

# Reducing the Number of People with Mental Illnesses in Jail

## Six Questions County Leaders Need to Ask

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### Introduction

Not long ago the observation that the Los Angeles County Jail serves more people with mental illnesses than any single mental health facility in the United States elicited gasps among elected officials. Today, most county leaders are quick to point out that the large number of people with mental illnesses in their jails is nothing short of a public health crisis, and doing something about it is a top priority.

Over the past decade, police, judges, corrections administrators, public defenders, prosecutors, community-based service providers, and people with mental illnesses and their families have mobilized. Most large urban counties, and many counties smaller in size, have created specialized police response programs, established programs to divert people with mental illnesses charged with low-level crimes from the justice system, launched specialized courts to meet the unique needs of defendants with mental illnesses, and embedded mental health professionals in the jail to improve the likelihood people with mental illnesses are connected to community-based services.

Despite these tremendous efforts, the problem persists. By some measures, it is more acute today than it was ten years ago, as counties report a greater number of people with mental illnesses in local jails than ever before. Why?

After reviewing a growing body of research about the characteristics of people with mental illnesses who are in contact with local criminal justice systems, analyzing millions of individual arrest, jail, and behavioral health records in a cross-section of counties across the United States, examining initiatives designed to improve outcomes for this population, and meeting with countless people who work in local justice and behavioral health systems, as well as people with mental illnesses and their families, the authors of this brief offer four reasons why efforts to date have not had the impact counties are desperate to see:

#### **There are insufficient data to identify the target population and to inform efforts to address this challenge.**

New initiatives are frequently designed and launched after considerable discussion but without sufficient local data. Data that establish a baseline in a jurisdiction—such as the number of people with mental illnesses currently booked into jail and their length of stay once incarcerated, their connection to treatment, and their rate of rearrest—inform a plan's design and maximize its impact. Furthermore, eligibility criteria are frequently established for diversion programs without the data that would show how many people actually meet these criteria. As a result, county leaders subsequently find themselves disappointed by the impact of their initiative. Counties that recognize the importance of using this data to plan their effort often find the data they need do not exist. It is rare to find a county that effectively and systematically collects information about the mental health and substance use treatment needs of each person booked into the jail, and records this information so it can be analyzed at a system level.

**Program design and implementation is not evidence based.** More and more research that is emerging on the subject of people with mental illnesses who are involved in the justice system demonstrates that it is not just a person's untreated mental illness, but also co-occurring substance use disorders and criminogenic risk factors that contribute to his or her involvement in the justice system. Programs that treat only a person's mental illness and/or substance use disorder but do not address other factors that contribute to the likelihood of a person reoffending are unlikely to have much of an impact. Further, intensive supervision and limited treatment resources are often not targeted to the people who will benefit most from them, and community-based behavioral health care providers are rarely familiar with (or skilled in delivering) the approaches that need to be integrated into their treatment models to reduce the likelihood of someone reoffending.

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**The initiative is small in scale.** With resources scarce, diversion programs or improvements to reentry planning are frequently launched as pilots, rarely taken to scale, and as a result unable to serve many of the people who would be eligible for them. Compounding problems, community-based treatment and other supports are frequently stretched so thin in the community that they have the capacity to reach just a small fraction of the people who need them.

**The impact of the initiative is not tracked.** County leaders making a significant investment in community-based services and supervision for people with mental illnesses should know what impact that investment has had on these four key measures: *the number of people with mental illnesses booked into jail, their average length of stay, how often they're connected to treatment, and their rearrest rates.*

But few counties have benchmarked these numbers and capacity to collect and analyze data is so limited that county leaders would be considered fortunate to get data on how many people were served and how many people completed a program. Without outcome data, however, it is hard for the people who administer programs and services to focus on clear targets. Similarly, it is hard for county leaders to hold program administrators accountable for desired results.

## What Does “Mental Illness” Mean?

The term “mental illness” is defined by *The Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition, as “a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects dysfunction in the psychological, biological, or developmental processes underlying mental functioning.”<sup>1</sup>

For the purposes of this brief, the term should be understood also to encompass co-occurring substance use disorders, as well as “serious mental illness” (SMI) or “serious and persistent mental illness” (SPMI), which are defined as a mental, behavioral, or emotional disorder that is diagnosable within the past year, is chronic or long lasting, and results in a significant impairment in social, occupational, or other important areas of functioning.<sup>2</sup>

Some states specify the diagnoses that they accept as qualifying for an SMI such as schizophrenia, schizoaffective disorder, bipolar disorder, and severe forms of major depression and anxiety. SMI and SPMI are often used interchangeably by states.

To assess their community's existing efforts to reduce the number of people with mental illnesses in jail, county leaders should ask themselves the following questions:

- 1. Is our leadership committed?**
- 2. Do we conduct timely screening and assessments?**
- 3. Do we have baseline data?**
- 4. Have we conducted a comprehensive process analysis and inventory of services?**
- 5. Have we prioritized policy, practice, and funding improvements?**
- 6. Do we track progress?**

Leaders in counties across the U.S. who scan these questions will readily respond affirmatively. Indeed, there are many counties that can provide excellent examples of what successfully addressing one or more of these questions looks like. But no county has taken the steps necessary to satisfy all the above questions. Doing so is hard—extraordinarily hard. These issues are complex. Resources are limited. And a host of independently elected officials and a tangled web of private and not-for-profit service providers must set aside their own agendas and collaborate extensively.

To be clear, this brief does not assume that the number of people with mental illnesses in jail can be reduced *only* when counties have addressed all of these questions. But county leaders will find that thoughtful consideration of each of these six questions will help them determine to what extent their efforts will have a system-level impact, not only resulting in fewer people with mental illnesses in jail, but doing so in a way that increases public safety, applies resources most effectively, and puts more people on a path to recovery.

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# 1. Is Our Leadership Committed?

