specialists do not continue to case manage individuals after their release from MCDC.

Classification

The correctional specialists' primary case management duty is classification of inmates for placement in appropriate housing and program activities. Classification includes:

- Conducting risk and diagnosis assessments for newly arrived inmates to determine housing placements;
- Carrying out routine and unscheduled classification reviews;
- Evaluating inmates with special custody problems (e.g., mental illness, suicide risk, escape risk); and
- Referring inmates to Detention Center programs and services (e.g., Model Learning Center).

Counseling

Correctional specialists provide brief counseling services to assist inmates with personal, family, financial, or legal problems. They see inmates for regularly scheduled visits or in response to inmate requests. In terms of mental health needs, correctional specialists:

- Screen inmate requests for mental health services and refer them to the MCDC mental health staff as needed;
- Intervene in mental health crisis situations; and
- Hold brief face-to-face meetings at least once per week with inmates assessed with a suicide risk.

Discharge Planning

Correctional specialists work with attorneys, parole and probation officers, family members, and community-based service providers to plan for inmate discharge. They also relay court and release information to inmates.

VII. Discharge Planning

What is Discharge Planning?

Discharge planning takes place at the corrections phase of the criminal justice system and prepares inmates for release from incarceration and reintegration into the community. In general, discharge planning involves:

- Developing a plan of activities an inmate will complete before release (e.g., basic life skills training, job search assistance), and
- Linking inmates to needed services upon release (e.g., referral to mental health and substance abuse treatment, assistance locating housing).

What Discharge Planning Services are Available in Montgomery County?

A. Detention Center Correctional Specialists

DOCR Correctional Specialists provide discharge planning services for all inmates in the general population (except inmates in the JAS program). Correctional specialists work with attorneys, parole and probation officers, and community-based service providers to plan for inmate discharge. They also relay court and release information to inmates. Due to large caseloads, correctional specialists provide limited discharge planning for individual inmates and are unable to provide follow-up services to inmates after release from jail.

DOCR requires all inmates to attend at least one Community Release Class within two months of their scheduled release date. The weekly classes, led by the case management supervisor (Correctional Specialist III), address career planning, community-based treatment, and housing.

- Career planning - A representative from Montgomery Works introduces inmates to services available at the County's One-Stop Employment and Training Center. Montgomery Works staff also help inmates with job searches, resume development, and other employment needs. In addition, correctional specialists help inmates obtain proper documentation (e.g., social security cards, birth certificates), allow inmates to make phone calls related to their job search, and take them to job interviews.

- Treatment - The DOCR case management supervisor assesses the social service needs of each inmate, and provides information on community-based treatment programs and providers.
- Housing - Correctional specialists refer inmates who need housing to public housing agencies and/or residential treatment facilities. According to MCDC staff, the limited stock of affordable housing in Montgomery County restricts the correctional specialist's ability to successfully refer all inmates to appropriate housing.

B. Community Re-Entry Services

Introduction

DHHS' Community Re-Entry Services (CRES) provides discharge planning and case management services for inmates in the Jail Addiction Services Program, inmates housed in the Crisis Intervention Unit, and youthful Moral Recognition Therapy (MRT) offenders. The CRES staff includes a clinical supervisor and three therapists.

In general, CRES staff identify community-based services and help inmates prepare for release and transition to community services. CRES activities include:

- Assessing clients' community-based service needs;
- Identifying appropriate services and providers in the community;
- Working with inmates, family members, attorneys, courts, and community providers to get clients accepted into treatment programs; and
- Helping to motivate inmates for participation in community-based treatment.

CRES staff usually refer inmates to community-based services at sentencing, by recommending alternatives to incarceration to the trial judge. Staff also arrange referral to community-based services after sentencing, by going back to the judge for a modification of the sentence. For the remainder of the cases, CRES staff refer inmates to community services as they complete their sentence and prepare for release.

CRES therapists do not provide on-going services and case management after clients leave MCDC. CRES staff noted that on-going case management would be useful because their clients usually need additional support after release to reintegrate into the community successfully.

Jail Addiction Services Participants

CRES staff meet with each participant when they enter the JAS program to assess their service needs. Assessment is an on-going process as the inmate's mental health and substance abuse problems stabilize. CRES staff estimate that it takes approximately 90 days upon entry to the jail to completely assess the inmate's needs. CRES staff work

with the inmate, the inmate's family, and legal counsel to locate an appropriate community treatment program placement, and to motivate and prepare inmates for community-based treatment. They recommend the plan for diversion to community-based treatment to the court.

CRES staff often refer JAS participants to intensive long-term residential substance abuse treatment. Others are referred to shorter term residential treatment or to outpatient substance abuse and mental health treatment. Most of the JAS participants are placed in residential treatment when they leave MCDC, and later move into outpatient services.

Crisis Intervention Unit Residents

CRES staff assess all new inmates housed at the Crisis Intervention Unit (CIU). CIU inmates eligible for connection to community-based services must volunteer to work with CRES staff, agree to take their medication, and maintain mental stability. Those inmates not ready to work with CRES are continually re-assessed until they are stable and willing to participate.

CRES staff placed approximately 50 inmates from the Crisis Intervention Unit in community treatment services between January and December 2000. As with JAS participants, staff work with the eligible inmate, their family, and legal counsel to identify mental health and/or substance abuse programs in the community that will meet their needs. CRES staff also coordinate housing, clothing, and other needs. They meet weekly with inmates to assess whether they are ready for an alternative to incarceration and to identify an appropriate community program.

CRES often refers CIU inmates to Outpatient Addiction Services for intensive day treatment for mental illness and substance abuse, outpatient programs at community hospitals, and to local non-profit providers. Residential treatment programs with close monitoring and support by on-site staff best meet the needs of former CIU inmates (e.g., St. Luke's House, Montgomery House), but CRES staff indicate that those programs rarely have space available and have long waiting lists.

CRES staff report that they are unable to provide discharge planning to some of the most mentally disturbed CIU inmates, who are very mentally unstable and refuse to take psychotropic medication. Those inmates are not stable enough for referral to community-based services or are not accepted into community-based mental health programs. They complete their sentence and leave MCDC without a treatment plan or formal referral to a specific service provider. Data on the number of CIU inmates released without referral to a provider is not available.

If MCDC staff know the inmate's release date, they provide information about the Crisis Center and shelters and give the inmate three days worth of medication before release. However, some of these CIU inmates are released by a judge directly from a court hearing. They have no resources or personal affects, and MCDC mental health staff

are not notified of their release. If they return to the Detention Center on their own accord, they receive medication and information about community mental health resources. However MCDC mental health staff report that few of these inmates have the capacity or motivation to return to MCDC for medication and information about mental health resources.

CRES staff report that many of the inmates released without referral to services receive housing and mental health care through shelters and nonprofit mental health providers. Some continue to refuse treatment, do not take their medication, and often end up in the Detention Center again.

PATH Case Manager

The annual Projects for Assistance in Transition from Homelessness (PATH) grant funds case management, mental health, and substance abuse services for homeless individuals with serious mental illness and/or co-occurring disorders. The Department of Health and Human Services received a \$70,000 PATH grant in FY 2001 to hire a case manager to work with homeless, mentally ill inmates housed in the Pre-Release Center and Crisis Intervention Unit (CIU). DHHS expects to advertise for the position in the spring 2001.

Working out of DHHS' Community Re-Entry Services Unit, the case manager will provide the same case management and discharge planning services that CRES staff now provide to inmates in the CIU and Jail Addiction Services program. As with the CRES program, the case manager will not have the resources to provide follow-up case management after release from incarceration. CRES estimates a caseload of approximately 20 inmates.

C. Pre-Release Center

The Department of Correction and Rehabilitation's Pre-Release Center (PRC) helps inmates reintegrate into the community with the services they need to stay out of the criminal justice system. The Pre-Release Center provides close supervision and monitoring, dormitory style housing, and access to programs and services on-site and in the community. For individuals with a mental illness, a key aspect of the Pre-Release Center program is referral to community-based mental health services for long term care.

The Pre-Release Center houses approximately 150 inmates. All inmates participate voluntarily. To be eligible, they must have no serious detainers or pending charges, and no issues with the Immigration and Naturalization Service. Participants must be within six months of anticipated release from incarceration, and receive psychological clearance to participate. Most of the PRC residents come from the Montgomery County Detention Center inmate population. A few individuals participate in the PRC program before their trial and sentencing. PRC may also house State and Federal prison inmates who are Montgomery County residents and will be returning to the local community.

Participant Selection

PRC screeners visit the Detention Center every Monday and Tuesday to identify and screen Detention Center inmates for PRC participation. Staff screen eligible inmates using an extensive interview and two psychological tests. Staff use the psychological tests to determine whether the inmate's mental health is stable enough to manage the rigorous demands of the program. A mental illness does not preclude an inmate from participating in the PRC program. PRC staff indicate that between 20% and 25% of PRC clients take psychotropic medication, and that almost all PRC clients that have a mental illness also have a substance abuse problem. PRC staff also indicate that almost all of the female PRC participants have a mental health problem.

Every Wednesday, PRC staff select new program participants and obtain a judge's approval. All new residents sign a behavioral contract that identifies the conditions of participation, e.g., breathalyzer tests three times a day, urine tests three times a week, take psychotropic medication, attend mental health treatment. New participants whose mental health screening indicated a mental illness may receive another assessment by a PRC contract psychiatrist or psychologist.³⁵ The second assessment provides more information about mental status to help PRC staff identify appropriate mental health services.

Case Management

PRC staff assign new residents a counselor, who serves as a case manager and provides continuing care during PRC participation. PRC counselors have a caseload of approximately 14 residents. They assess new participants' needs and develop a treatment plan that identifies goals, services, and activities. The treatment plan includes participation in appropriate support groups at PRC in topics such as anger management, relapse prevention planning, and family guidance and support. Counselors may obtain information from the MCDC mental health staff to develop the treatment plan.

The counselors meet with each resident once a week individually and in a group, and complete monthly progress reports. Counselors also maintain communication with providers in the community to assess progress. Each PRC resident is also assigned a Work Release Coordinator, who helps residents find employment.

Referral to Services

In addition to the counselor and Work Release Coordinator, each PRC resident is assigned a Community Release Coordinator. The Community Release Coordinator works with PRC residents and counselors to connect them to services and appropriate community service providers.

³⁵ PRC contracts with three psychologists, primarily to conduct psychological testing and assessments. One works 20 hours per week and the other two work a few hours each week.

Community Release Coordinators work with the State public mental health system to identify mental health providers for inmates without health insurance. A large proportion of the PRC residents receive mental health and substance abuse services from Outpatient Addiction Services Program (DHHS), Community Connections, and Washington Assessment and Therapy Services. When possible, the Community Release Coordinator refers residents to the provider that served them before incarceration.

The time required to connect a PRC resident to community-based mental health services depends on the severity of the need. If the resident does not have an immediate need, linkage to mental health services typically takes approximately one month. If the resident needs medication right away, PRC staff try to connect them with a provider within two weeks. PRC staff sometimes send residents to the contract psychiatrist at the Detention Center to prescribe medication. In the future, a DOCR psychiatrist will come to the PRC twice a month to monitor residents' medication.

If residents do not comply with their behavioral contract during their stay, PRC staff suspend them from the program and transfer them back to MCDC. They usually return to PRC within two weeks, after agreeing to a revised treatment plan. PRC participation lasts between two and five months. A State parole/probation agent assigned to the program supervises most individuals whose sentence includes probation after they complete the PRC program. Drinking Driver Monitor Program staff supervise individuals on probation who had been sentenced for drunk driving.

D. Community Accountability, Reintegration and Treatment

The DOCR Community Accountability, Reintegration and Treatment (CART) program is an intensive non-residential pre-release program that helps individuals reintegrate into the community after incarceration. While the Pre-Release Center provides supervision and services at a DOCR facility, CART clients live at home. They participate in community activities and treatment services while supervised through caseworker visits and electronic monitoring equipment. Their daily activities are highly structured and monitored closely by CART staff.

Between 90% and 95% of the CART clients previously resided at the Pre-Release Center. CART serves as the next step in their transition from incarceration to release. CART staff assess new clients to identify needed services, including career counseling and employment services, group and individual counseling, substance abuse education, and mental health services. CART caseworkers refer the clients to appropriate service providers in the community.

Each CART counselor serves between 10 and 12 clients. They maintain daily phone contact with the clients, meet with the clients several times per week, and verify attendance at work, community service, and counseling. Clients undergo alcohol testing daily and drug testing three times per week. When the client is scheduled to be at home, the electronic monitoring unit provides staff with documentation that the client is in the home.

Each CART participant has a sponsor who provides support and helps the participant stay focused on their goals. The sponsors meet as a group once per week. The participant's family also provides support. The client, client's family and a CART counselor meet once per week at the client's home to assess progress. CART counselors also provide significant support for clients' sponsors and family members. The counselor's goal is to address the needs of the whole family as a unit, rather than attending to the client's needs in isolation. Staff report that approximately 90% of the clients, clients' families, and sponsors have a mental illness or other special need. CART staff try to address their needs and provide referral to community resources.

