STATEMENT OF SUSAN PAMERLEAU
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TO THE SENATE JUDICIARY COMMITTEE
UNITED STATES SENATE
REGARDING MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM

FEBRUARY 10, 2016

Senator Grassley, Senator Cornyn and members of the Committee: Thank you for this opportunity to testify today concerning the challenges of mental illness in the criminal justice system.

As Sheriff of Bexar County, Texas, I lead the 11th largest Sheriff's Office in the nation, and oversee the Bexar County Adult Detention Center, the third largest jail in Texas and the 16th largest in the nation.

Jails and Prisons: De Facto Mental Institutions?

According to the Vera Institute of Justice, in its February 2013 Research Summary, "Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications", mental illness, particularly serious mental illness, among the incarcerated is straining public budgets nationwide.

"The rate of serious mental illness is two to six times higher among incarcerated populations than it is in the general population" the report states. "Serious mental illness has been documented in 14.5 percent of men and 31 percent of women in jail settings. The vast majority of this population is charged with minor, non-violent crimes. Over 70 percent of people in jails with serious mental illness also have a co-occurring substance-abuse disorder."

It continues, "Despite these high rates, between 83 and 89 percent of people with mental illness in jails and prisons do not receive care."

In Bexar County today, over 700 of the 3,500 people in our jail are being treated for some type of mental illness. Of these, approximately 60% have been in and out of our jail six or more times. That's almost 450 people. Had we identified them early, the first time, think about the human capital we could have saved.

Most have not committed serious crimes, but are in jail because of untreated mental illness. Like other jails throughout the United States, the Bexar County Jail has become a de facto mental institution.

In 2015, 57,000 people… about 60% of those arrested… were booked into the Bexar County Adult Detention Center. For the other 40% … unless they were symptomatic, we didn't know if they had any

mental health issues. That first brush with the law could have been turned into treatment … as a condition of pre-trial release … rather than being caught up in the criminal justice system multiple times.

Housing the mentally ill in jail requires close monitoring and extensive services… at significantly higher cost than being in general population. Average daily cost is $60-$65, but four times higher, $200-$250 a day in a mental health unit. Across the state of Texas, housing an inmate in a mental health unit can climb as high as $350 a day.

Many function well in general population with psychotropic medications. However, some think they are OK, stop taking medications, then become disruptive and assaultive. And … end up in the mental health unit.

Across America, law enforcement is increasingly relied upon to manage individuals suffering from mental health episodes. One example of this is the responsibility is in the execution of emergency detentions. In 2015 alone, together the Bexar County Sheriff's Office and the San Antonio Police Department processed 9,392 for all of Bexar County.

County Sheriffs are also tasked with executing mental health warrants issued by the courts. Sheriffs must also respond to crisis calls in the community, often with a mental health provider. At the Bexar County Sheriff's Office, our Mental Health Unit has this responsibility.

Judge Tom Rickhoff presides as judge of Probate Court Number Two in Bexar County. In a September 2013 article in the Texas Bar Journal, "Dangerous Minds", Judge Rickhoff and co-author Ellen Patterson examined the tragedies of mass shootings and other violent acts at the hands of the mentally ill. Rickhoff believes it is possible to identify those who are "manifestly dangerous mentally ill" (or MDMI) individuals, and he advocates legislative solutions.

"In the 60's this country hospitalized 600,000 mentally ill patients but now provides beds to fewer than 40,000," he writes. "With this discharge rate more than 90 percent, often without an enforceable treatment plan, who should be surprised by today's tragic headlines?"

He continues, "The basic mental health laws in this country have not undergone dramatic change since the '60s. Attempts at legislative reform have brought mixed results. We must reform the judge-created gatekeeper rule for involuntary commitment that requires one to be a very serious danger to self or others, and which for evidence is entirely reliant on the subjective judgment of psychiatrists. If a team can grasp an individual's violence risk potential and identify the MDMI earlier, effective treatment will result."

Bexar County's Success Story

Over the past 10 years, Bexar County has developed an overarching system to address mental health issues.

Since 2012, both the Bexar County Sheriff's Office and the San Antonio Police Department mandate Crisis Intervention Training for all Patrol officers.

In 2009, the 15 deputies assigned to our Mental Health Unit received Crisis Intervention Training, teaching deputies how to recognize someone in a mental health crisis, and use de-escalation techniques to diffuse the situation.