Are county policymakers—such as commissioners, supervisors, or managers—and key leaders from the criminal justice and behavioral health fields fully invested in the goal of reducing the number of people with mental illnesses in jail?

## Why it matters

Reducing the number of adults with mental illnesses in jails requires a cross-systems, collaborative approach involving a county-wide committee or planning team. Strong leadership, including the active involvement of people responsible for the county budget, is essential to rally agencies reporting to a variety of independently elected officials. The designation of a person to coordinate the planning team's meetings and activities and to manage behind-the-scenes details pushes the project forward and ensures that the work gets done.

## What it looks like

- ✓ **Mandate from leaders responsible for the county budget:** The elected body representing the county (e.g., county commissioners) has established a clear mandate for behavioral health and criminal justice system administrators to implement systems-level reforms necessary to reduce the number of people with mental illnesses in jail.
- ✓ **Representative planning team:** The planning team comprises key leaders from the justice system, such as the sheriff or jail administrator, judges, prosecutors, defense bar, law enforcement executives, and community supervision officials; key leaders from the behavioral health system, such as the director of mental health services, other community-based behavioral health care providers, such as substance use treatment providers, and health care financing experts; representatives from the community, including consumer or family organizations (e.g., National Alliance on Mental Illness [NAMI]); and representatives from county government, such as commissioners or a county manager, and representatives of municipal government.
- ✓ **Commitment to vision, mission, and guiding principles:** The planning team is clear on the mandate, and is committed to making the necessary agency-level changes. Formal agreements, such as memorandums of understanding (MOUs), are in place to effectuate team function and document the initiative's vision, mission, and guiding principles, as well as to formalize the expectation that top decision makers will be in attendance for planning meetings.
- ✓ **Designated planning team chairperson:** The chairperson is a county elected official or other senior-level policymaker who is in routine contact with leaders responsible for developing the county budget and administering the law enforcement and behavioral health systems, and who can engage the stakeholders necessary to the success of the initiative. County leaders have charged the chairperson with holding agency administrators accountable for the implementation of the plan. These agency administrators are aware that the project coordinator must provide routine updates to county leaders, often in an open forum, such as a commission meeting.
- ✓ **Designated project coordinator:** The planning team has assigned a project coordinator to work across system agencies to manage the planning process. The project coordinator—who might also be the county's criminal justice coordinator—facilitates meetings, builds agendas, provides meeting minutes, and organizes subcommittee work as needed. The project coordinator also assists with research and data analysis, and is in constant communication with planning team members.

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## 2. Do We Conduct Timely Screening and Assessments?

Is screening for mental illness and substance use conducted for everyone booked into jail, along with full, follow-up assessments, as time allows, for people who screen positive for these conditions? Are assessments measuring a person's risk of flight while awaiting trial and a person's risk of reoffending also conducted and combined with screening information to guide decision making from the pretrial phase through final case discharge?

### Why it matters

To reduce the number of people with mental illnesses in jail, counties first need to have a clear and accurate understanding of the prevalence of mental illnesses in their jail populations. This requires the universal screening of every person booked into jail for mental illness, as well as for other behavioral health needs, such as substance use. Additionally, assessing for criminogenic risk (or the likelihood that someone will commit additional offenses) further informs release decisions, such as whether to require supervision or services to reduce the risk of reoffending. Without this foundational information, counties are ill equipped to track whether the number of people with mental illnesses in jail is actually being reduced, and if those identified with behavioral health needs are getting connected to the right types of interventions. [See Box: The Criminogenic Risk and Behavioral Health Framework]

### What it looks like

- ✓ **System-wide definition of mental illness:** The county has established a definition of mental illness that is consistently applied throughout the local criminal justice and behavioral health systems. At the state level, a definition of mental illness and/or serious mental illness (SMI) exists to determine eligibility for treatment and services funded by the state. In many counties, health officials use the state's definition to guide service-delivery decisions, however, that is not the case in every county. Health care providers working in the jail often use a definition of mental illness that is distinct from what local or state health officials use. For example, a jail may screen only for suicide risk rather than screening for mental illness based on a system-wide definition of mental illness. Judges may receive pretrial release and sentencing recommendations concerning behavioral health needs that are not based on formal screening. Or mental health clinicians working inside the jail may describe a person's mental health needs in terms that do not align with the state's definition of who qualifies for publicly funded mental health services. Adopting a single definition of mental illness that is consistently used by local behavioral health systems, as well as the jail, courts, and community corrections, ensures that all systems are using the same measure to consistently identify the population that is the focus of the initiative's efforts.

### Adopting a Definition of Mental Illness

When establishing its definition of mental illness, a county may decide to focus on the population with SMI, which is defined by the state and denotes the population with the most severe impairments who are often eligible for publicly funded services. The planning team may adopt the state's definition, or may choose another definition based more on local considerations. In any case, the definition is one that both criminal justice and mental health professionals can understand and use with confidence.

Although this may at first seem a simple task, many planning teams struggle with this exercise. The focus needs to remain on the practical use of the definition to determine the target population of the initiative. For example, a county may agree to use the state's definition of Serious Mental Illness (SMI) but describe it in more detail to include a diagnosis established through an assessment process that, without treatment, impairs the day-to-day functioning of the individual.

Because many people are released within 24 hours, screening immediately at booking for mental illness based on the county's established definition casts the widest net to include people with mental illnesses of varying degrees of severity, thus capturing the true prevalence of mental illness in the jail.

- ✓ **System-wide definition of substance use disorders:** The planning team agrees on a consistent definition of substance use disorders, a definition that may include substance use disorders that co-occur with mental illnesses. It is critical to be aware of the presence and severity of a substance use disorder both to identify a clinical need and to address the condition as a risk factor for reoffending.