Like PRC, a judge must approve a transfer to the CART program. Participants spend two and a half months, on average, in the CART program. A parole/probation agent or Drinking Driver Monitor Program staff supervise most individuals after they complete the CART program.

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Promising Practices

I. Overview

OLO's research uncovered a number of interesting programs across the country that address the mental health needs of people involved in the criminal justice system. This part of the report briefly describes seven programs in other jurisdictions that provide diversion, treatment, case management/discharge planning services. These programs offer some perspective on the different ways jurisdictions provide mental health services for people involved in the criminal justice system.

II. Diversion

A. Community Service Officers, Birmingham, AL³⁶

Birmingham's police department operates a police/mobile crisis team hybrid program to respond to the needs of people with mental illness in the community. A team of civilian social workers within the Police Department, called community service officers (CSOs):

- Respond to calls involving people with mental illness,
- Divert people to appropriate mental health service before arrest, and
- Serve as liaisons between clients and the police, social service agencies, and mental health care providers.

CSOs operate out of police headquarters seven days a week, 15 hours per day. They accompany sworn officers to calls involving a person with a mental illness to address mental health needs and allow police officers to return to their patrols as quickly as possible. They also respond to mental-health related calls when a police presence is determined unnecessary, and to calls for service involving people that the CSOs have served before. In calendar year 2000, CSO's responded to more than 2,100 calls for service.³⁷

The CSOs save officer time by addressing mental health needs so that officers can return to their patrol right away. For example, CSO's also save officers' time by accompanying individuals to hospital emergency rooms, referring individuals to appropriate services, and working with the individual's family and service providers.

³⁶ Lurigio, Arthur and Swartz, James, "Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness", in *Policies, Processes and Decisions of the Criminal Justice System*, Office of Justice Programs, National Institute of Justice, U.S. Department of Justice, Washington, D.C., 2000, pgs. 65-66.

³⁷ Calls involving people with mental illness make up the bulk of CSO cases, however, CSOs also respond to calls for people needing other social services, e.g. elderly in need of care.

Relationship to Montgomery County - Birmingham's pre-booking diversion program resembles Montgomery County's planned use of the Police Department's Crisis Intervention Team, combined with the Department of Health and Human Service's Mobile Crisis Team. In Birmingham, social workers are assigned to the police department to form a coordinated response to mental health needs. In Montgomery County, MCPD and DHHS plan to use the Crisis Intervention Team to forge closer ties between the police officers and the Mobile Crisis Team. Trained Crisis Intervention Team officers will respond to calls involving people with a mental illness. The officers can call the Mobile Crisis Team to the scene, as necessary, to provide additional information and support, mental health assessment, and referral to mental health services.

B. Mental Health Courts, Broward County, Florida and King County, Washington³⁸

Mental health courts are specialized courts designed to divert defendants with serious mental illnesses or disabilities from the criminal justice system to appropriate supports in the community. To qualify to participate, mental health courts typically require that clients:

- Are accused of a nonviolent, low-level misdemeanor offense, and
- Have a mental illness or disability that can be adequately treated in the community.

Attachment 7, beginning on ©18, contains the Executive Summary of "Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload". It summarizes the origin of the mental health court and issues associated with mental health courts.

Broward County (Fort Lauderdale), Florida

The country's first mental health court was established in Broward County in 1997, with \$1.5 million of state funds and \$650,000 of County funds. A judge, State's attorney, public defender, court monitor, case manager, and court liaison staff the mental health court. They are trained in mental health issues and are assigned to the mental health court full-time.

The court receives referrals from a variety of sources, including jail psychiatric staff, police officers, attorneys, family members, and probation officers. All defendants must volunteer to participate and receive a competency evaluation.³⁹ If the defendant is not mentally competent, mental health court staff refer the defendant to mental health treatment to be stabilized, before they can appear before the mental health court.

³⁸ Lurigio, Arthur and Swartz, James, "Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness", in *Policies, Processes and Decisions of the Criminal Justice System*, Office of Justice Programs, National Institute of Justice, U.S. Department of Justice, Washington, D.C., 2000, pgs. 80-82.

³⁹ Defendants charged with assault may participate, with the victims' agreement.

Defendants appear before the mental health court to determine whether the defendant is appropriate for the program and can be safely released into the community. The mental health court staff work together to formulate a treatment plan for defendants accepted into the program. The court liaison identifies and refers defendants to community-based providers for psychiatric and social services. The case manager and the court monitor oversee defendants' participation in treatment, and prepare periodic reports to the court on each defendant's progress.

The judge suspends the defendants' criminal charges pending successful completion of the treatment plan. After successful completion, mental health court staff arrange long term psychiatric care and the judge dismisses the charges. If the clients do not comply with the treatment plan, the case managers work with defendants to get them back on track. Defendants who continue to fail to comply receive sanctions appropriate for their crime (e.g., incarceration, probation).

King County (Seattle), Washington

King County based its mental health court on the Broward County model, with a few significant differences. Defendants participating in King County's mental health court must waive their right to a trial, and plead guilty or no contest to their crimes. The mental health court then sentences the defendant to mental health treatment (with or without probation), and the crime stays on their criminal record. In contrast, Broward County's mental health court does not require defendants to plead guilty, and dismisses the charges after successful completion of a mental health treatment plan.

The King County mental health court rarely offers deferred adjudication (withholding the sentence until successful completion of the program), and only to defendants with no prior involvement with the criminal justice system. In cases of non-compliance with the treatment plan, defendants in King County's program are more likely to face jail time than defendants in Broward County's program.

King County mental health court funds, totaling \$900,000 in FY 01, come from the U.S. Department of Justice and the county's criminal justice and mental health systems. As in Broward County, King County uses a team approach to refer defendants to treatment and services for their mental illness. The court liaison and representatives from the mental health system develop a treatment plan for each defendant and link him or her to mental health services. Defendants sentenced to probation are assigned to a special probation officer who works exclusively with the mental health court and carries a caseload of fewer than 40 clients.

Relationship to Montgomery County – During FY 2001, staff began considering developing a mental health court in Montgomery County. Representatives from the County Executive, State's Attorney, and Chief Judge of the District Court plan to continue discussion of a mental health court in Montgomery County and to investigate different mental health court models.

C. Pre-Trial Services Diversion, Harris County (Houston), Texas⁴⁰

Harris County's Mental Health Initiative diverts nonviolent pre-trial defendants with mental illness from incarceration to community-based treatment. The County's Pre-Trial Services Agency and Mental Health and Mental Retardation Authority screen defendants for mental illness, recommend a treatment plan to the court, and coordinate diversion.

Harris County's Pre-Trial Services Agency (PTSA) staff interview all defendants:

- Charged with a Class A or B misdemeanor or felony offense, and
- Booked by the Houston Police Department or at the Harris County Jail.

PTSA staff conduct interviews 24-hours per day, seven days a week and record interview responses and observations in a database. Part of the interview includes questions and observations about the defendant's mental status. PTSA staff also present all defendants to a judge at a probable cause hearing, to determine if there is enough evidence or probable cause for a trial.

If the PTSA staff suspect that a defendant has a mental health problem, they forward the defendant's record to Harris County's Mental Health and Mental Retardation Authority (MHMRA). MHMRA assigns seven counselors/social workers to the court's probable cause hearing room 20 hours per day, seven days per week, to conduct mental health assessment of all defendants referred by PTSA, before the defendants' probable cause hearing. They consult MHMRA databases to determine whether the defendant has been a MHMRA client before. MHMRA staff also develop a plan for diversion to community-based services.

PTSA staff present the results of MHMRA's mental health assessment and recommendations for diversion to the judge at the probable cause hearing. If the judge releases the defendant with mental health treatment conditions, PTSA and MHMRA staff work together to implement the treatment plan/conditions. One common condition of release is that the defendant participate in MHMRA's New START program. This program provides intensive case management support to defendants with mental illness on parole or probation.

According to PTSA staff, the program is promising, but judges do not release as many defendants as are eligible for diversion. In addition, despite screening of all detainees, staff suspect that they do not identify all defendants with a mental illness.

⁴⁰ Oeller, Carol, "Screening for Mental Impairments During the Pre-Trial Stage", Report for a Texas Senate sub-committee on mental health issues prepared by the Harris County Pre-Trial Services Agency, July, 2000

Relationship to Montgomery County - The services provided by the Harris County Pre-Trial Services Agency and Mental Health and Mental Retardation Authority resemble services that the Montgomery County Pre-Trial Services Unit (PTSU) and Clinical Assessment and Triage Services Unit (CATS) plan to provide. After the CATS unit is fully implemented, PTSU staff will refer defendants that they suspect have a mental illness to the CATS unit for a mental health assessment. CATS staff will complete the assessment and attempt to develop a plan to divert the individual to community-based services. PTSU staff will present the information about the defendants mental health and the CATS diversion plan to the bond hearing judge.

A significant difference between the Montgomery County and Harris County pre-trial services, is that all Harris County defendants arrested for a Class A or B misdemeanor or felony offense are screened by pre-trial staff for mental health problems at booking. All of the defendants that pre-trial staff suspect have a mental illness receive a more extensive mental health assessment from MHMRA staff.

In Montgomery County, PTSU staff formally screen and CATS staff assess only those defendants that the District Court Commissioner detains at the Montgomery County Detention Center (about 62 % of all arrested individuals). Those released until trial by the District Court Commissioner are not screened for mental health problems before their release. These detainees may have a mental health problem contributing to their criminal behavior that is not identified at arrest.

III. Treatment

A. Housing and Mental Health Treatment, Fulton County, Georgia⁴¹

The Fulton County jail provides three levels of housing and mental health treatment for inmates with mental illness. The jail houses suicidal or acutely psychotic individuals in mental health crisis in an acute psychiatric infirmary. The infirmary has 14 single bed cells, a nursing station, and a security station. A licensed practical nurse is on duty 24-hours per day, seven days per week, under the supervision of a registered psychiatric nurse. Treatment is limited to dispensing psychotropic medication and reducing external stimuli that aggravate the inmates' crisis. It does not include therapy or rehabilitative programming. The average length of stay is approximately 72 hours. As soon as the crisis is resolved, the inmate is either returned to the jail's general population or transferred to the chronic care unit.

The chronic care unit consists of two units, each containing 18 cells and 36 beds. These units provide longer term housing for inmates whose psychiatric crises may be resolved, but whose illness precludes their successful adaptation to the general population. Fulton County uses the chronic care unit to assist in the transition back to the general population, although some inmates serve their entire sentence in the chronic care unit.

⁴¹ Steadman, Henry J., *Jail Diversion for the Mentally Ill, Breaking Through the Barriers*, National Institute of Corrections, U.S. Department of Justice, Grant # 89J01GHF8, 1990; Personal communication with Fulton County Jail mental health staff, February, 2001.

Fulton County jail staff report that the chronic care unit provides a safe environment relatively free from physical or emotional abuse from other inmates. Nurses are also better able to monitor inmates' compliance with medication and their overall mental condition in the chronic care unit. Mental health treatment available in the unit includes psychotropic medication monitoring and management, short-term therapy, case management, and discharge planning services.

The jail houses other inmates with mental illness in the general population. They receive psychotropic medication management and short-term therapy services. A registered psychiatric nurse also leads chemical dependency and medication compliance support groups in the general population twice per week.

Relationship to Montgomery County - The mental health treatment provided in the Fulton County Jail resembles the treatment provided in the Montgomery County Detention Center. The primary difference is that the Fulton County jail provides two specialized units for inmates with mental illness, including a unit for inmates in mental health crisis and a unit for inmates not in crisis, but not able to adjust to living in the general population.

The Montgomery County Detention Center (MCDC) has one unit for 35 inmates in crisis and/or with a serious mental health problem. Due to space limitations in the CIU, staff return many inmates with mental illness to the general population after stabilizing their mental health crisis, although placement in the general population can place stress on the inmate's mental health.

To begin addressing the needs of inmates in the general population with a mental illness, MCDC recently began housing inmates' on psychotropic medication in two units within the general population.⁴² DOCR also added three psychiatric nurses to the MCDC general population staff to administer and monitor medication, monitor mental health and suicide risk, and help coordinate mental health services upon release.

Another difference between the mental health treatment in the Fulton County Jail and the Montgomery County Detention Center is that Fulton County mental health staff provide short-term therapy to inmates housed in the chronic care unit and the general population. At this time, MCDC's resources do not allow staff to provide therapy to inmates with mental illness housed in the general population.

⁴² Inmates participating in specialized programs that call for particular housing classifications are not housed in these two units (e.g., Jail Addiction Services participants). Also, inmates placed in segregated cells for disciplinary purposes are not housed in these units.