Prior to 2009, our mental health deputies had to use physical force, on average, at least 50 times per year taking mental health consumers into custody. Since that time, in more than six years, force has only had to be used three times. The difference between 300 times and three times in six years is dramatic, and proves the value of Crisis Intervention Training.

This same training is critical for our Detention Officers and Dispatchers, too. Even the Bexar County Juvenile Probation Office partners with the Bexar County Sheriff's Office, the San Antonio Police Department, San Antonio Independent School District and community providers to train school resource officers on Crisis Intervention. School-based law enforcement officers are trained to identify, de-escalate and respond to children in mental health crises, including participation in role-playing exercises.

In collaboration with the Council of State Governments Justice Center and the other stakeholders in Bexar County, we knew a gap existed to identify those with mental illness early in the process. This past July, all law enforcement agencies in the San Antonio/Bexar County metropolitan area initiated a mental health screen at point of arrest, prior to magistration.

Each arresting officer asks four questions to determine if further assessment by a credentialed clinician is needed. If indicated, a more comprehensive mental health assessment may be required.

One significant initiative in Bexar County's criminal justice system that bears mentioning is the establishment of numerous specialty courts since 2001. The Mental Health Court, created in October 2009, has shown success in reducing recidivism rates 17 points better than those not in the program, since its inception.

But overall, the key to our success in addressing the challenges of the mentally ill in our criminal justice system has been collaboration with all the other stakeholders.

- Haven for Hope is one of those stakeholders. Haven is an important part of transforming individuals from being homeless, with mental illness and co-occurring substance abuse. It's much more than a homeless shelter. Haven provides wrap-around services such as counseling, housing and other services– from more than 90 community partners – starting on a path to stability, and ultimately avoiding a return to jail. Treatment and counseling, as well as help for substance abuse, begin in jail, and then continue as individuals move to Haven for Hope.
- Several years ago, University Health System, the county's hospital district, and the Center for Health Care Services, the regional mental health authority, partnered to build the Restoration Center. The Center is where law enforcement officers can bring individuals who are intoxicated, on drugs or having a mental health crisis. After completing appropriate documentation, they can be back on the streets in 15 minutes rather than spending countless hours in an emergency room. In five years, over $50 million has been saved for our community.

- In the early 2000's, the Bexar County Jail was busting at the seams with talk of building another even bigger jail. Instead, Bexar County Commissioners Court worked with the courts and the District Attorney to develop specialty courts addressing outcomes for those charged with drug and alcohol charges. Since then, a Drug Court, DWI Court, Veterans Treatment Court, Esparanza (Prostitution) Court, and a Misdemeanor Mental Health Court have been established. Their success rates are measured based on recidivism rates, which have been between 9 and 32 points better than those who do not participate.

The Bexar County Juvenile Justice System has long focused attention and resources on the mental health needs of children. All children referred to the Juvenile Probation Department receive a mental health screening and follow-up mental health assessments as needed.

- Led by Judge Laura Parker, of the 386th Juvenile District Court, specialty courts in the juvenile system help girls with a history of mental health issues and trauma who are first-time offenders. Recently, Juvenile Probation received a grant to develop a similar program to help boys with a history of mental health issues who are first-time offenders.
- Juvenile probation officers partner with treatment providers from the Center for Health Care Services. Working together as a team, they provide intensive home-based services.
- To be effective, robust counseling, psychiatric services (scheduled and expedited), stabilization treatment and evaluation and transition services upon release are all important factors to ensure continuity of care.

The Challenges Ahead

Bexar County has made tremendous strides in its criminal justice system with regard to mental illness. However, we know challenges remain and there is still much work to be done. Andrew Keller, Ph.D. is CEO of Meadows Mental Health Policy Institute in Dallas, Texas. He shared the Institute's findings regarding Bexar County:

- Overall capacity for both ongoing and intensive services across all safety net providers is insufficient for the identified need, resulting in an overreliance on crisis, emergency, and criminal justice services.
- While service availability is better in comparison with other Texas communities, the system has capacity to serve less than one in five non-forensic super-utilizers and no dedicated capacity for forensic super-utilizers.
- Access to inpatient care for adults is limited less by a lack of bed capacity than by insufficient funding for uninsured patients in the community to pay for care in beds that exist, back-ups related to high forensic use of San Antonio State Hospital, and a lack of systemic coordination across crisis program and emergency providers.
- To stem the tide of people with mental health needs ending up in jail, key priorities in the mental health system need to be:

- Developing a single coordinated emergency response system across funding silos.
- Ramping up capacity for the 2,450 highest utilizers of jail, homeless, crisis, emergency response system, emergency rooms, and inpatient care.
- Investing in services up-stream (First Episode Psychosis care for the 300 new cases of psychosis that emerge every year in Bexar County, school-based services to narrow suspension/expulsion to break the school-to-prison pipeline)

The Face of Mental Illness

It's important to "see" the faces of mental illness in the criminal justice system …

Paul is 76, diagnosed with Schizophrenia, but refuses treatment. He's been booked into the Bexar County Adult Detention Center 45 times since 1991 – mostly for criminal trespassing, usually at a local church. He says he is Jesus Christ and he belongs there. He refuses to leave, and he ends up in jail.

Kenny, 60, is a small, fragile man with a severe mental illness. In 2015 alone, he was arrested and booked for criminal trespassing 14 times. Kenny loiters at a neighborhood grocery store entrance because he believes that he lives there. Though the psychiatrist has ordered him to be placed on psychotropic medications, Kenny refuses treatment. So he's jailed, he's released, he's re-arrested … and he will surely return to jail again and again.

Paul and Kenny would be better served in a hospital or treatment center. However, due to underfunded mental health services, their stories are not unique. Our jail is home to hundreds with similar stories.

Just as compelling as providing community-based treatment services as an early intervention, availability of forensic beds in state systems are needed, also. Today, an inmate may wait in jail 6-8 months before being transferred to a state facility to restore competency.

Christopher is one of five children, from a prominent family of community leaders. Christopher, however, is mentally ill. His family writes:

> *Christopher, born in 1987, is now a young man at age 28. As the youngest of four children he was always full of adventure and had plans to follow in the footsteps of his siblings, all successful college graduates. He is also a very proud big brother to his now 19 year-old step-brother, a student at Trinity University.*
>
> *His plans for the future began to shatter when his mental illness emerged at age 17, at the time when he should have been visiting college campuses and making plans for his future. It was initially assumed his aberrant behavior was related to teenage experimentation with alcohol, marijuana and other drug use. However, it became apparent that the self-medication was his way of coping with a mental state that couldn't yet be imagined.*

Initially, diagnoses were related to bipolar and manic depression and later it was determined he has what's called schizo-affective disorder. He has spent several years in and out of mental health institutions because the medications used to stabilize him caused erratic results, nor provided long-term stability.

Christopher's most recent wait in the Bexar County Jail was 8 months before he was finally transferred to Vernon for care. He was scared, confused and helpless.

Christopher is currently in Vernon State Hospital in north Texas, a result of his arrest more than five years ago when in a psychotic episode he attempted to stab his father. He was criminally charged for domestic violence. One can only speculate on his intent since he was in full blown psychosis. The police were called to de-escalate the issue. Against the family's wishes, charges were filed, he was jailed and ultimately experienced one of his most devastating mental and physical declines. This charge has never been adjudicated because of his mental incompetence and inability to be stable for any long period of time.

Unfortunately, in Texas the process by which people like Christopher are assessed for placement in a long term treatment program (6 months to a year) is to be arrested, assessed as incompetent at the county jail level and then determined through the court system. The primary option for care for people like Christopher, with mental health disorders, is an overburdened criminal justice system and state hospitals that have multi-month wait lists. There are few community solutions in the private sector for members of the community who have disorders like Christopher's. Christopher is just one of many stories, however, there are countless families whose efforts are consumed with trying to find help for their loved one. As resourced as Christopher's family is personally and professionally, it is their son's story that highlights the helplessness they and others experience and the distress they feel for other families struggling to navigate the system.

This is a tragedy for a high percentage of the population (20%) who suffer from behavioral health issues and for whom a minor infringement of civil laws gets them in the court system where they then create huge expenses. There's little adequate treatment and an unimaginable amount of time is spent waiting for the process to work for them… just to get a bed at the state hospital.

We have to find solutions to improve the system and provide needed services, including a dire shortage of community long-term treatment beds anywhere! Complicating care is the lack of continuous and coordinated access to medicines. There are too many multiple and erratic eligibility processes and failures of access. Social Security, SSI, Medicare and Medicaid do not work together with private insurers or each other to provide continuous patient access to critical medications. A week without medication begins an individual's decline and a 4 to 6 week failure to provide meds can send a person into a debilitating spiral. It is estimated that $2-4 billion a year in Texas is wasted on the Incarceration side which could be more effective on the community side of treatment and care.