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- ✓ **Validated screening and assessment tools for mental illness and substance use:** To ensure the accurate identification of the behavioral health needs of everyone booked into jail, the county has implemented validated screening tools and assessment processes. The Brief Jail Mental Health Screen and the Texas Christian University Drug Screen V (TCUDS V) are validated mental health and substance use screening tools that are available in the public domain, are easy and efficient to administer, and do not require specialized staff such as a sworn officer or a mental health professional to conduct.<sup>3</sup>
  - ✓ **Efficient screening and assessment process:** The development of a screening and assessment process requires the planning team to determine the best party to conduct the screening. In some jurisdictions, jail personnel do the screening; in others, it is a contracted or embedded medical or behavioral health care provider. The logical time and place for screening for mental illnesses and substance use disorders is at booking into the jail, and within this churning environment, quick and efficient processing is necessary. If a person screens positive for a mental illness, a full clinical assessment by a mental health professional is necessary to confirm the screening result. Because an individual may be released from jail before the assessment can be completed, a process is in place to connect him or her to a mental health care provider to complete the assessment process.
  - ✓ **Validated assessment for pretrial risk:** Many jurisdictions do not screen for criminogenic risk until after a defendant's case is adjudicated. It is also essential, however, to conduct a pretrial risk assessment to inform decisions about a defendant's pretrial release, eligibility for pretrial diversion, and conditions of pretrial supervision. Such screenings are conducted prior to a person's first appearance/arraignment in order to inform the court of pretrial risk of failure to appear and risk for new criminal activity.<sup>4</sup> Mental illness in and of itself is not considered to be a risk factor, but is considered in relation to release and case-planning decisions.<sup>5</sup>
  - ✓ **Mechanisms for information sharing:** The planning team has developed information-sharing agreements between agencies that protect the individual's privacy and support the need to share behavioral health information. The results of screening and assessments are used to inform key decisions related to pretrial release, diversion, discharge planning, and specialized pretrial and post-conviction community supervision. Jurisdictions often create a flag process that serves as an indicator of the need to connect a person to services and to gather the necessary releases to enable discussing the case. A data match of all people booked into jail and the behavioral health system's database identifies people who have previously received behavioral health care services and may require reestablishment of services.

## Key Considerations for Information Sharing

Good communication is at the heart of effective collaborations between criminal justice and behavioral health systems, but often concerns about confidentiality, privacy law, and incompatible information systems hamper best efforts to share information effectively. Counties need to develop the information-sharing policies and protocols necessary to facilitate system analysis and case management, while adhering to professional codes of ethics and privacy law. Some key considerations are:

- **Identifying information:** A discussion with interagency stakeholders about what information is needed to inform decision making and case planning and how this information will be used can help address concerns about confidentiality and build trust across agencies. Identifying the minimum necessary information to share helps keep the flow of information manageable and also adheres to the principles underlying privacy law.
- **Agreements:** It's critical to understand relevant federal and state law relating to privacy and information sharing, and to develop appropriate interagency agreements (such as MOUs) and local protocols (such as release-of-information forms) when protected information is involved.
- **Training:** Ongoing staff training must be a priority when collecting, sharing, and analyzing information.
- **Evaluation:** Regular reviews are necessary to identify opportunities to improve information-sharing processes and data analyses.

## In Practice: The Screening and Assessment Process Salt Lake County, Utah

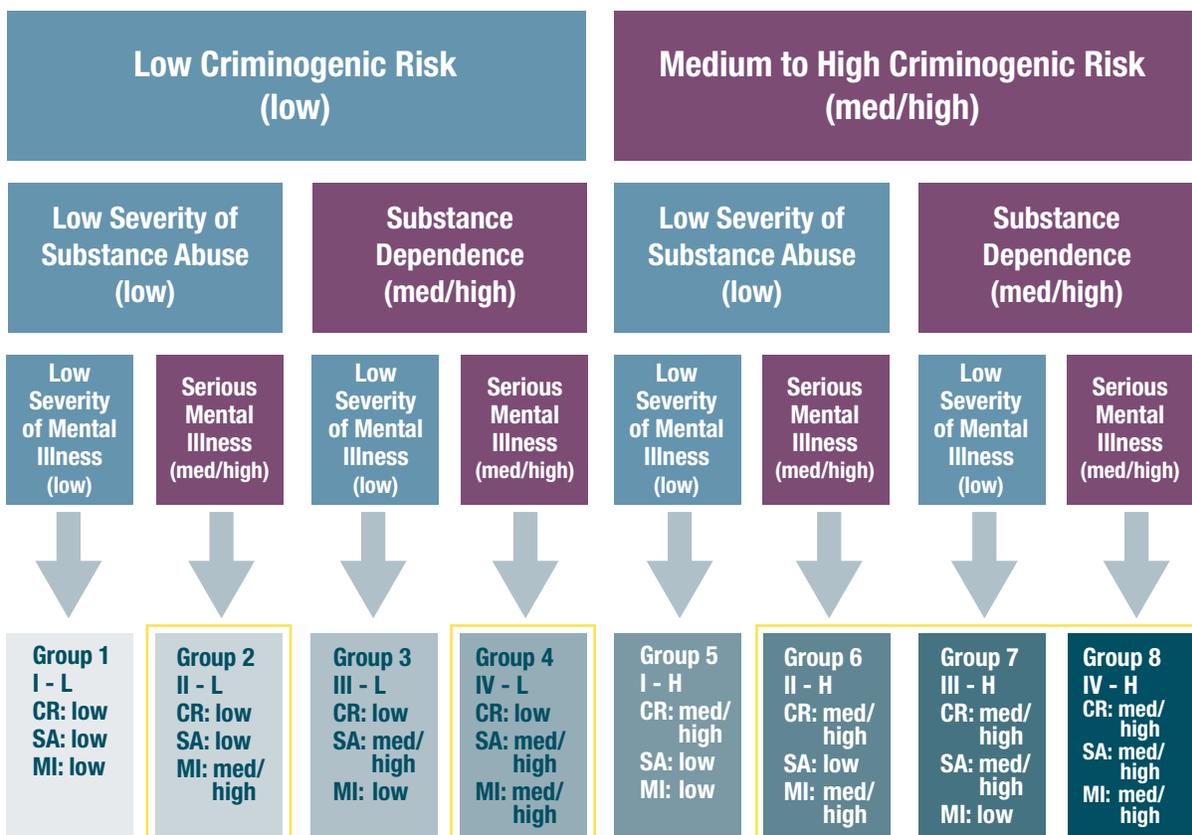
Salt Lake County, Utah, screens for mental health, substance use, and criminogenic risk at booking for everyone charged with a class B misdemeanor or above. Implemented in December 2015, county officials are tackling challenges such as information sharing and staffing needs, as well as coordinating with a statewide data bank. Moving forward, a more accurate assessment of prevalence will better inform Salt Lake County of the service and supervision needs of people booked into jail, as well as provide a baseline to measure progress in reducing the number of people with mental illnesses in their jail.