IV. Case Management/Discharge Planning

A. Thresholds Program, Cook County, Illinois⁴³

The Illinois Department of Mental Health partially funds a program to divert offenders from jail and provide housing, intensive mental health treatment, and case management services. Thresholds, a non-profit psychiatric rehabilitation center in Chicago, operates the program.

The goal of the program is to stop the cycle of crime and incarceration of people with mental illness. Launched in 1997, the program targets non-violent offenders in the Cook County Jail with serious mental illness and a history of recidivism. They also target the offenders who are most difficult to link with community services effectively.⁴⁴ The program has served 45 people since 1997, and none have been rearrested to date. According to Thresholds staff, the program costs approximately \$26 per day per person, compared with about \$70 per day to keep the same person in the Cook County Jail, or \$400 daily to house the person in the local public mental hospital.

Thresholds caseworkers work with Cook County Jail staff to identify potential candidates for the program and develop a diversion plan. Caseworkers advocate to the court for the diversion of the inmate into the program's custody. Once released, staff find and pay for affordable housing for their clients, usually in hotels where other Thresholds clients live. Clients also receive medication management, intensive individual counseling, and a \$5 per day allowance. Each client is assigned a caseworker who is on call 24-hours per day and visits the client at least once per day. The case worker often helps the client with daily tasks such as shopping or laundry. Case workers also take groups of clients out for social excursions, such as a day at the beach or a baseball game. All services are available for as long as clients need them.

Relationship to Montgomery County – The Thresholds program resembles Montgomery County's Assertive Community Treatment Team (ACT). Like Thresholds, the ACT Team provides comprehensive treatment, case management, and support services for people who have not successfully responded to traditional services. The ACT Team does not provide housing, but will refer clients that need housing to appropriate providers. The ACT Team does not provide a daily allowance or organize social events for clients.

The ACT Team also differs from the Thresholds program because the courts in Montgomery County do not currently divert people with mental illness directly to the ACT Team directly. DHHS is taking steps to inform DOCR and court staff of ACT Team services, to increase the use of ACT Team services for people involved in the criminal justice system.

⁴³ Lydersen, Kari, "For Jailed Mentally Ill, a Way Out", *The Washington Post*, June 28, 2000, Pg. A3

⁴⁴ Clients must have a mental illness that can be treated effectively with medication.

B. Maryland Reentry Partnership (REP) Initiative, Baltimore, Maryland⁴⁵

The Maryland Reentry Partnership Initiative brings together public and private agencies to plan and provide a continuum of services for offenders released from Maryland's prisons who are returning to four neighborhoods in East Baltimore. FY 2001 represents the first year and pilot phase of the Initiative, which is funded with federal, state, and local dollars.

The organizations listed in Table 5 collaborate to plan and provide re-entry services for offenders. They identify eligible clients, assign staff to develop pre- and post-release treatment plans, and provide support and assistance after release.

Table 5: Maryland Reentry Partnership Initiative Partners

Agency	Function
Enterprise Foundation	Provides overall management and administrative services for the Initiative.
Maryland Department of Corrections	Identifies eligible participants.
Metropolitan Transition Center	Leads the development of a case management plan for each client during incarceration and after release, and identifies community service providers.
Empower Baltimore Management Corporation (EBMC) Village Center Sandtown-Winchester Community Development Corporation Druid Heights Community Development Corporation	Serve as the re-entry points for clients upon release from incarceration, and assign a case manager and client advocate to each participant to provide support and assistance upon release.
Maryland Division of Parole and Probation	Provides oversight after release for clients on parole and probation.
Baltimore Police Department	Provides law enforcement oversight after release.
EDEN Jobs	Helps clients find employment.
Baltimore Mayor's Office on Criminal Justice	Provides policy input.

During Incarceration

The Metropolitan Transition Center assigns a transition coordinator to each participant during incarceration. The transition coordinator assesses the client's needs and works with him or her to develop a case management plan that helps prepare the

⁴⁵ Levy, Joann M., Senior Program Director for Community Building, Enterprise Foundation, Baltimore, MD. Public presentation on the REP Initiative at the National Institute of Justice's Annual Conference on Criminal Justice Research and Evaluation, Washington D.C., July 16 – 19, 2000.

inmate for release. A typical plan may include GED classes, drug treatment, or prescription of psychotropic medication during incarceration. The transition coordinators monitor inmate progress and provide support to help them meet the goals outlined in their case plan.

Inmates also work with their transition coordinator and case manager (assigned by the Community Development Corporation or Empower Baltimore Management Corporation) to develop a post release case management plan. That plan addresses items such as housing arrangements, job placement, community-based mental health treatment, and regular drug or alcohol tests. Thirty days before release, the client reviews the case management plan at a meeting with the transition coordinator, the case manager, a neighborhood representative, a police representative, the client advocate, and family members.

After Release

Within 24 hours of release from incarceration, the client reports to his or her respective Community Development Corporation or Empower Baltimore Management Corporation Village Center. The client meets with the transition coordinator, case manager, police representative, neighborhood representative, and client advocate to review the case management plan again. If the crime committed by the offender involved a victim, the client and client's representatives meet with the victim within 72 hours of release to introduce the victim to the case management plan.

The case manager provides on-going support and oversight to the client after release. The client advocate helps the client troubleshoot everyday challenges, such as transportation or personal problems. After the client meets all of the objectives in the case management plan, the follow-up phase of the program begins. During this phase the case manager contacts the client every three months for one year, and then twice in the second year.

The REP pilot involves 250 inmates scheduled for release beginning in April, 2001. Those inmate currently receive the services provided to participants during incarceration. Organizers plan to eventually serve all offenders returning to the four target neighborhoods. The Initiative is not limited to inmates with mental health and/or substance abuse problems.

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Summary of Findings and Observations

This OLO report serves as a guide to the array of mental health services provided by County departments to people involved in Montgomery County's criminal justice system. This part of the report summarizes the services available in the County and describes OLO's observations about the County's current package of programs and services.

In sum, Montgomery County provides a range of services throughout the criminal justice system for individuals with mental illness. The Department of Correction and Rehabilitation (DOCR), Department of Health and Human Services (DHHS), and Montgomery County Police Department (MCPD) are working together with a shared goal to serve individuals with mental illness from entry to the criminal justice system through release from incarceration. The services provided by these departments fall into the following six categories:

- Diversion,
- Screening, Assessment and Classification,
- Crisis Intervention,
- Treatment,
- Case Management, and
- Discharge Planning.

I. Diversion

Finding. Various opportunities for diversion exist in the County's criminal justice system. County staff expect the Montgomery County Police Department (MCPD) to divert more people to community-based services after implementation of the MCPD Crisis Intervention Team.

Diversion programs redirect people with mental illness who have committed a non-violent crime from the criminal justice system into public mental health and other services. Montgomery County programs that divert individuals from the criminal justice system to community mental health services include:

- Emergency Evaluation Petitions;
- Crisis Center, DHHS;
- Mobile Crisis Team, DHHS;
- Clinical Assessment and Triage Services, DHHS;
- Intervention Program for Substance Abusers, DOCR; and
- Daily Supervision Services Program, DOCR.

Some of these services divert people before arrest and booking. Others divert defendants at their bond hearing or first trial appearance. Some Montgomery County programs also coordinate diversion to community-based resources during incarceration. County staff anticipate that the recent training provided to the MCPD Crisis Intervention Team officers will increase the use of pre-booking diversion opportunities.

Observation. The success of diversion services depends on the availability of community-based public mental health services.

Many of the individuals with mental illness involved in the criminal justice system do not have private health insurance and rely on the public mental health system. As County police officers and others divert individuals from the criminal justice system, County staff need access to sufficient community mental health services to make appropriate placements.

In particular, County staff report a need for:

- Residential treatment services that include close monitoring and support by on-site staff, and
- Community-based treatment for people with co-occurring disorders (mental health and substance abuse disorders).

County staff also report a need for easier access to placement in the State mental hospitals for people involved in the criminal justices system who have not responded to treatment and whose mental illness puts them or others in danger.

II. Screening, Assessment and Classification

Finding. The Montgomery County Detention Center (MCDC) has a comprehensive system in place to screen, assess, and classify individuals detained at the Detention Center.

Screening, assessment and classification activities identify people with a mental illness and triage them to appropriate services. Most of the screening, assessment and classification of individuals arrested in Montgomery County takes place at entry to the Detention Center and during incarceration, through the:

- Central Processing Unit, DOCR;
- Detention Center Intake Unit, DOCR;
- Detention Center Medical Unit, DOCR;
- Detention Center Mental Health Services, DOCR;
- Pre-Trial Services Unit, Assessment Section, DOCR; and
- Clinical Assessment and Triage Services, DHHS.

Staff in the Central Processing Unit, Intake Unit, and Medical Unit screen for mental illness at entrance to MCDC. The new Clinical Assessment and Triage (CATS) Unit will also assess the mental health of people entering the Detention Center. Pre-Trial Services Unit staff screen defendants before their bond hearing. During incarceration, correctional officers observe inmates for signs of mental illness and refer inmates that they suspect have a mental illness to mental health services staff for assessment and triage to appropriate mental health care.

Observation. The District Court Commissioner releases approximately one-third of all arrestees until their trial and without supervision. These individuals, who are not detained at the Detention Center, do not receive formal mental health screening.

Law enforcement officers arrest approximately 15,000 individuals each year and bring them to the Central Processing Unit (CPU) for booking. Although CPU staff observe everyone brought to the CPU for suicide risk, they only conduct a formal mental health screening for individuals who are detained by the District Court Commissioner and admitted to MCDC. The District Court Commissioner detains approximately 60% of the 15,000 individuals.

For approximately 35% of the 15,000, the District Court Commissioner charges them with a crime and releases them, with or without bond, until trial. Those individuals do not receive a formal mental health screening. They may have a mental illness that contributed to their crime that is not identified or addressed at this point in the system.

III. Crisis Intervention

Finding. Crisis Center and Mobile Crisis Team staff address mental health crises in the community. Montgomery County Detention Center (MCDC) staff refer incarcerated individuals in mental health crisis to MCDC mental health staff to assess and stabilize the inmates. The Department of Correction and Rehabilitation (DOCR) has also implemented new procedures and activities to prevent suicide at the Detention Center.

Crisis intervention is an immediate response to a mental health crisis situation. Crisis intervention services in Montgomery County's criminal justice system are provided by:

- Crisis Center and Mobile Crisis Team staff, DHHS, and
- Detention Center Mental Health staff, DOCR.

DHHS' Crisis Center and Mobile Crisis Team are available to address mental health crises before people enter the Detention Center. They often respond to requests for assistance from police officers. MCDC mental health staff provide crisis intervention services to Detention Center inmates. In response to a crisis, the mental health staff may

transfer the inmate to the Crisis Intervention Unit, place the inmate under 15-minute watch in the general inmate population, and/or refer the inmate to MCDC's contract psychiatrist for medication. They try to admit inmates who have not responded to MCDC mental health care and are a danger to themselves or others to a State mental hospital.

DOCR recently increased efforts to prevent suicide in the jail by publicizing indicators of suicide risk and asking family members and other visitors to inform DOCR staff of any suicidal gestures. DOCR also improved the lines of communication between DOCR staff regarding suicidal inmates, and made the files of suicidal inmates a different color to bring their special status to the attention of MCDC staff.

Observation. MCDC staff usually transfer inmates in mental health crisis to the Crisis Intervention Unit (CIU) for close observation by mental health staff. Due to limited space in the CIU, some inmates in mental health crisis remain in the general population under 15-minute watch by correctional officers.

The Crisis Intervention Unit holds 32 inmates. When the Unit is full, inmates in mental health crisis remain in the general population under 15-minute watch. Mental health staff go into the general population to assess and check on these inmates, but they are not under the constant care and observation of mental health staff. Also due to limited space, CIU staff may return inmates with a mental illness to the general population immediately after stabilizing the mental health crisis. The transition to the general population can be difficult for inmates with mental illness.

IV. Treatment

Finding. Mental health treatment for inmates in the MCDC general population is limited to medication management. Inmates housed in the Crisis Intervention Unit (CIU) receive additional services, including development of a treatment plan and limited therapy. DHHS' Outpatient Addiction Services program provides treatment in the community for individuals involved in the criminal justices system. DHHS contracts with additional mental health and substance abuse treatment providers in the community.

Mental health treatment in criminal justice systems typically involves prescribing and managing medication, developing treatment plans, and providing group and/or individual therapy. In Montgomery County, DOCR's Detention Center mental health services staff provide treatment for jail inmates. DHHS' Outpatient Addiction Services staff and DHHS contractors provide mental health and substance abuse treatment for people without private health insurance in the community. DHHS' Jail Addiction Services staff provide substance abuse treatment for JAS participants in the jail, and are aware of co-occurring mental health problems.