This isn't just an issue for Christopher or his family. This is an issue that affects everyone. The prevalence of mental illness suggests that everyone has a story of a friend or family member

who suffers from mental illness. And if you have somehow escaped that reality in your life, certainly you should be motivated by the financial and societal impacts of our lack of appropriate mental illness treatment and care options.

Mental illness is not limited to any particular ethnicity or socio-economic group. It affects families from every sector of our society. Today, former *Washington Post* investigative reporter Pete Earley is testifying before this committee concerning his challenges trying to get help for his own son.

And this is personal for me, too.

As a survivor of an abusive marriage, I know my husband's rages were often a result of a paranoid schizophrenic personality. Ultimately, he took his own life… and would have killed me had I been standing in front of him.

More to the point… my own brother was mentally ill, and in and out of mental institutions in the 60's and 70's. That was long before we knew what manic/depressive or bipolar disorder was, and before we knew that lithium could control the chemical imbalances in the brain. I know firsthand the impact of mental illness on a family, and the desperation of families to find help for their mentally ill loved ones.

Jails are not the place for those suffering from mental illness. Until the community resources are available to meet the needs of those with mental illness, people like Paul, Kenny and Christopher will likely return to jail again and again.

ATTACHMENTS:

1. *"Treatment Alternatives to Incarceration of People with Mental Health Needs"* - Vera Institute – Research Summary, February 2013
2. *"Dangerous Minds"* – Article by Judge Tom Rickhoff & Ellen Patterson, Texas Bar Association, September 2013
3. *"Bexar County Specialty Courts Resolution,"* Bexar County Commissioners Court, February 4, 2014
4. *"Public Defender for the Mentally Ill"* – Media Release, June 5, 2015
5. *"Stepping Up"* – Article by Sheriff Susan Pamerleau, Huffington Post, August 11, 2015
6. *"Where Police Violence Encounters Mental Illness"* – Article by Matthew Epperson, The New York Times, January 13, 2016
7. *"Haven for Hope Jail Outreach Program"* – Article by Camille Garcia, Rivard Report, January 19, 2016
8. Bexar County Sheriff's Office – Arrest & Booking Sheet
9. *"Bexar County Smart Justice,"* Council of State Governments Justice Center
10. SAMHSA Gains Center – Sequential Intercept Model

Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications

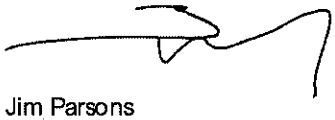
David Cloud • Chelsea Davis

RESEARCH SUMMARY • FEBRUARY 2013

DIRECTOR'S NOTE

Jails and prisons are expensive to operate and costs are even greater when the person entering custody requires treatment for a mental health condition. Because they are so costly, providing access to treatment in lieu of a prison or jail sentence can save money while also improving health outcomes and reducing the likelihood of rearrest in the future.

States are increasingly realizing the potential for non-custodial options to improve the health of individuals and the well being of communities. However, many people with serious mental illness still find themselves caught in a revolving door of repeat incarceration. By compiling the research on the benefits and cost savings that can be realized by providing treatment as an alternative to incarceration, we hope that this brief is helpful to decision makers and practitioners as they consider more cost-effective and humane policy options.



Jim Parsons
Director, Substance Use
and Mental Health Program

Introduction

The disproportionate number of people with behavioral health disorders involved in the criminal justice system puts a tremendous strain on scarce public resources and has a huge impact on health care and criminal justice budgets. However, with appropriate treatment and access to community-based services, this population is less likely to be incarcerated and more likely to lead healthy, productive lives, resulting in substantial costs savings.

Scope of the Problem

The rate of serious mental illness is two to six times higher among incarcerated populations than it is in the general population. Serious mental illness has been documented in 14.5 percent of men and 31 percent of women in jail settings.[1] The vast majority of this population is charged with minor, non-violent crimes.[2] Over 70 percent of people in jails with serious mental illness also have a co-occurring substance-use disorder.[3] Veterans returning from combat are also at higher risk for mental health and substance-use problems and are therefore more apt to be involved in the justice system.[4] Despite these high rates, between 83 percent and 89 percent of people with mental illness in jails and prisons do not receive care.[5] Moreover, mental health treatment in correctional settings is generally inadequate. People with serious psychiatric needs are more likely to be violently victimized[6] and more likely to be housed in segregation while in prison[7] and stay for longer periods. For example, on Rikers Island, the average stay for all persons is 61 days, but it is 112 days for those with a mental illness despite no differences in criminal charge or risk of re-arrest.[8] These disparities result in significant financial and social costs to everyone involved.