## The Criminogenic Risk and Behavioral Health Needs Framework

With mounting research that demonstrates the value of science-based tools to predict a person's likelihood of reoffending, criminal justice practitioners are increasingly using these tools to focus limited resources on the people who are most likely to reoffend. At the same time, mental health and substance use practitioners are trying to prioritize their scarce treatment resources for people with the most serious behavioral health needs. A person who screens positive for mental illness and/or substance use should be connected to appropriate treatment at the soonest opportunity; however, when that person is also assessed as being at a moderate to high risk of reoffending, connection to treatment is an even higher priority, along with interventions such as supervision and cognitive behavioral therapy to reduce the risk of recidivism.

The framework depicted in Figure 1 outlines a structure for state and local agencies to consider how information about risk of reoffending, and substance use and mental health treatment needs can be considered in combination to prioritize interventions to have the greatest impact on recidivism.

FIGURE 1. THE CRIMINOGENIC RISK AND BEHAVIORAL HEALTH NEEDS FRAMEWORK



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### 3. Do We Have Baseline Data?

Has the county established baseline measures of:

- the number of people with mental illnesses booked into jail,
- their average length of stay,
- the percentage of people connected to treatment, and
- their recidivism rates?

#### Why it matters

Baseline data highlight where some of the best opportunities exist to reduce the number of people with mental illnesses in the jail, and provide benchmarks against which progress can be measured. Knowing **the current number of people with mental illnesses admitted** into the jail helps county leaders determine whether new prevention and diversion strategies are resulting in fewer jail bookings of people with mental illnesses. **Calculating the average length of stay** for people who screen positive for mental illness helps the county recognize whether people with mental illnesses are especially likely to languish in the jail. Tracking **connections to treatment** illuminates to what extent there is continuity in care, post release. Without a baseline **recidivism rate**, the county cannot assess whether investments in community-based supervision and treatment are reducing the rearrest and reincarceration rates among people with mental illnesses released from jail.

#### What it looks like

✓ **A system-wide definition of recidivism:**

The planning team agrees on how it is measuring recidivism, recognizing that rearrest, convictions for a new crime, or the return to custody for violating conditions of release (i.e., technical violations) are each important, but distinct, ways of measuring whether a person engages in criminal activity and/or how law enforcement, the courts, and corrections respond to the behavior of someone released from jail and/or under community supervision. Agreeing on a definition of recidivism also requires using a consistent time period for reporting recidivism data (e.g., one, two, and/or more years).

#### In Practice: Adopting a Definition of Recidivism Bexar, Dallas, El Paso, Harris, and Tarrant Counties, Texas

The five most populous counties in Texas follow the state's standard measure of recidivism as rearrest within one, two, and three years of release from jail. These counties use the same recidivism definition to measure recidivism for people diverted to community-based supervision or other alternatives to incarceration. Although these counties also frequently measure recidivism in other ways, such as reincarceration for violation of a condition of release, they do use a common measurement of recidivism.

- ✓ **Electronically collected data:** Data that draw on results of screening and assessments that are conducted for each person admitted to jail are collected electronically to support ongoing analysis. In many cases, this analysis requires access to multiple databases. Some counties have navigated this situation by creating an integrated data management system. Others use a more “home-grown” data warehouse system, and still others may rely on a master spreadsheet approach. The end goal is to have the capacity to capture and analyze key data effectively.

- ✓ **Baseline data on the general population in the jail:** To provide a point of comparison that can be used to determine whether disparity exists in bookings, length of stay, or recidivism rates, data must be collected not just for people with mental illnesses, but also for people without mental illnesses. This comparison can be especially useful when data on both populations are disaggregated further by risk level, race, or gender.

- ✓ **Routine reports generated by a county agency, state agency, or outside contractor.** Reports containing information about the number of people with mental illnesses in jail, length of stay in jail, connections to treatment, and recidivism should not be a one-time deliverable. The baseline data should be generated with the understanding that this will be a report that is updated at least annually, using consistent definitions to track changes year to year.

## Key Considerations for Developing an Integrated Data System

County officials must know the number of people booked into jail. For most counties, collecting and analyzing data, and doing so on a regular basis, is challenging, to say the least. It is not unusual for jail admission and release data to be in one information system maintained by the county. Arrest data, on the other hand, may be found in a statewide database, while gathering information about people who have received community-based health services requires the cooperation of behavioral health care agencies. The gold standard for a system that enables a county to establish baseline data, share information, and track progress is an integrated system that allows multiple agencies to enter as well as access the data. A single, integrated information system also enables rich reporting that includes connections to treatment or other data related to a person's experience after he or she returns to the community.

It is essential for IT staff to be involved in the planning discussion about developing an integrated data system. For some counties the IT staff may be a stand-alone department, for others it is a single person in the Sheriff's Office, and for others it might be a private contractor or local university research partner. The IT staff can assist the planning team to develop a programming solution to the challenge of tracking the flow of people with mental illnesses as they move through the criminal justice and behavioral health systems and receive treatment in the community. The system should also provide the ability to track recidivism for this population, as well as to identify high utilizers of justice, behavioral health, and other social services.