MCDC mental health staff prescribe and manage psychotropic medication for inmates in the general population. They transfer inmates in mental health crisis or inmates with serious mental illness to the Crisis Intervention Unit (subject to space availability). CIU inmates receive a mental health treatment plan and limited therapy, in addition to medication management.

The Jail Addiction Services (JAS) program provides substance abuse treatment for inmates who volunteer to participate in the program. Many JAS participants suffer from substance abuse and mental illness. The JAS participants' treatment plan brings any mental illnesses to the JAS staff's attention, but the program does not provide specific mental health treatment services.

DHHS' Outpatient Addiction Services (OAS) staff provide substance abuse treatment and limited mental health treatment for individuals in the community who do not have private health insurance. OAS clients involved in the criminal justice system include people:

- Diverted from the criminal justice system to community-based treatment,
- Supervised by the Pre-Trial Supervision Unit until trial,
- Whose sentence includes mental health or substance abuse treatment,
- Participating in the Pre-Release Center or Community Accountability and Reintegration programs, and
- Referred to treatment after release from MCDC.

Observation. Mental health treatment for inmates in the general Montgomery County Detention Center population is limited to medication management.

Improving diversion opportunities will reduce the need for mental health care within MCDC, but there are and will continue to be people incarcerated at MCDC who have serious mental health needs. MCDC staff house most inmates with a mental illness in the general inmate population. Those inmates only receive prescription and management of psychotropic medication. Due to limited resources, only inmates housed in the Crisis Intervention Unit (up to 32 inmates) currently receive a mental health treatment plan and limited therapy.

Two recent MCDC initiatives should improve mental health care for inmates in the general population. First, MCDC staff began housing all inmates on psychotropic medication in two MCDC general population housing units. They also assigned three new psychiatric nurses in the general population to administer medication, monitor mental health and prevent suicide, and coordinate services.

V. Case Management

Finding. DOCR's Pre-Trial Services Unit provides case management services for people under pre-trial supervision. MCDC correctional specialists provide limited case management for inmates in the MCDC general population. Inmates in the Jail Addiction Services program and Crisis Intervention Unit receive more comprehensive case management services.

In general, case management in the criminal justice system involves identifying inmates' service needs, accessing appropriate services, monitoring inmate progress, and providing on-going support and assistance. The following programs currently provide case management services in the criminal justice system in Montgomery County:

- Detention Center Correctional Specialists, DOCR and
- Pre-Trial Services Unit, Supervision Section, DOCR.

The Pre-Trial Services Unit's Supervision Section (DOCR) provides case management for pre-trial defendants. MCDC inmates in the general population receive some case management services from MCDC correctional specialists. However, the correctional specialists' large caseloads (between 100 and 150 inmates each) limits the time devoted to each inmate and the depth of case management provided.

In addition, Community Re-Entry Services staff provide case management services for inmates participating in the Jail Addiction Services program and inmates housed in the Crisis Intervention Unit. The Assertive Community Treatment Team provides case management services in the community, but currently serves few people referred from the criminal justice system.

Observation. PTSU case management ends with the completion of pre-trial supervision. None of the case management services provided in the Detention Center continue after release from incarceration. The Assertive Community Treatment Team provides comprehensive long-term case management in the community, but rarely serves individuals involved in or referred from the criminal justice system.

To maintain community stability and reduce recidivism, people involved in the criminal justice system usually have multiple needs that require long-term case management support after release from incarceration. The case management provided by MCDC correctional specialists, Community Re-Entry Services, Pre-Release Center, and Community Accountability, Reintegration and Treatment ends upon release from incarceration. Without continued support after release, inmates often end up back in the criminal justice system.

The Assertive Community Treatment (ACT) Team case management model could be very useful for the criminal justice population. The ACT Team provides comprehensive, long-term case management and treatment in the community for

individuals who have not succeeded in traditional treatment programs. ACT Team clients must meet medical necessity criteria under the public mental health system and cannot receive services from the ACT Team and another outpatient treatment provider simultaneously. Few of the ACT Team clients served to date were referred by the Montgomery County Police Department and Montgomery County Detention Center.

VI. Discharge Planning

Finding. Inmates in the general MCDC population receive limited discharge planning services. Inmates housed in the Crisis Intervention Unit, and those participating in the Jail Addiction Services, Pre-Release Center, and Community Accountability, Reintegration and Treatment programs receive more comprehensive discharge planning services.

Discharge planning services help inmates reintegrate into the community, maintain stability, and stay out of the criminal justice system in the future. A key component of discharge planning is referral to mental health and other services in the community. The following Montgomery County programs provide discharge planning services in the criminal justice system:

- Detention Center Correctional Specialists, DOCR
- Pre-Release Center, DOCR
- Community Accountability, Reintegration and Treatment, DOCR and
- Community Re-Entry Services, DHHS.

Due to large caseloads, MCDC correctional specialists provide limited discharge planning for inmates in the general population. Community Re-Entry Services staff provide discharge planning services to inmates in the Jail Addiction Services program and inmates housed in the Crisis Intervention Unit. The Pre-Release Center and Community Accountability, Reintegration and Treatment programs provide discharge planning services through gradual transition into the community and referral to community mental health and other resources.

Observation. Due to large caseloads and multiple responsibilities, correctional specialists provide only limited discharge planning services to inmates in the general population.

Discharge planning is an important component of mental health services for people who are incarcerated in the County. Research indicates that without adequate discharge planning services, inmates are more likely to end up back in the jail.

Inmates housed in the Crisis Intervention Unit and those participating in JAS, PRC, and CART receive comprehensive discharge planning services. The majority of inmates, however, receive limited discharge planning from MCDC correctional specialists. Because correctional specialists have caseloads of 100 to 150 inmates and a

broad spectrum of responsibilities (counseling, housing classification, discharge planning), they are unable to devote very much time to discharge planning for individual inmates. MCDC does require inmates to attend a community release class that addresses career planning, community treatment services, and housing.

The availability of community resources also impacts discharge planning. County staff throughout the criminal justice system report the need for sufficient public mental health services, housing, and case management for individuals released from incarceration.

Comments on the Final Draft

The Office of Legislative Oversight circulated a final draft of this report to the Chief Administrative Officer, Department of Correction and Rehabilitation, Department of Health and Human Services, and Montgomery County Police Department. The final report incorporates all of the technical corrections received from Executive Branch departments by March 15, 2001. The written comments transmitted by the Chief Administrative Officer are included in their entirety beginning on the following page. OLO appreciates the time taken by Executive Branch staff to review and provide feedback on OLO's draft report.



OFFICES OF THE COUNTY EXECUTIVE

Douglas M. Duncan
County Executive

Bruce Romer
Chief Administrative Officer

MEMORANDUM

March 14, 2001

TO: Jennifer Kimball, Legislative Analyst
Office of Legislative Oversight

FROM: Bruce Romer, Chief Administrative Officer

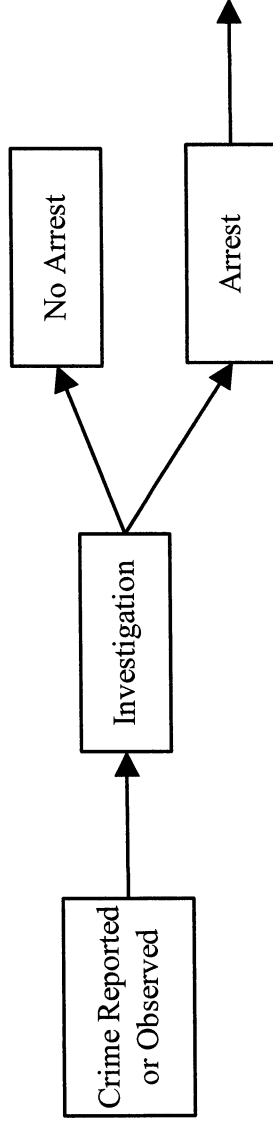
SUBJECT: Office of Legislative Oversight DRAFT Report 2001-2, Mental Health Services in the Criminal Justice System - A Description of Montgomery County Services and Promising Practices from Other Jurisdictions

Thank you for the opportunity to comment on the DRAFT OLO Report 2001-2, Mental Health Services in the Criminal Justice System - A Description of Montgomery County Services and Promising Practices from Other Jurisdictions. This OLO report provides a comprehensive description of the mental health services provided by the County departments and their inter-relationship. I would like to acknowledge my appreciation of OLO's process for gathering information which fully included Executive branch staff and compliment Ms. Kimball for an excellent job.

We look forward to participating with the Council in its review of this report and in addressing these issues.

cc: Charles A. Moose, Ph.D., Chief of Police
Charles L. Short, Director, Department of Health and Human Services
Arthur M. Wallenstein, Director, Department of Correction and Rehabilitation
Robert Green, Warden, Montgomery County Detention Center
Corinne Stevens, Chief, Crisis, Income and Victim Services, DHHS
Mildred Holmes Williams, Chief, Adult Mental Health and Substance Abuse Services, DHHS

ENTRY INTO THE SYSTEM



Montgomery County Mental Health Services

Diversion

Emergency Evaluation Petitions
Crisis Center, DHHS
Mobile Crisis Team, DHHS

Screening, Assessment, and Classification

Central Processing Unit, DOOCR

Crisis Intervention

Crisis Center, DHHS
Mobile Crisis Team, DHHS

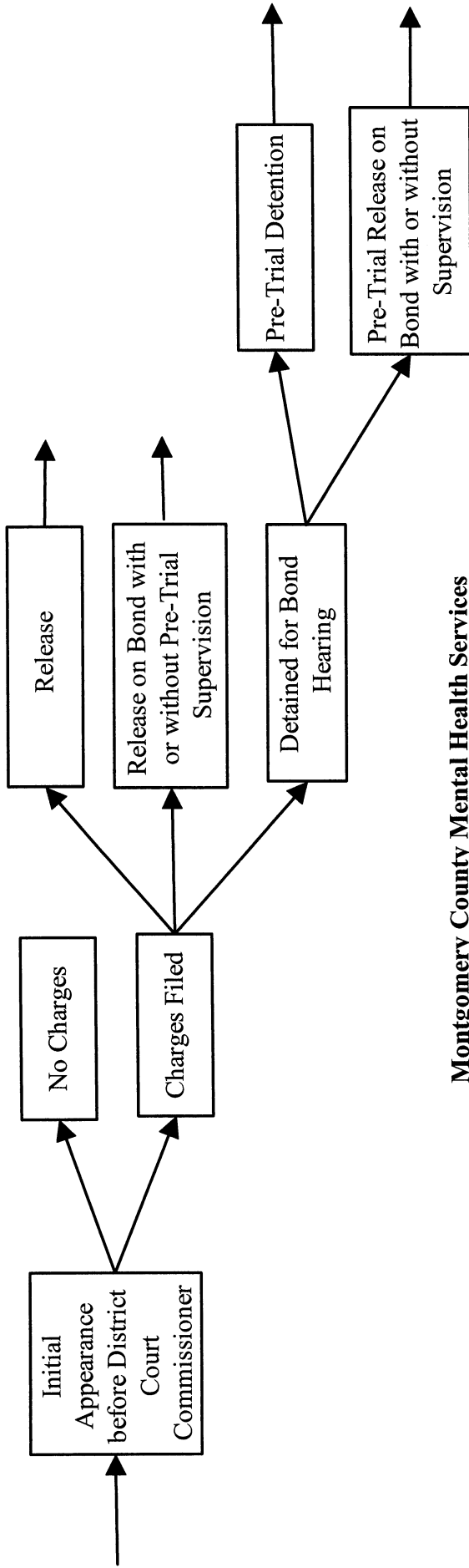
Treatment

Crisis Center, DHHS
Mobile Crisis Team, DHHS

Case Management

Assertive Community Treatment Team, DHHS

PROSECUTION AND PRE-TRIAL SERVICES



Montgomery County Mental Health Services

Diversion

Clinical Assessment and Triage Services, DHHS
Daily Supervision Services Program, DOCR

Screening, Assessment and Classification

Central Processing Unit, DOCR
Detention Center Intake Unit, DOCR
Detention Center Medical Unit, DOCR
Detention Center Mental Health Services, DOCR
Clinical Assessment and Triage Services, DHHS
Pre-Trial Services Unit, Assessment Section, DOCR