Treatment Alternatives to Incarceration

Local governments are employing a range of programs that involve partnerships between community health and justice systems. These programs are proving to be effective approaches to appropriately addressing the high rate of serious mental illness among incarcerated populations—thereby improving health and justice while saving money.

PREVENTION: LAW ENFORCEMENT, CRISIS INTERVENTION TEAMS, AND COMMUNITY-BASED SERVICES

How it works: Specialized policing responses (SPRs)—specifically, crisis intervention teams (CITs) and police-mental health co-responder teams—are trained to link people with mental illnesses to treatment without arrest.[9] SPRs are built

on partnerships between mental health providers in the community and designated police units, with the aim of identifying serious mental illness, de-escalating situations with minimal police force, decreasing stigmatization, and when appropriate linking a person to treatment rather than booking them into jail.

How it can save money: SPRs can produce savings by curbing reliance on police, jails, and emergency rooms to handle crisis situations involving a person with mental illness.

> Research shows that CITs increase the connection of persons with mental illness to psychiatric services in the community and diverts them from unnecessary and expensive jail detentions and emergency room visits. For example, community-based treatment services in Texas cost an average of $12 a day for adults as opposed to a jail bed at $137 or an emergency room visit at $986.[10]

"...community-based treatment services in Texas cost an average of $12 a day for adults as opposed to a jail bed at $137 or an emergency room visit at $986."

> CIT officers are 25 percent more likely to transport a person to treatment in the community emergency evaluation and treatment facilities than police without special training.[11]

> CITs reduce the use of unnecessary force and reduce stigma.[12] An evaluation conducted by officials in New Mexico reported that since the implementation of CIT in Albuquerque, the use of high-cost SWAT teams as a response to mental health crisis situations decreased by 58 percent.[13]

> Diversion from hospital admission offsets additional service costs and improves longer-term health outcomes that can mitigate future risk of re-arrest or hospitalization.

JAIL DIVERSION

How it works: Jail diversion helps people with behavioral health needs receive treatment through various alternatives to incarceration. While programs that divert people to treatment incur health-care system costs, providing treatment in the community is typically less expensive than serving people in criminal justice settings. There is also the potential for large cost offsets, because diversion can prevent further criminal justice involvement.

How it can save money:

> Jail diversion helps reduce expenditures associated with unnecessary arrests and detentions. For instance, it can cost two to three times more for a person with serious mental illness to become involved in the criminal justice system compared to receiving treatment in the community.

"A cost-effectiveness assessment of jail-diversion programs in New York City showed an average of $7,038 lower jail costs per person."

> A study of 25,133 people in Connecticut found that the state spent nearly double the amount to both incarcerate and treat a person with serious mental illnesses, compared with the cost of treatment alone.[14]

> A cost-effectiveness assessment of jail-diversion programs in New York City showed an average of $7,038 lower jail costs per person.[15]

> Implementation of a diversion program in Massachusetts serving 200 people saved an estimated $1.3 million in episodic emergency health services (for example, ER visits, ambulance) and jail-related costs.

> Forensic Assertive Community Treatment (FACT) is an example of a justice-health partnership that yields fewer jail bookings, greater outpatient

contacts, and fewer hospital stays.[17] For example, evaluations of Project Link in Rochester, NY and the Thresholds Jail Program in Chicago, IL demonstrated cost savings of between $39,518 and $18,873 per participant, respectively.[18] A randomized trial of a California-based FACT program showed that while providing intensive outpatient services was more expensive at the outset, such costs are subsequently offset by reduced jail and hospital stays.[19]

COURTS

How it works: Specialized courts, including drug, mental health, and veterans courts have shown to be an effective way to divert people with behavioral health needs from incarceration and into treatment.[20] These voluntary programs operate both pre- and post-adjudication, and allow participants to access treatment as an alternative to incarceration.