## In Practice: How Baseline Data Informs Planning

When a county analyzes the number of people with mental illnesses in the jail, the average length of stay in jail for this population, rates at which they are connected to treatment, and their rearrest rates—or determines whether this information can even be assembled—the findings help illuminate strategies that will deliver the greatest return on investments.

Jurisdiction	Metric	Finding	Action Taken
<b>Bexar County, Texas</b>	The number of people with mental illnesses in jail	County does not know how many people with mental illnesses are in the jail.	Bexar County established universal screening for mental illnesses.
<b>New York City, New York</b>	Length of stay	People with mental illnesses stayed in jail 112 days on average as compared to 61 days for those without mental illnesses.	New York City implemented early pretrial diversion options to move people with mental illnesses out of jail in a timely way.
<b>Franklin County, Ohio</b>	Connection to care post-release	More than one in three of people who had contact with the behavioral health care system in the year prior to their incarceration did not have contact with the behavioral health care system in the year following their release from jail.	The local Alcohol Drug And Mental Health (ADAMH) board would establish a jail liaison team to provide in-reach service to get follow-up appointments within two weeks of release.
<b>Salt Lake County, Utah</b>	Recidivism rate	One out of three people on pretrial supervision and one out of two people on county probation did not fulfill the requirements of their supervision.	Salt Lake County recommendations included establishing intensive supervision caseloads for people who are assessed as being moderate to high risk of reoffending and who are also assessed as having an SMI.

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## 4. Do We Conduct a Comprehensive Process Analysis and Inventory of Services?

In partnership with advocates and people working on the front lines of the justice and behavioral health systems, county leaders conduct an exhaustive, end-to-end analysis of the system's processes from the point of law enforcement's contact with a person with a mental illness through final case discharge. This comprehensive analysis goes beyond the sequential intercept mapping exercise familiar to many counties that have reviewed what programs and services exist at arrest, booking, pretrial detention, release, and community supervision. This analysis flags decisions and actions—or failures to act—that contribute to the high prevalence of people with mental illnesses in jail. It also provides county leaders with a detailed understanding of services and supports that are available—and missing—in the community.

### Why it matters

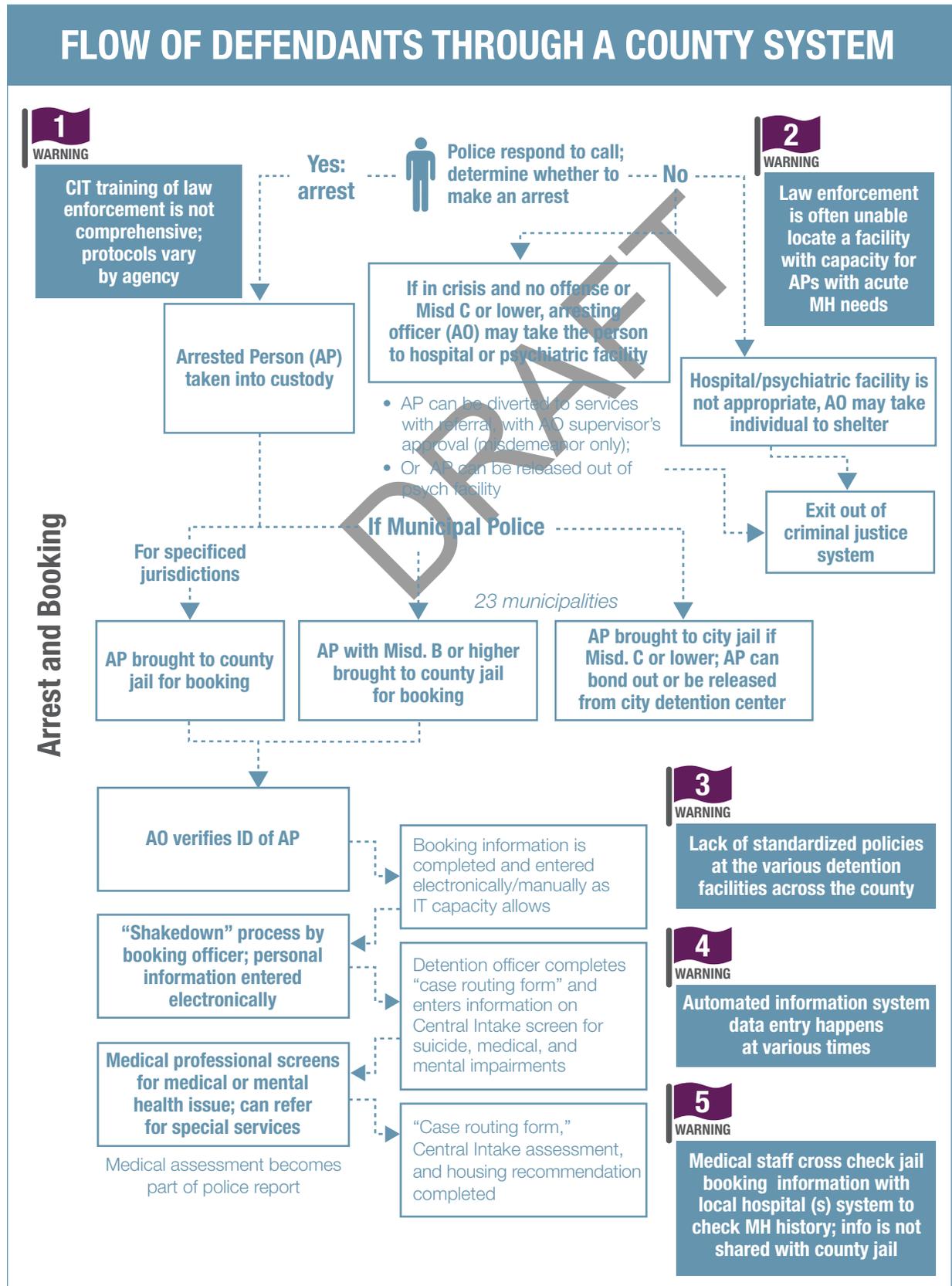
In every county, there is a timeline that includes the moment when a 911 call center receives a mental health call for service—or when a person identified with having a mental illness is booked into jail, or when defense counsel receives the results of that person's mental health screening—each an opportunity to improve the response to the person's mental health needs. Counties must create policies and processes that ensure that a person's mental health needs are accurately identified and the right type of information is shared appropriately and efficiently to inform key decisions related to diversion, pretrial release, specialized probation supervision, and connection to community-based services.