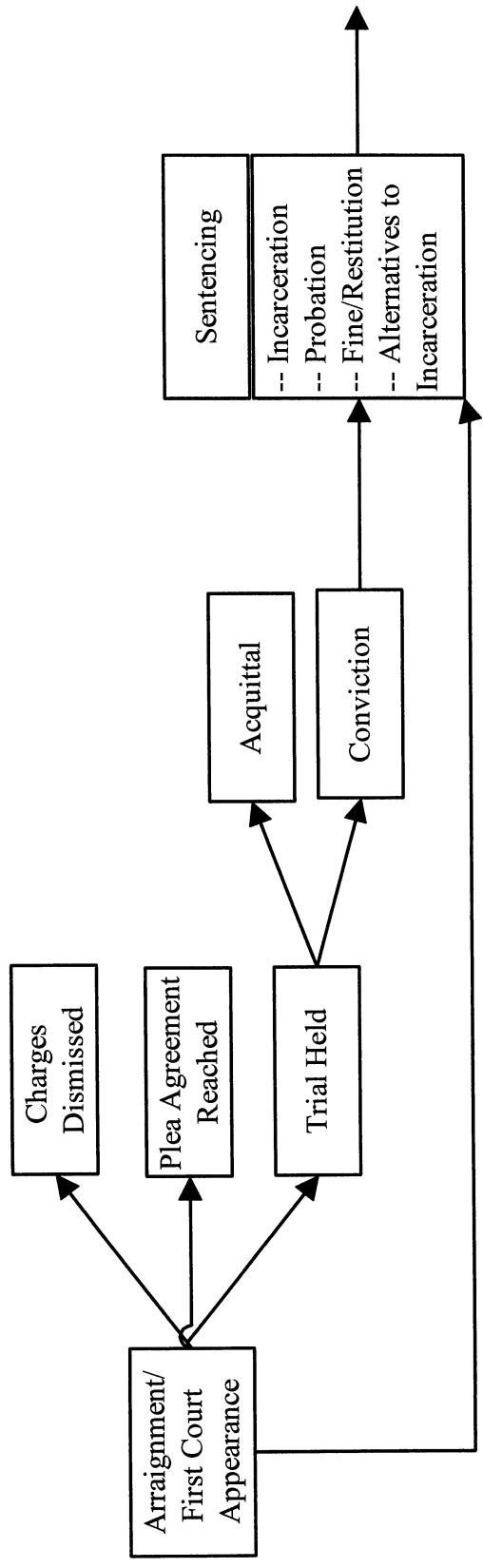
Treatment

Outpatient Addiction Services, DHHS

Case Management

Pre-Trial Services Unit, Supervision Section, DOCR

ADJUDICATION AND SENTENCING



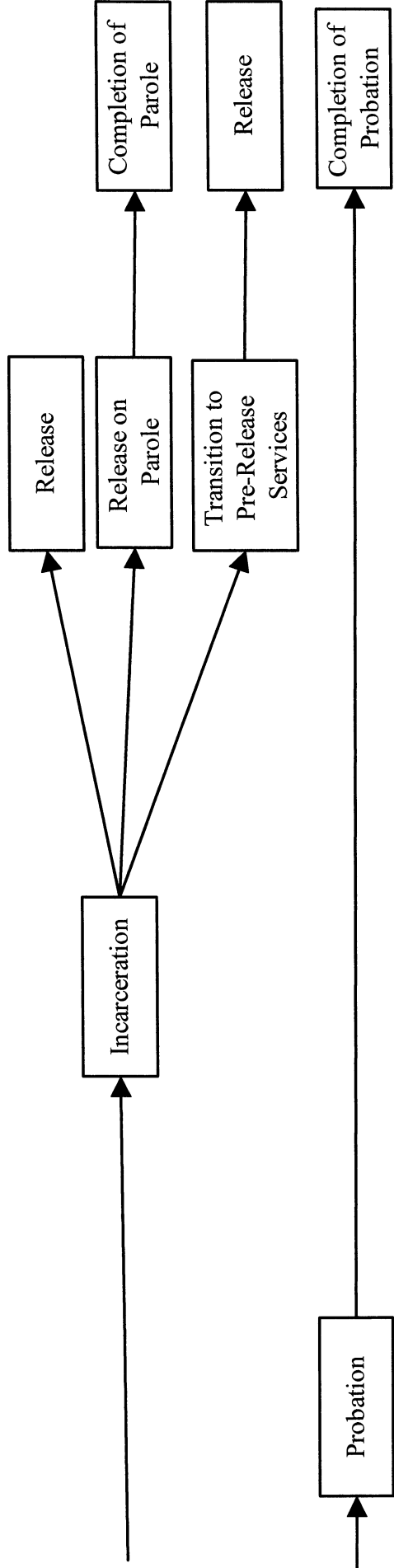
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Montgomery County Mental Health Services

Diversion

Intervention Program for Substance Abusers, DOCR

CORRECTIONS



Montgomery County Mental Health Services

- Diversion**
Clinical Assessment and Triage Services, DHHS
- Screening, Assessment and Classification**
Detention Center Intake Unit, DOCR
Detention Center Medical Unit, DOCR
Clinical Assessment and Triage Services, DHHS
Detention Center Mental Health Services, DOCR
- Crisis Intervention**
Detention Center Mental Health Services, DOCR
- Treatment**
Detention Center Mental Health Services, DOCR
Jail Addiction Services, DHHS
Outpatient Addiction Services, DHHS
Assertive Community Treatment Team, DHHS
- Case Management**
Detention Center Correctional Specialist, DOCR
- Discharge Planning**
Detention Center Correctional Specialist, DOCR
Community Re-Entry Services, DHHS
Pre-Release Center, DOCR
Community Accountability, Reintegration and Treatment Program, DOCR

CIRCUIT COURT DISTRICT COURT OF MARYLAND FOR.....County/Baltimore City

Located at..... Case No.....

Court Address

PETITION FOR EMERGENCY EVALUATION

(HEALTH-GENERAL ARTICLE, SECTIONS 10-622 et seq.)

Your Petitioner..... requests that this Court order an emergency evaluation of

Name of Petitioner

and in support of this Petition states as follows:

Name of Person to be Evaluated

1. The person making this Petition is:

Name..... Home Phone..... Work Phone.....

Address.....

Relationship or interest in evaluatee.....

2. The person alleged to be in need of emergency evaluation is:

Name..... Date of Birth.....

Address.....

Sex..... Race..... Ht..... Wt..... Hair..... Eyes..... Complexion.....

Driver's License No..... Other.....

3. The spouse, child, parent or other relative of the emergency evaluatee, or other individual interested in the emergency evaluatee is:

Name..... Relationship.....

Address..... Telephone.....

4. A petition for emergency evaluation of the evaluatee was previously filed on.....

Date(s)

and was granted/denied.

5. The evaluatee has been hospitalized in the past at the following facilities:

When..... Where..... Diagnosis.....

6. The evaluatee is presently receiving psychiatric treatment from:

Name..... Address..... Telephone No.....

7. The evaluatee has been prescribed the following medication for his/her mental disorder:.....

8. The evaluatee is is not taking the medication as prescribed. OR Do not know.

9. The evaluatee is demonstrating the following behavior that leads me to conclude that he/she is presently suffering from a mental disorder:.....

10. There is clear and imminent danger of the evaluatee doing harm to self or others because:.....

I hereby certify and declare under the penalties of perjury that the matters and facts stated in this Petition are true to the best of my knowledge, information, and belief.

Date

5

Petitioner

TO THE PETITIONER: You may be required to appear before the Court. If an evaluation is ordered, it would also be most helpful if you could summarize the activities of the hospital and provide hospital authorities with any information that is pertinent to this Petition. Any petitioner who is



ADDITIONAL CERTIFICATION BY PEACE OFFICER, PHYSICIAN OR PSYCHOLOGIST

I. I am a Peace Officer as below indicated and I have personally observed the actions of the emergency evaluatee and based on my observation I have reason to believe that _____ is mentally disordered and is in clear and imminent danger of causing personal harm to himself or others and therefore under the provisions of Health-General 10-622 I have transported the evaluatee to _____ for evaluation.

Date and Time _____

Peace Officer

Department

I.D. No.

I. I am a duly licensed physician or other person qualified under Health-General 10-622 and after examination of the emergency evaluatee, I have reason to believe that _____ is mentally disordered and is in clear and imminent danger of causing personal harm to himself or others and therefore under the provisions of Health-General 10-622 I do hereby authorize the evaluation. I have requested the assistance of _____ for transport to _____

Name of Peace Officer Facility

Date and Time _____

Physician, Psychologist, Local Health Officer

SUICIDE SCREENING FORM

Inmate's Name: _____ Date: _____
MCPID# (CPU) _____ MCDC # _____

Is there anything about this individual that would warrant a referral to Mental Health Services based on any of the questions below? If you check YES to any questions, please fill out a referral for Mental Health. Write NO if not applicable. All items MUST be filled out.

- (1) Did you obtain any information about this individual from family, staff, transporting officers, attorneys, health care providers or community suggesting that he/she may be a high risk for suicide or are you aware of any issues that MCDC needs to be concerned with?

CPU: _____
R&D: _____
MED: _____

- (2) Did the individual respond YES to the following question: "Are you currently experiencing any thoughts/feelings of helplessness or hopelessness or suicide?"

CPU: _____
R&D: _____
MED: _____

- (3) Does the individual have a mental health history indicating he/she may be a high risk for suicide and/or does he/she give a history of self destructive behavior?

CPU: _____
R&D: _____
MED: _____

- (4) Is the individual currently on anti-depressant medication and/or currently under the care of a mental health provider for depression?

CPU: _____
R&D: _____
MED: _____

- (5) Have you observed behaviors during the interview with this individual that may suggest to you that he/she is depressed or suicidal? (appears withdrawn, sad, depressed, crying, teary eyed, quiet, non-communicative):

CPU: _____

(6) Do you have any knowledge that may suggest that the individual may be unable to adjust or cope due to a medical/physical condition?

CPU: _____
R&D: _____
MED: _____

(7) Do you have other relevant information suggesting to you that the individual may pose a suicide risk?

CPU: _____
R&D: _____
MED: _____

If you answer YES to any of the above items, please elaborate and then fill out a referral for Mental Health:

CPU _____
R&D _____
MED _____

Did you submit a referral for Mental Health ?

CPU: YES _____ NO _____
R&D: YES _____ NO _____
MED: YES _____ NO _____

Was Shift Commander Notified ? If applicable, indicate other action taken:

CPU: YES ___ NO ___ Other action taken: _____
R&D: YES ___ NO ___ Other action taken: _____
MED: YES ___ NO ___ Other action taken: _____

Staff Signature:

CPU _____ Print Name: _____ Date: _____
R&D _____ Print Name: _____ Date: _____
MED _____ Print Name: _____ Date: _____

MH Assessment Performed by: _____ I.D.# _____ Date _____
Disposition: CIU ___ WQ Hid ___ GP ___ HSDB/HRSDDB ___ Psychiatric Referral ___
If HSDB/HRSDDB: Staff notified: _____ Date: _____

Form Reviewed by: _____ I.D.# _____ Date: _____

Attachment 5 Correctional Behavioral Health Data Sheet
 Department of Health and Human Services/Addiction Services Coordination
 Correctional Behavioral Health

General Information

S.S.# _____
 MCDC ID# _____
 MCP ID# _____ Last Name _____ First Name _____ M.I. _____
 D.O.B. _____ Male Female Race _____ Residency _____ Single Married
 Street Address: _____ City _____ State _____ Zip _____
 How Long: _____ Previous Address: _____ Education _____
 Employment? Yes No Most Recent (Where-When) _____
 Any Source of Income? Yes No Health Insurance Yes No Rx Coverage Yes No
 If parent, with whom do children reside? _____
 Any documented DJJ or Child Welfare History? Yes No Any documented HX violence? Yes No

Mental Health

Any documented behavioral health disorder? Yes No Suicide history or risk? Yes No
 Any documented diagnosis? Yes No Type: _____ Psychotropic Medicine? Yes No
 Last episode of mental health or substance abuse treatment: _____ Last episode of substance abuse: _____
 Current usage Past usage Type _____ Dosage _____ Last dose: _____
 Compliance with treatment protocol at last episode? Yes No _____
 (Name of therapist, psychiatrist, counselor, or case manager)
 Program name _____ Ever been hospitalized for psychiatric care? Yes No

Incarceration Information

Reason for current arrest _____ Prior incarceration Yes No Number of times: _____
 Type of offense: _____ Start and end date of last incarceration: _____
 Average Length of incarceration for: _____
 MCDC CIU JAS
 Status at time of release: _____ Any case management while incarcerated? Yes No
 (Bond, PTSU, PRC, DPP, Court order to treatment)
 CRE MRT Intake Unit Other

Recidivism

Lapse from release to re-arrest: _____ Type of offense: _____
 Lapse from release to Crisis Center, Homeless Services, Substance Abuse Treatment, or Hospitalization: _____
 Length of stay at last service episode: 0-30 31-60 61-99 90+ Reason for discontinuing: _____
 Time of Release: _____
 Employment Status Housing Status Medication Status

Findings and Recommendations

Finding I: Staff Commitment

My overall impression of the staff at this facility was very positive. At all times during my visit, staff were cooperative, polite and interested in talking about constructive changes. They were willing to express opinions, identify specific problems and offer ideas for enhancements. It was also apparent that they are an extremely busy and proud staff who knew their jobs well.