How it can save money:

> Similar to jail and police-based diversions, specialized courts can decrease criminal justice costs associated with arrest and incarceration, recidivism, and court costs, as well as through decreased use of more expensive treatment options (such as inpatient care).[21]

> A recent meta-analysis examined mental health courts in four jurisdictions and found that participants were less likely to be arrested, had a larger reduction in arrest rate, and spent fewer days incarcerated during the one and one-half years of follow-up after program entry compared to people with similar pro□les who only went to jail.[22]

> Court diversion often reduces jail stays for those with mental illness and therefore can save correctional facilities and local governments signi□cant costs. Research has shown that mental health court participants spend less time in jail than comparison groups.[23]

> Court diversion also helps reduce the risk that people with mental illness spend time in prison. Pennsylvania estimated that an average person incarcerated in prison costs the state $80 per day, while a person with mental illness costs $140 per day.[24]

> A RAND Corporation evaluation of a Pennsylvania Mental Health Court found that over a two-year period, both average mental health services costs and jail costs were reduced, suggesting that the MHC program can help to decrease total taxpayer expenditures. The largest savings were generated by avoiding jail and hospitalization for the subgroups with the most severe psychiatric needs.[25]

"Pennsylvania estimated that an average person incarcerated in prison costs the state $80 per day, while a person with mental illness costs $140 per day."

COMMUNITY REENTRY PLANNING

How it works: The □rst weeks following release from jail or prison is a perilous time, as people experience 12.5 times the risk of death and are more likely to come into contact with emergency room services.[26] Transitional planning to coordinate services for people with substance use and mental health treatment needs in their communities upon release from a correctional facility reduces recidivism and improves health outcomes.[27]

OPPORTUNITIES UNDER THE AFFORDABLE CARE ACT (ACA)

Health reform offers new opportunities to bolster treatment alternatives, enhance treatment capacity in the community, and save states and local jurisdictions money. These opportunities are a result of Medicaid expansions; mandates to enroll vulnerable populations in health coverage; greater support for people with mental health and substance use problems; and a focus on integrated care and interagency collaboration.

- In 2014, among states that opt to expand, Medicaid is likely to support more community-based organizations partnering with diversion programs that provide substance use and mental health services.
- The ACA will increase the health insurance coverage among jail populations, which will help people with mental health and substance use problems access care in the community.
- Partnerships between justice and health systems combined with increased access and coverage for substance use and mental health treatment are likely to help to dramatically reduce correctional health care costs incurred by localities.

How it can save money:

- Inadequate transition planning can result in a host of negative, costly outcomes, including compromised public safety, overdose, hospitalization, suicide, homelessness, and re-arrest. Addressing treatment and social-service needs prior to release can be a cost-effective way to mitigate the incidence of these events.[28]
- Frequent Users Service Enhancement (FUSE) initiatives are being implemented across the country with positive implications for cost savings. These programs target individuals who cycle in and out of public systems such as correctional facilities, hospitals, and shelters by linking them to supportive housing and other services with the goal or breaking this costly cycle.
- New York City's targeting of supportive housing to people with multiple stays in jail and homeless shelters has proven to be successful, with a 91 percent housing retention rate, 53 percent reduction in jail days, and 92 percent reduction in shelter days. Keeping people from cycling between the jail and the shelter system showed cost offsets of $2,953 per person, per year.[29]
- An evaluation of a program in Seattle that linked people with chronic co-occurring mental health and substance-use disorders to supportive housing showed improved outcomes in health and housing: a 45 percent reduction in jail bookings and a 42 percent reduction in jail days, generating more than $4 million in cost-savings to public services after one year.[30]
- A randomized trial found that a community-based transition planning program that links former prisoners to comprehensive primary-care services prior to release from prison resulted in signi□cant reductions in costly emergency room visits.[31]
- Research in Washington State found that untreated substance-use disorders are a major driver of chronic disease progression that can increase risk of hospitalizations, loss of productivity, and dependence on social insurance programs. Health insurance expansions that extended coverage to substance-use treatment slowed the growth of health expenditures for Washington's Medicaid population.[32]
- Ensuring that people with mental health needs who are eligible are enrolled in Medicaid can reduce costs to the justice system by lowering recidivism rates. In Washington State, having Medicaid at release was associated with a 16 percent reduction in the average number of subsequent detentions, and enhanced community service use after jail release.[33]

Conclusion

Effective interventions are possible at several stages in the criminal justice process, but the success of these programs relies on strong community-based services. The most cost-effective strategy is to provide accessible treatment that keeps people with mental illness out of the criminal justice system in the □rst place.