Without completing a comprehensive process analysis, these opportunities are often not identified and thus are missed. Timely information is not generated or shared appropriately, or perhaps a defense counsel, judge, or probation officer receives this information but does not use it to inform their decisions. The detailed, point-by-point system review helps county leaders determine where these breakdowns in process occur and where improvements can be made. Recognizing that successful implementation of a plan hinges on the accessibility of community-based treatment, which typically is in limited supply (if it exists at all) in most counties, it is important that an inventory of services and supports also be conducted.

### What it looks like

- ✓ **Detailed process analysis:** The county planning team, perhaps organized into subcommittees, traces each step of a person's involvement in the justice system, from the moment when police receive a mental health call for service to the person's admission to jail to the person's release from jail and connection to community-based treatment, services, and supervision. At each decision point, the team asks questions such as:
  - What is the process associated with the decision?
  - Is the process timely and efficient?
  - What information is collected at that point in the process?
  - How is that information shared and with whom?
  - How is that information acted upon?
  - Are the people involved in each decision point trained in their role?
- ✓ **Service capacity and gaps identified:** The planning team identifies what options exist at each decision point, including crisis services, diversion opportunities, and community-based treatment, services, and supervision. The team also identifies what services are not available, or exist but do not meet capacity needs.
- ✓ **Evidence-based programs and practices identified:** County leaders are provided with a detailed description of existing services and gaps in services that apply the latest research about what works to meet the needs of people with mental illnesses and reduce the likelihood that they will commit a new offense. This scan of service capacity also reflects historical data or best estimates related to demand for these services.

FIGURE 2. A COUNTY'S PROCESS ANALYSIS FOR THE ARREST/BOOKING STAGE



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## 5. Have We Prioritized Policy, Practice, and Funding Improvements?

Do key findings from the system analysis inform the development of action items? Are these action items prioritized for county leaders to maximize the impact of existing resources and to identify new resources to reduce the number of people with mental illnesses in their jail?

### Why it matters

The planning team must make policy recommendations and budget requests that are practical, concrete, and aligned with the fiscal realities of the county. Being in routine communication with the people responsible for the county budget (e.g., county commissioners and other officials) engages these leaders in the planning team's ongoing efforts and increases the likelihood that the recommendations will be received favorably.

Recognizing the limitations (and opportunities) that distinct funding streams present is critically important. The planning team's budget proposal should identify external funding streams including federal programs such as Medicaid, federal grant opportunities, and state block grant dollars as the first source for funding. Opportunities for local philanthropic support should also be considered. The final gaps in funding will represent new county investments.

### What it looks like

- ✓ **Prioritized strategies:** For a county to reduce the prevalence of mental illness in jail, it must accomplish one or more of the following: *reduce the number of people with mental illnesses admitted to jail, reduce their length of stay, increase their connections to treatment, and lower their recidivism rates.* Drawing on the system analysis described earlier, the planning team determines the most achievable ways of accomplishing one or more of these goals, with an emphasis on strategies that impact people with the most serious behavioral health needs who are also at the highest risk of reoffending. [See Box: The Criminogenic Risk and Behavioral Health Needs Framework]
- ✓ **Detailed description of needs:** The planning team's proposal includes funding for additional personnel and increased capacity for mental health and substance use treatment services, as well as support services that may include housing and employment. The request for additions for treatment and support services is based on data-informed projections and takes into account budget constraints. All programming requests include evidenced-based approaches such as validated risk assessment, motivational interviewing, and research-based curricula that are carefully matched to the particular needs of the population. Infrastructure improvements, such as one-time costs for software/information systems and training are also included in the budget proposal. Further, the planning team has reconciled all considerations regarding staffing requests, as there is often debate over placement of the staff, whether personnel are sworn or unsworn, whether mental health clinicians are behavioral health agency employees who are embedded in the jail or community supervision agencies, or if outsourcing to private nongovernmental organizations is an appropriate option. Finally municipal officials are engaged in the planning process to account for the role cities play in local law enforcement responses to people with mental illnesses, the use of jail resources for people who commit municipal offenses, and opportunities for shared funding and resources.
- ✓ **Estimates/projections of the impact of new strategies:** At a minimum, the plan projects the number of people to be served and explains to what extent new investments made will affect one or more of the following key measures:
  - Reduce the number of people with mental illnesses booked into jail
  - Reduce the length of time people with mental illnesses remain in jail
  - Increase connections to treatment
  - Reduce recidivism

The county commission does not endorse a plan that does not set out to meet these requirements. If policies or programs are adopted that do not address the key measures, the county cannot expect to reduce prevalence rates. The proposed strategies include an impact analysis that describes the number of people to be served and the estimated improvement in services.

## Key Considerations for Training

Training is an ongoing process that is critical to implementing and sustaining new policies and programs. The implementation of evidence-based practices such as risk assessment or curriculum-based interventions necessitate adherence to training requirements to ensure fidelity. If a program or practice is implemented without a plan for quality assurance that includes training, the anticipated outcomes of the intervention will be jeopardized. A county's training plan should include a regular check for current certifications, refresher training, and internal coaching to maintain quality and consistency. Many “off-the-shelf” curricula include web-based training that can help a county provide necessary training on a meaningful scale.