I was also impressed with Acting Warden Smith. He is truly concerned about the health and security at this facility and wants to support staff across all disciplines. His executive staff is similarly motivated. The findings in this report do point out needed changes in practice, environment and staffing. However, with the level of commitment and professionalism at this facility, I feel that most of the changes in practice can be achieved within a reasonable timeframe.

Finding II: Intake Screening

Multiple screenings are conducted by different staff within the intake process (Central Processing, Receiving, Classification). Each of these screens contains some questions related to suicide risk. This process is fragmented. It does not integrate all screening components or provide a clear description of the multiple risk factors that may be associated with a particular inmate. Additionally, some important risk factors, such as family history of suicide, are not being looked at during this process.

Overview

I observed six forms where suicide information is recorded. Most of the data collected is not integrated into one final assessment. These forms and specific suicide risk data collected are as follows:

Forms	Risk Indicators
Central Processing Criminal Warrant Envelope	Suicidal symptoms/statement /history
Inmate Screening Form	Mental decompensation, medical emergency risk & suicide risk
Medical Receiving & Screening Form	Recent hospitalization, medications, mental suicide attempt, current suicide thoughts)
CIU Mental Status Form	Suicide tendencies: Unknown, ideation, recent gesture, prior ideation, prior gesture, multiple gesture, medication, treatment history, diagnosis, substances, Mental status, sex offenses, violent behavior, delirium/dementia
Initial Placement Screening	Medication for mental illness, feel you have emotional or mental problems, mental decompensation risk, attempted suicide, if yes, when do you feel suicidal now, prior incarcerations none vs. more than 4
Section II Risk Assessment (Counselor)	Attempted suicide, if yes, when? Suicidal at this time? Mental decompensation, risk?

Recommendations

- Integrate the above screening components so that all components build upon each other and that the final intake risk assessment is made with the benefits of prior suicide assessments conducted during the intake process. (See the suicide screening form in Attachment B as an example of how to integrate these processes.)

2. Modify the Suicide Screening Process in the Central Processing Unit (CPU) to:
 - a. Ensure that a completed copy of the Criminal processing criminal warrant form is sent to the next step in the screening process (R&D);
 - b. Change responsibility for completing the suicidal screen on detainees in the CPU from the Police Department to the Corrections Department;
 - c. Ensure that the CPU officer asks the transporting Police officer if h/she observed or heard anything unusual or strange especially in regard to the inmates risk for suicide or violence toward others;
 - d. Structure the suicide screening to include a standard set of questions/behaviors that are always asked/ observed.
3. Incorporate the following risk indicators in the screening process:
 - a. Observations of Transportation officer (see above);
 - b. Family history of suicide;
 - c. Family history of serious mental illness (especially for young persons who may themselves be at the onset of psychosis);
 - d. Stressful events (e.g., anniversary of a family member's death);
 - e. Hopelessness; and
4. Facilitate more privacy and sensitivity and focus on building rapport when administering the suicide screening questions. This should be accomplished via training and supervision and is especially needed in the CPU and R&D areas.

Finding III: Medical Assistance

When medical staff are called to an emergency they are not initially given information as to the severity of the incident (e.g., bleeding, suicide attempt). Therefore, they are unable to adequately prepare for the emergency. Additionally, reportedly some officers are arriving at a scene requiring CPR and are not initiating the procedure. It is thought that the officers may be uncomfortable with their skills in this area.

Recommendations

1. Modify the emergency response practice to ensure that the Medical Department is informed of the severity of an incident simultaneously with the request for medical assistance. This should be done in a way that does not make the first responders (usually officers) feel that they are diagnosing.
- 2) Through a cooperative effort of Medical and Security staff, determine the basis and extent of the reported problem regarding officer unwillingness to administer CPR and implement appropriate corrective action.

Finding IV: Supervision of High Risk Inmates

Current staffing, coupled with environmental constraints, make it difficult to supervise inmates with suicide-risk indicators. Reportedly, this is problematic in the R&D observation areas, CPU, PC, Disciplinary housings and the two-cell holding area for women.

Overview

My observations are as follows:

There are not regularly assigned officers in most of these areas and, due to work load, rounds are extremely brief. Both of these factors hinder adequate officer-inmate communication. Emphasis appears to be more on meeting the facility requirements than communication with the inmate. This is not to say that the officers observed were not busy. All officers were extremely busy. In fact, when I was in CPU, E block, CI, CII and CIU, my observations were that adequate inmate-officer communication could not be formed with the current staffing. Officer-inmate communication flow is one of the greatest strengths for early identification of potential risk (e.g., changes in mood) and timely interventions prior to crisis. It did not seem to be adequately established in these areas.

Communication barriers hindering supervision were compounded by environmental concerns related to safety and to privacy for interviewing inmates. The facility is old and there were many obvious places immediately identified by officers, medical and mental health staff where a person could commit suicide. This is especially problematic in R&D, protective custody, discipline housing and the women's holding cells and Pods (e.g., vents, exposed bars on cells and windows, the sprinklers, beds that have areas that can easily be used for hanging. Additionally, visibility in many of these areas is difficult as there are only small windows in the doors.)

Recommendations

1. Do not place inmates with a major mental illness and/or with known suicide risk factors in isolation. These inmates should be afforded adequate programming and supervision. Consideration should be made to reinstate a step-down unit for these inmates with but with appropriate programming. (Reportedly, the previous step-down unit failed due to lack of adequate programming.) Additionally, these inmates should be routinely reassessed to determine their current mental health status, suicide risk and need to a higher level of care.
2. Modify the policy regarding the use of fifteen or 20-minute checks to supervise inmates on suicide precaution. This intensity of monitoring is not sufficient to ensure the safety of a suicidal inmate. Equally problematic is that for staff it creates a false sense of security. "It takes less than three or four minutes to die." Persons who are suicidal need continuous observation to ensure their safety. The National Commission of Correctional Health Care (NCCHC) recommends; "If sufficient staff are not available, do not isolate inmate, house person in a dormitory and check every 10-15 minutes."
3. Increase supervision and monitoring for inmates in protective custody and discipline housing. I recommend more regularity in officer's assignment to these posts, daily mental health staff rounds, training for officers and the use of a multi-disciplinary targeted team approach involving mental health, medical, security and counselor staff. The training should reinforce communication skills and sensitivity to daily living concerns that staff may get hardened to in this environment.

Identify, through the newly established Quality Improvement Committee, environmental safety concerns for those areas where suicidal inmates and inmates at higher risk of suicide are likely to be housed and develop a protocol which defines safe practices for addressing them. Simultaneously, develop a request to support appropriate changes to the environment where these inmates will be confined. Include: removing or covering protrusions and bars where a person could hang, (e.g., bars on windows in CIU) selecting an appropriate bunk style, installing smaller mesh over vents and shatter-proof ceiling fixtures and replacing sheets with materials that can't tear, etc. It would be helpful for the Committee to contact NIC for a list of publications on suicide-related environmental issues in jails.

Finding V: Tracking Inmates assessed at intake with high risk indicators

A management system to track and monitor high risk inmates only exists for inmates who attempt suicide at the correctional facility. Follow-up communication between medical, mental health, classification, counselor and other staff on inmates with high-risk indicators is fragmented and not governed by specific policies. Nursing staff and the mental health staff work independently after a person is identified as suicidal. There is no evidence of an interdisciplinary process (e.g., treatment team meetings, a central mental health/medical record) for the management and follow-up of these inmates or for their reassessment at high-risk stressful periods. In the last three suicides, two victims had been assessed with high-risk suicide indicators. (See Attachment C: list of stressors inherent for inmates in a correctional environment).

Recommendations

1. Develop, through a cooperative effort of Medical, Mental Health Counselor, Classification and Security Staff, a management protocol which facilitates an interdisciplinary approach to tracking and reassessing inmates at higher risk of suicide at the facility. Among the high-risk inmates to be tracked are: inmates who have a major mental disorder, young inmates whose immediate family members have a major mental disorder, inmates who were identified at the facility as being suicidal and inmates with prior attempts outside the facility.

2. Develop a Mental Health Special Needs Plan for all persons with major mental illness as well as inmates at higher risk of suicide who are not in CIU housing areas. Currently, such plans are only developed for CIU residents. Two of the recent suicide victims would probably have had special needs plans had this practice been in operation. Note: This type of follow-up requires treatment planning and intervention. It will require additional mental health staffing and an interdisciplinary team approach involving medical and counselor staff. (See NCCHC Jail Standards for definition and content of Special Needs Plan.)
3. Repeat assessments to determine suicide risk at known stressful times for persons with major mental illness and persons with identified high-risk suicide indicators. Stressors should be person-specific and include those related to an individual's history (e.g., date of the death of loved one) as well as criminal justice involvement (e.g., court hearing before and after). During discussions, facility staff recommended that counselor staff be asked to see inmates with suicide indicators on a more frequent basis (once a week). The expectation is that the counselor would assess for suicide risk during each contact and, as appropriate, initiate a mental health referral for a more in-depth assessment. If this process is implemented counselors will need training and periodic supervision from Mental Health while they conduct the screenings.
4. Continue the current mental health procedure of assessing juveniles for suicide intent before and after a court hearing and extend this practice to persons with major mental illness and persons with prior suicide attempts.
5. Provide training for the court-assigned correctional officers regarding identifying and referring high-risk inmates.
6. Implement practice for nursing staff to be proactive in tracking inmates who refuse or do not receive their prescribed psychotropic medications, document the reason and notify mental health. Additionally, it is recommended that nursing staff be trained to provide appropriate medication awareness programs to inmates who are resistant to taking their prescribed mental health medications.

Finding V: Staff Debriefing

Staff debriefing is not currently provided at the facility following a suicide event but debriefing is available to inmates who express a need for it. Debriefing is important for all staff and inmates involved or impacted by a facility suicide. It was apparent to me that the staff at this jail had not been adequately debriefed following the three suicides. Feelings of anger and disappointment were expressed by staff regarding the facility's non-responsiveness to their debriefing needs.

Recommendations

1. Add staff debriefing as a critical component to the Montgomery jail suicide prevention protocol. Debriefings are an effective tool to prevent unnecessary staff pain and they result in cost savings related to sick leave, staff burn-out and overtime. Debriefings for staff should not be confused with investigation. They provide a separate process for the healing of staff. It is also important to involve all impacted staff and not just security staff in the debriefings. Finally, debriefings should be separate from the facility investigation process following a trauma event. Investigators should not be in the debriefing groups to seek facts for the investigation. (See Attachment D.)
2. Modify the inmate suicide debriefing policy to ensure that all inmates who observe a suicide and who are impacted by the suicide participate in structured debriefing. They should not be asked if they want or need a debriefing but instead invited to the service as a routine procedure. Making people feel that they have to say they need a debriefing is not conducive to participation.

Finding VI: Communication with Family & Lawyers

Information from family, lawyers, other agencies serving inmates is sought by numerous staff but there is no standard protocol regarding specific suicide risk information to obtain from family members and where to record it.

Recommendations

1. Develop a formal protocol to solicit information regarding suicide intent and history from families, lawyers and other agencies working with inmates at the facility.
2. Post a sign in the waiting room and visiting room to encourage families, lawyers and other visitors to report suicide-related behaviors and statements to the shift commander or other designated personnel. The protocol should also require the inmate in question to be placed on continuous observation until an assessment of suicide intent by a qualified mental health staff determines that the inmate is not suicidal. If the inmate in question is currently receiving mental health treatment the treating mental health professional should be consulted.

Finding VII: Mental Health Community Linkages

Adequate linkages have not been established between the jail and community mental health providers. Background information to enhance staff assessment of suicide and to determine treatment history and needs at intake to the jail are not routinely obtained or documented. Additionally, formal community linkages are not routinely made for persons with major mental health needs at release from jail to the community.

Recommendation

1. Seek county support to develop a social work services at the jail that would provide the facility with the capacity to obtain prior assessment and treatment records and make linkages with community providers upon admission and discharge from jail.

Finding IX: Mental Health Services

The care and treatment of inmates with mental health disorders are not provided in accordance with acceptable community standards. Many of the essential practices, e.g., an interdisciplinary treatment approach, comprehensive suicide assessment, follow-up treatment and services to meet basic living needs are not available.

Overview

The medical and mental health staff interviewed are a dedicated staff who were aware of the deficiencies in care of inmates with mental illness. Reportedly, they have requested resources to enhance service delivery, but have not been successful due to budget cuts. They have just started an Quality Improvement Committee which, hopefully, will further their efforts to achieve an interdisciplinary approach.

Mental health services for inmates at the Montgomery Detention Facility are aimed primarily at providing classification assessments, crisis intervention, managing inmates on the 27-cell mental health unit and providing medication therapy to approximately 80 inmates. Reportedly, (other than medications) there is minimal treatment for persons on the CIU and no treatment for inmates discharged from the CIU to another housing area. Therefore, inmates with suicide risk factors and inmates with a major diagnosis are not routinely provided follow-up and support services when they are in the general population, disciplinary or protective housing areas.