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ABOUT VERA'S SUBSTANCE USE AND MENTAL HEALTH PROGRAM

The Substance Use and Mental Health Program (SUMH) conducts applied research to help public officials and community organizations develop empirically driven responses to the substance use and mental health needs of people involved in justice systems. SUMH staff collect and analyze quantitative and qualitative data and evaluate existing programs to understand the experiences of those affected by psychiatric disorders or substance use and policies that prolong their involvement in the justice system.

The program's work includes:

- Using information-sharing to improve access. Many people in contact with the criminal justice system have mental health and substance use problems, and other chronic health needs. Yet health and justice systems rarely share information in ways that improve awareness of clients' needs or promote continuity in care. SUMH's Justice & Health Connect provides resources to build capacity to share information with the aim of improving access to care, reducing contact with the justice system, and addressing health disparities.
- Measuring the impact of drug policy. States are increasingly reconsidering ways to respond to non-violent drug offenses and there is a pressing need for empirical evidence that can help inform these decisions. SUMH conducts research on the impact of drug policy, such as the use of treatment-based alternatives to incarceration in lieu of lengthy prison sentences.
- Informing jail reentry planning. Many people leaving jail face a range of problems, from accessing mental health treatment to securing a place to live. Evidence shows that access to appropriate services can improve individual health outcomes and reduce the likelihood of future arrests. SUMH is working with jail administrators and communities in New York City and Los Angeles to design more accessible and effective reentry services.
- Informing legal representation for people with mental illness. The growth in the number of people with serious mental illness in the criminal justice system coupled with the expansion of diversion programs creates new and complex challenges for indigent defense providers. SUMH and Policy Research Associates are researching the resources constraints, ethical dilemmas, practical challenges and best practices that impact the ability of indigent defense attorneys to provide effective assistance of counsel that meets the needs of this population.

WHY THIS WORK MATTERS

There are three times as many people with serious mental illness in jails and prisons than in hospitals, and about two-thirds of people in prison report regular drug use. However, justice systems around the country are ill equipped to provide behavioral health services, and individuals often fail to get the help they need. SUMH research helps jurisdictions design policies that increase access to treatment, reduce reliance on the criminal justice system as a response to these problems, and improve public safety.

For More Information

The Vera Institute of Justice is an independent nonprofit organization that combines expertise in research, demonstration projects, and technical assistance to help leaders in government and civil society improve the systems people rely on for justice and safety.

For more information about the Substance Use and Mental Health program, contact Jim Parsons at (212) 376-3043 or jparsons@vera.org. This research summary can be accessed at www.vera.org/pubs/treatment-alternatives-to-incarceration.

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VERA INSTITUTE OF JUSTICE

Dangerous Minds

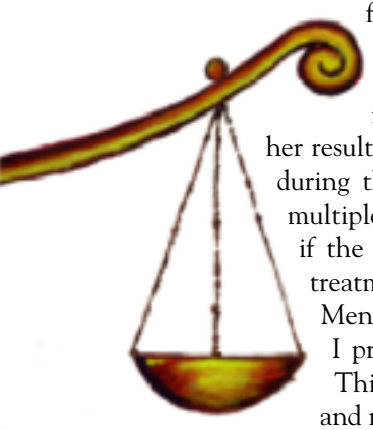
Addressing violence and serious mental illness from one judge's perspective.

BY JUDGE TOM RICKHOFF AND ELLEN PATTERSON

HOW SHOULD THE LEGAL AND MEDICAL COMMUNITIES RESPOND TO VIOLENCE GENERATED BY MENTAL ILLNESS, AND WHAT RESOURCES ARE AVAILABLE TO PREVENT THIS VIOLENCE? Bexar County Probate Court No. 2 Judge Tom Rickhoff suggests legislative reform to help identify those who are "manifestly dangerous mentally ill" (MDMI). The judge updated a paper written in 2006 with the rare focus on protecting the public, with current research by legal intern Ellen Patterson.