- ✔ **Estimates/projections account for external funding streams:** The plan describes to what extent external funding streams can be leveraged to fund new staff, treatment and services, and one-time costs. These external funding sources may include:
  - Federal program funding, including Medicaid, veterans’ benefits, and housing assistance
  - State grants for mental health and substance use treatment services
  - Federal and state discretionary grants
  - Local philanthropic resources
- ✔ **Description of gaps in funding best met through county investment:** County dollars typically have far greater flexibility than federal dollars administered through Medicaid or state block grant funding. It is vitally important that budget requests made to the county officials articulate how their dollars are uniquely effective in meeting a particular need, or that fill a gap that no other funding source can, such as ongoing administrative support or additional probation officers.

## In Practice: How Process Analysis Informs Planning

Jurisdictions that have completed an analysis of their jail population have identified key findings and related system-wide responses that can potentially help to reduce the number of people with mental illnesses in their jails.

Identified Gap	Data Illustrating Gap	Objective	Measure Addressed	Projected Cost and Identified Source of Funding	Data to be Tracked
Crisis Intervention Team (CIT)-trained officers are not available to provide 24/7 coverage	Number of mental health calls for service that did not have CIT-trained officers all shifts	Increase level of trained CIT officers to achieve 24/7 coverage	Measure #1: the number of people with mental illnesses booked into jail	Cost: Specialized one-week training of 25 officers at a time; overtime (OT) costs for the officers; training materials  Funding: Local law enforcement assumes the cost for OT, all other costs shared by participating agencies on pro-rated formula	Number of MI calls; percent of calls responded to by CIT-trained officers; number of calls disposed of without jail booking  Compare against baseline data of the number of people booked into jail who are screened for mental illness
Specialized probation supervision alternatives are not available for people identified with SMI and moderate-to-high-criminogenic risk	Number of probation revocations for this population, including for technical violations and new crimes	Develop specialized caseload that is co-supervised by probation staff and a mental health professional	Measure #4: recidivism	Cost: Full-time probation officer and mental health professional staff; other staff-related needs, such as space and equipment  Funding: Determine whether low-risk caseloads can be consolidated to create capacity for specialized caseloads; identify potential grant opportunities; determine whether Medicaid funding can be utilized for case management	Track the number of probation revocations; track successful probation completion rates; track recidivism rates for people assigned to special caseloads

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## 6. Do We Track Progress?

Is there an established process for tracking the impact of the plan on the four key outcomes (the number of people with mental illnesses booked into jail, their length of stay in jail, connections to treatment, and recidivism)?

### Why it matters

Once planning is completed and the prioritized strategies are implemented, tracking progress and ongoing evaluation begins. The planning team must remain intact and the project coordinator must continue to manage the implementation of the new strategies. Monitoring the completion of short-term, intermediate, and long-term goals is important, as it may take years to demonstrate measurable changes in prevalence rates. Showing evidence of more immediate accomplishments, such as the implementation of new procedures, policies, and evidence-based practices, contributes to the momentum and commitment necessary to ensure this is a permanent initiative. Tracking outcome data also gives the planning team the justification necessary to secure continuation funding and/or additional implementation funding.

### What it looks like

- ✓ **Reporting timeline on four key measures:** County leaders receive regular reports that include the data that is tracked, as well as progress updates on process improvement and program implementation.
- ✓ **Process for progress reporting:** The planning team continues to meet regularly to monitor progress on implementing the plan. The project coordinator remains the designated facilitator for this process and continues to coordinate subcommittees involved in the implementation of the policy, practice, and program changes, as well as to manage unforeseen challenges. As it may take several years to demonstrate significant change in prevalence rates, it is important to capture incremental progress, including policy and system improvements such as the implementing screening and assessments, establishing connections to treatment and developing data tracking capacity. In addition, the planning team remains abreast of developing research in the field and the introduction of new and/or improved evidence-based strategies for consideration.
- ✓ **Ongoing evaluation of programming implementation:** The evidenced-based programs adopted by the county are implemented with fidelity to the program model to ensure the highest likelihood that these interventions will achieve the anticipated outcomes. A fidelity checklist process ensures that all program certifications and requirements are maintained, and that ongoing training and skills coaching for staff is provided.
- ✓ **Ongoing evaluation of programming impact:** Particularly for curriculum-based programming and screening and risk assessment, it is important to assess whether the activity is achieving what was intended. Many counties establish a relationship with a local university to assist with research and evaluation, as well as with the validation of screening and risk tools.

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## **In Practice: Using Data to Sustain Your Program Johnson County, Kansas**

In 2008, Johnson County, KS, began an effort to reduce the number of people with mental illnesses in its jail with the establishment of a Criminal Justice Advisory Council (CJAC) that, as a first project, studied how people with mental illnesses moved through its justice system. After process mapping and data analysis was completed, the county decided to pilot a “Co-Responder Program” to deploy a mental health professional to respond to law enforcement calls for service involving people with mental illnesses. The program was funded through a 2010 federal Justice and Mental Health Collaboration Program (JMHCPC) grant that supported a collaborative effort between the City of Olathe (KS) Police Department, the Johnson County Mental Health Center, and the Johnson County Sheriff’s Office. Upon completion of the grant in 2013, a comparison of 2010/2011 data (the year prior to the implementation of program) to 2011/2012 data showed

- 808 contacts were made by the co-responder; 10 resulted in a jail admission
- Hospitalizations decreased from 54 percent to 17 percent
- Referrals to services increased from 1 percent to 39 percent

Over the period of the grant, repeat calls for service to the same address are estimated to have decreased 20 percent. Through a survey, Olathe Police Department officers reported marked improvement in their ability to respond to the needs of people with mental illnesses. It was the top priority of the Olathe Police Chief, Steven Menke, to fully fund the co-responder position, which was approved by the Olathe City Council.