In regard to the CIU, this unit confines an acutely mentally ill population. Reportedly, on September 1, 1999 the clinical profile of the CIU residents was as follows: 17 inmates with command hallucinations, 7 major depression of which some had psychotic features, 2 acutely suicidal on 15-minute observation, 1 panic disorder and 2 bi-polar.

Reportedly on September 1, 1999, there were four inmates who met the community standard for inpatient care (imminent danger to self or others). Reportedly, access to psychiatric inpatient care is only readily available to inmates requiring inpatient competency or insanity examinations. The hospital is resistant to serving inmates who meet the imminent danger criteria and when they do admit the inmate is often discharged after a brief stay. Reportedly, two of the above four inmates had been admitted to the hospital and discharged to the jail still psychotic.

The large volume of acutely mentally ill inmates is compounded by the fact that forced medication is not allowed in the jail. During my visit, there was one man yelling continuously, making statements about Jesus Christ. The psychologist stated that the man was psychotic but had refused medication. He also reported that the man had been yelling for days and was disturbing the sleep and general peace of other residents.

Services and supervision of inmates on the CIU are not consistent with community standards. For example, vital signs are not taken for inmates on the unit (most of whom are on psychotropic medications). Hygiene is poor for psychotic women and one man has only showered twice in the whole month of August. Treatment, other than medication, is not routinely provided. Inmate workers who are CIU residents clean feces from the cells of the male residents. Female psychotic residents clean their own waste. The unit does not have 24-hour nursing or psychiatric aide staff.

In regard to suicide prevention, this unit by virtue of the population served is very vulnerable to suicide attempts and has the highest frequency of suicide attempts of any unit in the facility (See attached summary of facility suicide incidents since 1996). However, supervision is inadequate. Suicide assessments are not complete and reportedly supportive treatment is not available. The suicidal inmates are locked in their rooms and checked every 15 minutes by the single officer who is responsible for supervision of the entire CIU unit. This unit consists of a two-tiered, 24-cell male unit and the separate 3-cell, locked unit for women.

Reportedly, much of the inadequate mental health care at the facility has been facilitated by staff cuts which occurred three years ago. Prior to this day, a treatment program was available to inmates on CIU and the mental health staff provided treatment services to inmates in other housing areas. These services were eliminated with the staff cuts: from 6 full-time staff to 3.5 full-time staff. Finally, there is no clerical staff to support this unit. Valuable treatment staff time is consequently spent doing call-outs for the psychiatrists, filing, etc

Recommendations

1. Increase the visibility of mental health services at the Detention Center. The facility orientation rule book should be amended to describe clear procedures for inmates to obtain mental health services as well as hours of operation and location of the unit. Additionally, the effectiveness of the new procedure to access mental health services through case managers needs to be reassessed. Staff and inmates interviewed were unclear if the procedure is actually in operation.
2. Re-establish a community standard for the mental health and medical care provided to inmates with major mental illness and other inmates at risk of suicide. To assist the facility re-establish a level of community practice within their mental health service, I recommend collaboration with County Mental Health Director, the County Attorney and the Local Chapter of the Alliance for the Mentally Ill. These consultants in conjunction with the Facility Mental Health Director and the Nurse administrator should prepare a plan to expand services and treatment protocols to meet community mental health care standards. Among the areas to address are:
 - a. Access inpatient care and treatment
 - b. Provide an interdisciplinary team approach to assessment and treatment
 - c. Expand mental health services and staffing. Guidelines from NYS (Attachment E) would indicate that seven staff would be needed for a facility with 9200 admissions and a average daily census of 660. However this does not include the extra nursing care that would be necessary for a mental health unit with persons with acute mental health treatment needs
 - e. Increase security staffing on the CIU
 - f. Increase psychiatric time to review treatment plans, address medication needs and facilitate access to psychiatric inpatient care
 - g. Provide twenty-hour psychiatric nursing services for persons on the CIU and to offer facility wide, mental health medication training programs
 - h. Provide appropriate follow-up and support services to inmates with mental health needs who are housed off the CIU Unit.

3. Enhance the mental health suicide prevention practices to:
 1. Provide a comprehensive suicide assessment. The current assessment is not consistent with acceptable practice and does not address the special stressors involved in the jail environment. (See The Suicidal Patient Clinical and Legal Standards of Care, Bruce Bongar, American Psychologist Association, 1991, APA Order Department, P.O. Box 2710, Hyattsville, MD, 20784.)
 2. Provide continuous supervision and appropriate treatment to acutely suicidal inmates.
4. Provide clerical support.
5. As part of the interdisciplinary approach assign responsibility for medication call-outs and tracking to the Medical Department. (See Attachment F for a list of resources to plan enhancements to the mental health service.)

Finding X: Training

Suicide training is provided at the facility via established orientation and in-service training programs. These training are given to all security, medical, classification, counselor staff. The Orientation training is outdated and reinforces many old myths about suicide. See Table I (Appendix C) for my detailed comments on the orientation training. The in-service training programs are more current but use only didactic methods. Finally, there is not a clear protocol regarding the frequency of suicide training following the initial orientation.

Recommendations

1. Replace the Orientation Program used at this facility with A NIC-recommended curriculum.
2. Ensure that all staff in contact with juveniles (including counselors in Disciplinary and PC) are trained in the differences in suicide risk between Youths vs. adults. Obtain a copy of the module on Suicide and Depression in the NIC Curriculum on Managing Youthful Violent Offenders in Adult Institutions.
3. Integrate experience-based training techniques within the in-service suicide training curriculums used at the facility, (e.g., break class into groups and give them case studies to use in identifying key indicators, utilizing role-playing itechniques, etc). This type of training promotes increased retention of the curriculum.
4. Provide suicide training every two years for all staff in contact with inmates. NCCHC standard states that training in suicide should be provided every two years for Correctional Officers.

Finding XI: Jail Diversion

Reportedly, persons with major mental disorders are being held in the jail on minor offenses. These individuals are vulnerable to suicide, and whenever legally possible, should not be detained in the jail setting. Their presence in a jail setting requires more intense staffing and programs to ensure their safety and the safety of other inmates. The jail environment does not appropriately address their needs, making them even more vulnerable to suicide.

Recommendation

1. Examine, under the direction of the newly established Quality Improvement Committee, admissions to the facility for a sample period. Determine the volume of inmates with major mental disorders and minor offenses being admitted to the jail. If indicated by the study results, convene a task force involving the sheriff's office, local police department, youth providers, community Mental Health center, state psychiatric center representative, social services and other appropriate agencies to find appropriate alternatives to jail incarceration for persons with mental illness charged with minor offenses. (Note: This may also be an appropriate issue for the current Criminal Justice Committee in Montgomery County.)

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Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage**

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**Emerging Judicial Strategies for the Mentally Ill in the Criminal Caseload:
Mental Health Courts in Fort Lauderdale, Seattle, San Bernardino, and Anchorage**

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EXECUTIVE SUMMARY

The Origin of a Mental Health Court Approach

Beginning with the emergence of drug courts, the last decade has seen a growing number of court-based, “problem-solving” initiatives that seek to address the problems (“root causes”) that contribute to criminal involvement of persons in the criminal justice population. While breaking ground for other “hands-on” judicial treatment innovations, the drug court model has itself continued to evolve to address substance-abusing court populations across the country. From the one begun as an experiment in Miami in 1989, drug courts have grown in number to roughly 500 in the United States (and abroad) currently. The judicial problem-solving methodology originating in drug courts has been adapted to address other serious problems associated with large numbers of persons in the criminal caseload. These have included community issues (community courts), family violence (domestic violence courts), and drug offenders returning to the community after serving prison terms (re-entry courts). One of the most challenging applications of this therapeutically-oriented judicial approach, the mental health court, has focused on the mentally ill and disabled in the criminal justice population. This report describes the emergence of the mental health court strategy in four pioneering jurisdictions in the United States, beginning with Broward County, Florida, where the idea was first innovated. The Broward County Mental Health Court model has been adapted to different settings and challenges in King County (Seattle), Washington; Anchorage, Alaska; and San Bernardino, California.

The immediate pressures that have led to the development of the mental health court strategy include crises in community mental health care (the long-term effects of deinstitutionalization), the drug epidemic of the 1980s and 1990s, the dramatic increase in homelessness over the last two decades, and widespread jail overcrowding. Each of the mental health court jurisdictions has responded to both the critical problems faced by the mentally ill in already overcrowded jails, and the relatively common co-occurrence of mental illness among the large numbers of substance abusers in the criminal justice population. Local jails, which have been struggling for decades, to deal with chronic overcrowding, have been particularly challenged by the need to care for the large numbers of mentally ill persons found in their charge. As many jurisdictions have turned to increasing emphasis on drug crimes and quality of life offenses, the jail and court populations have increasingly included mentally ill and disabled individuals who have extensive histories of involvement with the justice system and who have not been successfully engaged by community mental health treatment agencies.

Common Features of the Four Mental Health Courts

The four pioneering mental health court initiatives share a number of common attributes. Each court is voluntary; the defendant must consent to participation before he can be placed into the court program. Although the mental health eligibility requirements for participants differ somewhat from court to court, each jurisdiction accepts only persons with demonstrable mental illness likely to have contributed to their involvement in the criminal justice system. The mental health courts share the objective of preventing the jailing of the mentally ill and/or of securing their release from jail to appropriate services and support in the community. In addition, each of the courts gives a high priority to concerns for public safety, in arranging for the care of mentally ill offenders in the community. This concern for public safety risk explains the predominant focus on misdemeanor and other low-level offenders and the exclusion of offenders with histories of violence.

The four mental health courts also seek to expedite early intervention through timely identification of candidates. The goal of early screening and referral of defendants within time frames ranging from immediately after arrest to a maximum of three weeks after the defendant's arrest, depending on the jurisdiction. Each of the courts makes use of a dedicated team approach, relying on representatives of the relevant justice and treatment agencies to form a cooperative and multi-disciplinary working relationship with expertise in mental health issues. Another core ingredient of the mental health courts' approaches is the emphasis on creating a new and more effective working relationship with mental health providers and support systems, the absence of which in part accounts for the presence of mentally ill offenders in the court and jail systems. Each mental health court provides supervision of participants that is more intensive than would otherwise be available with an emphasis on accountability and monitoring of the participant's performance. The four mental health courts share the core role of the judge at the center of the treatment and supervision process, to provide the therapeutic direction and overall accountability for the treatment process.

Differences among the Four Mental Health Courts

The nation's first four mental health courts also differ from each other in important respects. The nation's first mental health court in Broward County was designed to be pre-adjudicatory and diversion oriented in its focus on misdemeanants. Eligible participants are placed into treatment programs prior to the disposition of their charges, which are held in abeyance pending successful program completion. The rationale for this approach was therapeutic: the court was to be as non-threatening and non-penal as possible and would seek to prevent further penetration by the mentally ill offender into the formal adjudication process. In contrast, the other jurisdictions opted for a conviction-based approach. In those sites, participants generally plead guilty in order to enter the program.

The implications of a candidate's decision to go to trial also differs in the four mental health courts. In King County, defendants must waive their right to a trial in return for admission to mental health court. They cannot choose to go to trial, get convicted and then seek to enter mental health court. None of the other sites has a strict policy against accepting

individuals who have opted for a trial, been convicted and then requested admission to the mental health court. However, in these cases, admission is far from ensured, and is decided on a case-by-case basis.

The four mental health sites also differ in their method of resolving criminal charges. Successful participants in Broward often have no conviction on their records, as charges are generally resolved through a “withheld adjudication.” The other three courts generally require pleas of guilty or no contest in order to enter the program, with the option of deferred disposition or deferred adjudication offered rarely to defendants with few or no prior contacts. In Anchorage and King County, only these few defendants may end up without a conviction. In San Bernardino, however, successful completion may result in the withdrawal of the plea and, later, expungement of the participant’s criminal record.

The mental health courts diverge also in their handling of non-compliant participants. While each court expects the treatment process to be potentially difficult, given the population of mentally ill offenders with which they have chosen to deal, they vary in the way they impose sanctions for non-compliance. Short of program termination, the most severe sanction is jail confinement. The use of this sanction seems least likely in Broward and Anchorage, somewhat more likely in King County, and relatively commonplace in San Bernardino. This difference in approach is accounted for in part by philosophical differences among the sites about the appropriate response to non-compliance; however, it is also related to the differences in the type of candidate admitted to the court. San Bernardino is the only site that accepts low-level felony offenders, who are usually incarcerated offenders with a previous diagnosis of mental illness as well as a record of prior convictions. In addition, most of the San Bernardino mental health court population has serious co-occurring substance abuse problems.