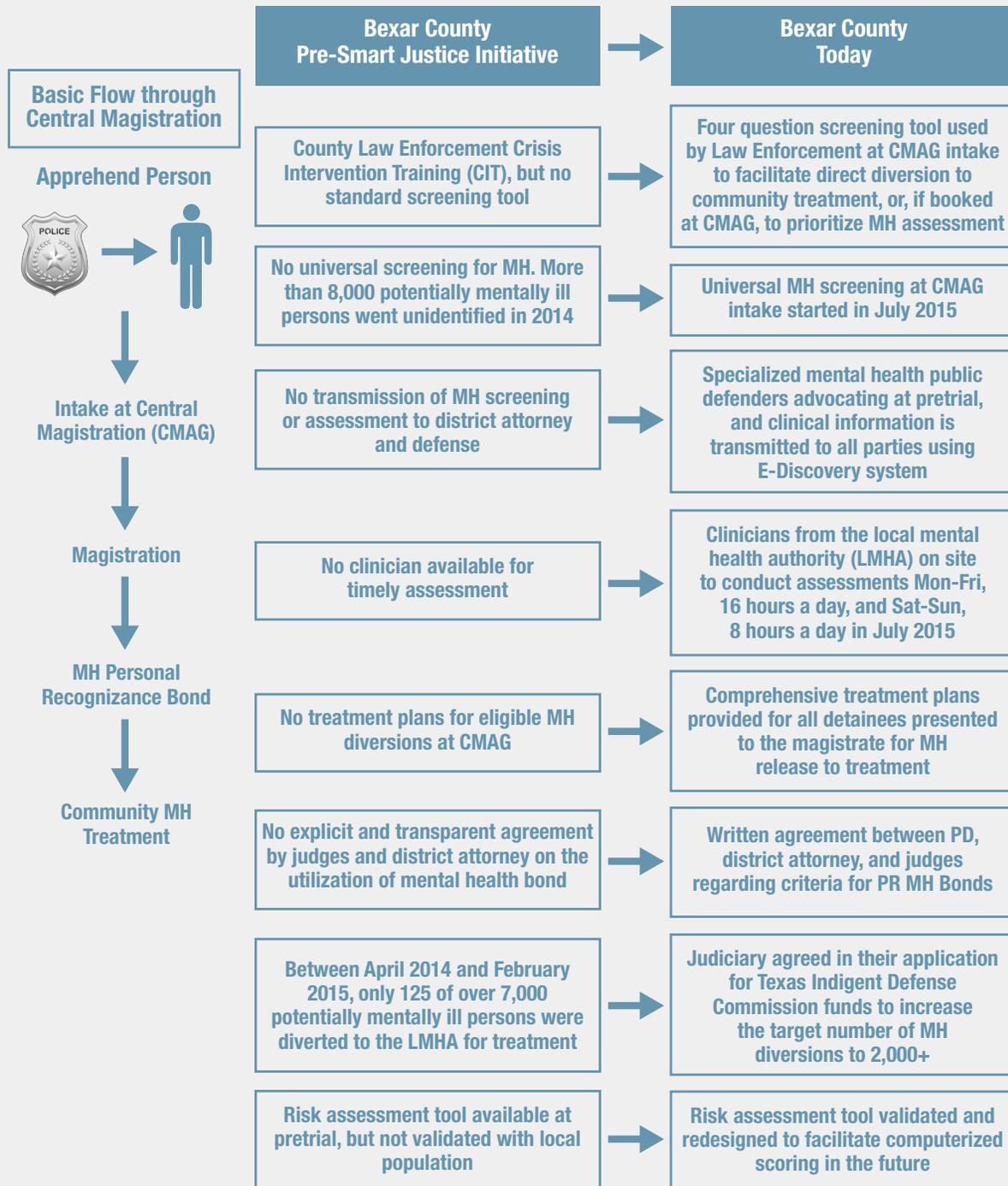
In 2013, a JMHCPC Expansion Grant was awarded to expand the program to the City of Overland Park, KS. On completion of the grant, a comparison of 2013/2014 data (the year prior to the implementation of the program) to 2014/2015 data showed significant improvements:

- 1,281 contacts were made by the co-responder; 25 resulted in a jail admission
- Hospitalizations decreased from 35.1 percent to 3.1 percent
- Officer surveys showed a 59-percent increase in officers feeling prepared to respond to calls involving people with mental illnesses

The Overland Park, KS, City Commission approved fully funding the co-responder position upon completion of the grant. The use of data to demonstrate the effectiveness of the Co-Responder Program proved essential to establishing continuation funding, as well as to efforts to grow the program county wide.

## In Practice: A County Demonstrates Progress

Below is an example of findings and the resulting responses that have taken place in Bexar County, TX.



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## Endnotes

<sup>1</sup> *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Washington, D.C.: American Psychiatric Association, 2013.

<sup>2</sup> <http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml>.

<sup>3</sup> For information about the Brief Jail Mental Health Screen, see <http://www.prainc.com/?product=brief-jail-mental-health-screen>.  
For information about the Texas University Drug Screen V, see <http://ibr.tcu.edu/wp-content/uploads/2014/11/TCUDS-V-sg-v.Sept14.pdf>.

<sup>4</sup> Fader-Towe, H. and Osher, Fred C. *Improving Responses to People with Mental Illnesses at the Pretrial State: Essential Elements*. (New York: The Council of State Governments Justice Center, 2015)

<sup>5</sup> The Council of State Governments Justice Center and the American Psychiatric Association Foundation, “On the Over-Valuation of Risk for People with Mental Illnesses.” (New York, The Council of State Governments Justice Center, 2015).

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Stepping Up: A National Initiative to Reduce the Number of People with Mental Illnesses in Jails, which is sponsored by the National Association of Counties, the American Psychiatric Association Foundation, and The Council of State Governments Justice Center, calls on counties across the country to reduce the prevalence of people with mental illnesses being held in county jails.