Issues Raised by the Emergence of a Mental Health Court Model

Early Identification of Mental Health Court Candidates

Problem-solving courts of different types share in common the need to identify their target population candidates as early in criminal processing as possible. The original drug court model was premised on the assumption that intervention with addicted offenders should occur shortly after arrest to maximize the opportunity to begin treatment when individuals may be most open to the possibility. In domestic violence courts, there is urgency to correctly assess the risks posed to victims and implementing options for treating or otherwise dealing with the offenders before further harm can occur. To be effective, mental health courts share that critical need to identify mentally ill or disabled candidates at the earliest possible stages of processing to avoid the damaging experience of arrest and confinement, to intervene medically to stabilize offenders and then to situate them in an appropriate placement process.

Like the other types of courts, however, the mental health court model faces serious challenges in identifying appropriate candidates early through appropriate and effective screening and evaluation procedures. Collectively, the early mental health courts employ informal and formal methods for identifying possible candidates and assessing them in some depth before detouring them from the normal adjudication process. These methods may include

informal referrals at arrest, arraignment or jail admission of persons appearing to suffer from mental illness or disabilities. They are followed by more in-depth clinical interviews at the jail or in court to assess the eligibility of defendants for the mental health court programs.

Fair, appropriate and effective screening procedures face three principal challenges: timeliness, accuracy, and confidentiality. Each of the courts has established procedures that identify mentally ill or disabled candidates as early as possible in the criminal process to maximize the opportunity to intervene and assist. The need to identify and assess the conditions of candidates quickly potentially conflicts with the need to conduct the thorough clinical assessment required for a reliable diagnosis on the basis of which processing in the mental health court can begin. To put it simply, it is hard to rush such an assessment and still have it be accurate and complete. This may be particularly true because of the difficulty associated with communicating with some mentally ill defendants.

Early intervention by the mental health court depends on timely and accurate information about the defendants' criminal justice and mental health backgrounds. However, the goal of early intervention and prompt treatment conflicts in part with the need for confidentiality and for consent by the defendants to share the mental health information with the court staff. Devising workable procedures that both enhance early intervention and enrollment of mentally ill offenders in the mental health courts and respect confidentiality pertaining to sensitive personal information represents one of the difficult challenges facing the mental health court approach.

Voluntariness

Some observers see special courts as vehicles for "coerced treatment," a term with favorable and unfavorable connotations. The favorable use of the term suggests that the judicial role and application of sanctions and rewards contribute a valuable tool for keeping participants in treatment and increasing the chances of successful outcomes. The unfavorable reference alludes to the problems associated with forcing treatment upon individuals who have not voluntarily consented, from a due process perspective and from the perspective that treatment cannot be effective unless it is wanted and the offender is "ready." In fact, most problem-solving courts are premised on voluntary participation by candidates, with the exception of some sentenced-based approaches (in which judges may simply sentence a person to treatment in court). This is especially true in diversion-based courts. Certainly, courts requiring guilty pleas from participants for admission must demonstrate that a plea was made knowingly and voluntary on the record. Even when appropriate procedures are observed to safeguard voluntariness in special courts, some critics argue that the choice (between, for example, drug court and jail) is a coerced choice.

The question of voluntariness is even more difficult for mental health courts. Although all the same legal issues dealt with in drug courts, domestic violence courts and community courts exist for persons entering the mental health courts examined in this report, they must also confront questions about a person's mental capacity and ability to comprehend the proceedings and the options being provided. Competency is a threshold issue that must be decided before an individual can be considered as a mental health court candidate in each of the courts. However, even among those deemed competent ("to stand trial"), serious questions may be raised about the

ability of persons to really understand the choices being presented and the consequences of those choices (e.g., going to trial or participating in the mental health court in one of several possible legal statuses).

If a requirement for voluntary participation in the special courts is not only competency as legally defined, but also an ability to understand and make reasonable decisions, then achieving voluntariness among mentally ill or disabled treatment candidates is a challenging proposition indeed. In the mental health courts, it means that sufficient time must be taken by defense counsel and by the court itself to make certain that the candidate's decision to enter the mental health court is in fact voluntary. This means having a grasp, beyond the threshold question of competency, of a defendant's mental condition. The potential fear is that defense counsel and/or the court may make decisions in the candidate's "best interest" when in fact the candidate, though competent, is thoroughly confused and afraid.

Conflict between Criminal Justice and Mental Health Treatment Goals

A challenge in the design of each type of problem-solving court was the need to craft an approach that resolved conflicts in values and goals inherent in criminal justice and treatment orientations (Goldkamp, 1999). For example, when substance abuse treatment professionals might stress tolerance for relapse and erratic performance (or a positive drug test) by drug abusers as part of the therapeutic process, criminal courts might normally be inclined to revoke conditional release (probation) and impose sanctions. While the criminal process might need to proceed expeditiously to adjudicate criminal charges, avoid unnecessary delay and dispose of cases, mental health professionals would require periods of time sufficient to diagnose the mentally ill defendant's condition, take immediate steps to stabilize the defendant and then to place the defendant in appropriate supportive services so that treatment could then proceed. From the perspective of mental health treatment, potentially the worst experience for many mentally ill persons would be arrest, jail and formal proceedings in the criminal court. In short, these conflicts in method, aims, values and style pose a particular challenge in the emerging mental health court initiatives to produce a hybrid model that attends to the basic requirements of each.

Defining Success

The drug court treatment process, from which the mental health court approach was adapted, was structured around clear phases of treatment through which a participant passed on the way to graduation. Requirements for graduation were clearly specified and typically included minimum periods of testing negatively for drugs of abuse, completion of all treatment activities, payment of fees, etc. Drug court participants therefore were able to chart their progress against clear expectations and rules for completion of the program. Charting a course for successful completion of requirements of the mental health court treatment process is more complex.

Mental health court participants may suffer from a variety of symptoms and illnesses and, thus, lack a common starting point. The steps necessary to stabilize participants and to situate them in living situations that will maximize their effective functioning are likely to differ

considerably from individual to individual. While a goal for substance abusers can clearly and measurably be abstinence within the time frame of the drug court treatment program, such a practical framework is not so readily available in the treatment of mental illness. Courts cannot say, "be cured within 12 months." They can expect that participants successfully follow the steps to improved functioning outlined in a treatment plan agreed upon by the participant and the mental health professionals. Thus, the challenge for setting achievable milestones for mental health court professionals is more complex and the functional equivalent of "graduation" may differ considerably from individual to individual.

Range of Responses to Participant Behavior/Performance

To an observer of other problem-solving courts, particularly drug courts where some of the in-court techniques were first developed, the mental health court model faces special challenges in devising responses to participant performance in treatment. One might argue that the experience of drug courts in the United States suggests that drug abusers respond well to a very structured system of incentives and sanctions when moving through the treatment process toward sobriety and improved functionality. These approaches are crafted based on assumptions about the behaviors of addicted persons, including a belief that very basic lessons and behaviors may have to be taught and re-taught for substance abuse treatment to be successful. Many drug courts have devised a rich range of responses rewarding participants for forward progress through treatment stages (until graduation). When these elements of the drug court model are applied to the mentally ill and disabled in the criminal justice system, the translation of the "rewards and sanctions" approach to mental health courts raises some difficult challenges. It is apparent that, because of the nature of mental illness (as compared to substance abuse or domestic violence), judicial responses have to be more generally encouraging and supportive as the court process seeks to move mentally ill and disabled participants into treatment and supportive services. Thus, depending on a defendant's illness, the judge's repertoire may need to draw on a wider range of incentives and supportive responses to participant progress than other problem-solving courts.

The notion that mental health courts should also call upon "sanctions" for poor performance is more difficult. In some cases, it may be clinically appropriate to employ the kinds of sanctions employed by drug courts in responding to noncompliance in treatment, including returning participants to earlier and more restrictive treatment stages or, even, making use of jail in selective instances. In other types of cases, however, it may be questionable as to whether "sanctions" (based on assumptions of deterrence) are at all appropriate to produce the improved mental health outcomes desired. Real questions, therefore, are raised about how the "coercive" power of the courts can be channeled to promote the goals of mental health treatment. Can a court "sanction" a defendant who fails to take medication? Does a court sanction a defendant who has difficulty functioning and understands little of the current circumstances or expectations due to mental illness?

Community Linkage and Resources

A critical element of the emerging mental health court model involves identification of the necessary treatment and related services in the community and the development of an

effective working arrangement between the courts and the service providers that helps place participants in appropriate services (and moves them out of jail) as quickly as is feasible. Moreover, the model is premised on a working relationship (as represented by the dedicated team approach) that facilitates ongoing supervision and case-management. Two important problems are faced by the mental health court approach.

First, if it is true that the court system finds itself having to address the needs of the mentally ill population, it is at least partly because existing institutions and services in the community (at least outside of criminal justice) have failed to serve this population. There is some irony, then, in designing a program that uses the court to place mentally ill and disabled participants in those very systems. Secondly, if the rationale for making use of these existing services is that the mental health court creates a new, synergistic relationship that improves both the court and treatment approaches, then the actual availability of these services and the resources to support them becomes a critical concern. A mental health court approach with a large population of persons in need of treatment but few services available in the area may have great difficulty in delivering treatment. Moreover, even when services are available and providers are enthusiastic about the court-based mental health treatment approach, effective identification of candidates in the criminal justice population risks placing a new and large demand on existing treatment resources.

Each of the mental health courts described in this report have identified potentially large populations of mentally ill and disabled defendants who are in need of mental health and related supportive services. Each has also found that treatment resources and funding are insufficient for the populations they are serving and plan to serve in the near future. When resources exist, they do not adequately provide the type or range of services the mentally ill and disabled persons in the criminal justice population require.

Mental Health Courts as a Community Justice Initiative

The mental health court strategy shares with prior problem-solving court undertakings the fact that a difficult problem has not been adequately dealt with through community institutions and services. Presumptively, effective community interventions could prevent the need to find and treat mentally ill citizens in the criminal justice system. The crime behaviors of the mentally ill range from nuisance and quality-of-life levels to more serious offenses, sometimes of the sort endangering themselves or the lives of other citizens. Although there are a range of behaviors associated with the mentally ill and disabled, it is highly unlikely that they have gone unnoticed in the community until their encounters with the criminal justice system. In fact, the presence of untreated, low-level mentally ill offenders represents an important quality of life and community justice concern in many localities.

Because other community networks or institutions have not effectively treated and supported the mentally ill—because community-based safety nets have failed—they enter the justice system, usually involved in minor, nuisance, and quality of life offenses. Often, by then, they have other serious problems—such as alcohol or other drug addiction, housing, employment and physical health problems—that also have not been addressed. In many instances, the mentally ill or disabled find themselves in criminal justice primarily because of their mental

illness and their inability to connect with or stay in supportive community-based treatment services.

Like the other special court approaches, the mental health courts described in this report attempt to address the problems of their target populations on two levels:

- by dealing with their problems in the criminal justice system, and
- by building linkages to community services and support structures that have for a variety of reasons failed to reach them prior to their criminal justice involvement.

Each of the mental health courts discussed has developed strategies for identifying mentally ill and disabled offenders at the earliest stages of processing, sometimes involving contacts from police officers at the arrest stage. Each jurisdiction has taken steps to implement early screening procedures to evaluate candidates for the court treatment process as soon as possible so that unnecessary delay, criminal justice processing, and jail confinement can be avoided. Each of the courts began with a primary focus on defendants entering the criminal process shortly after arrest (and being held in jail), but expanded to accept referrals from other courts, and other sources, such as attorneys, police, friends, relatives or other community contacts aware of individuals caught up in the justice system who were mentally ill or disabled. Each of the courts established a close link to the local jail, so that mentally ill inmates could be identified and admitted to the mental health court treatment process, at whatever stage of processing in the criminal justice system. In short, consolidating justice procedures to identify and enroll candidates in treatment has been an aim of these first pioneering mental health courts.

In each case, the “in-house” approach is closely tied to a focus on community treatment resources and linkages. Depending on the kinds of illnesses evidenced and the types of resources available in their locales, each of the early mental health courts takes steps to place participants in community-based treatment services, either immediately or after initial crises are addressed and individuals are stabilized. Each court emphasizes the importance of proper and timely diagnosis and of placement in proper treatment and supportive care services, where they exist. Each court builds the treatment process around court supervision as a critical, core element ensuring both that enrolling participants cooperate and that appropriate services are indeed provided. At the core of the mental health court approach is a newly established working relationship between the supervising court and community mental health treatment and related services.

Mental health courts, in this regard, represent important court-based community justice initiatives. They are strengthening the effectiveness of community mental health treatment approaches by offering their close attention and supervision. They are returning mentally ill persons from custody and processing in the criminal justice system to the community to function there. They are encouraging community-based justice and health approaches that would prevent mentally ill and disabled individuals from entering the justice system in the first place. Thus, successful court strategies would ideally put themselves out of business: they would find far fewer mentally ill persons in criminal justice, because they would be more effectively and appropriately dealt with through improved community intervention, services and support mechanisms.