Consider one victim's perspective. She awaits a subway and leans to hear the roar of the approaching train. Suddenly an arm shoots through the crowd, pushing her onto the tracks. She is dismembered by its steel wheels. This is not a hypothetical.[1] The incidents where mentally disturbed individuals shoved innocent victims onto subway tracks increased twice as fast between 1986 and 1991 than between 1975 and 1985.[2] Violence, whether at the hand of the mentally ill or the intentioned criminal, is no less damaging to the victim or shocking to society. The act is even more tragic when one considers the actor probably had access to, and most likely was, noncompliant with treatment. Family and friends too often wait in horror as their ill loved one deteriorates, often because they cannot overcome the onerous substantive and procedural obstacles for obtaining legal intervention. Many justifiably conclude, based on ignorance or personal experience, that the civil commitment process is ineffective.

Take for example the case of Pauline Wilkerson, who took her schizophrenic son to the woods, ostensibly for a hike, but then helped shoot and kill him. Why? She feared that he would kill her daughter and granddaughter.[3] Despite her repeated attempts, her son was refused treatment. Wilkerson served her resulting sentence, but her daughter died during the 20-year prison sentence. These multiple tragedies might have been avoided if the ill person had received immediate treatment under a Manifestly Dangerous Mentally Ill (MDMI) designation, which I propose herein for the most violent. This could help to separate the violent and nonviolent and thus reduce the stigma for all.



Contrast these tragedies to the hopeful atmosphere pervading an informal meeting room at the Involuntary Outpatient Commitment Clinic (IOPC) in Bexar County, Texas. Patients receive court-ordered post-hospitalization services. Their issues usually involve medication or treatment. A presiding civil judge who is an expert in available treatments and knows each patient well, in collaboration with a team of professionals, designs a plan for each patient, including a weekly clinic appearance.[4] The team—a psychiatrist, the judge, the court-appointed attorney, and the case managers—warmly greets each individual and then discusses with the patient concerns such as Medicaid and other health insurance, medications, living situations, feelings, goals, and frustrations. The patient receives appreciation for accomplishments, advice from the judge, and further interventions if necessary. Alternatively, the judge strongly admonishes the noncompliant and stands ready to order hospitalization as needed. The patient thus receives a consistent benefit from the same judge and team. Though a fledgling addition, the Bexar County IOPC has already improved hundreds of lives, arguably curbing potential violence and distress through a system of accountability and responsibility. Expanding the IOPC concept to other jurisdictions coupled with adopting an MDMI construct will save lives.[5]

While positive and effective programs such as the IOPC exist, there is still a compelling need to study and address violence in the mentally ill. First, evidence shows that the most preventable violence is committed by the mentally ill and is almost always due to refused medication.[6] Research has shown that those suffering from schizophrenia who neglect licit medication and instead turn to self-medication with illicit drugs such as cocaine naturally have a pattern of arrests for violence significantly higher than non-cocaine users.[7] While offenses may vary, every time a bizarre crime or mass shooting appears in the

newspaper with the line, "the motivation is unknown," many readers translate it as, "the act was irrational, committed by a sick person." The resulting stigma for the nonviolent is problematic.

Mass shootings now dominate the media. These shootings are not merely the result of hallucination, nor impulsive, but they require planning, preparation, and execution. The perpetrators know that they and many others, who are strangers, will be killed or wounded. Because the perpetrators frequently exhibit a lack of remorse, they often suffer from both a serious mental illness and a personality disorder. To further illustrate the increase and seriousness of the MDMI, a study of 30 rampage murders in the United States and Canada (which took place between 1949 and 1998) reported that two-thirds involved mentally ill perpetrators, the majority of cases occurring from 1985 onward.[8] Aiming our efforts at preventative mental health measures is a more effective solution than engaging in endless gun control debate, because Texas will never disarm. We need immediate action directed at the perpetrators. Until we embrace reform, this article will become ever more relevant.

Second, historians know that violence committed by the mentally ill impacts the course of history. Consider the assassination attacks against the Roman Emperor Hadrian; Presidents Garfield, McKinley, and Reagan; Chicago Mayor Anton Cermak; Pope John Paul II; and John Lennon. Each involved a mentally ill perpetrator, who likely exhibited the same warning signs seen today. These symptoms are timeless and occurring worldwide. When a person is in need of treatment, family members and the community must be empowered to help, and our society must furnish additional resources to ensure safety for all. Resources such as the IOPC merit strengthening both financially and through enhanced public awareness. But while it is true that treatments, medications, hospitals, and the criminal and civil mental health courts continue to advance, many people fear them. These fears should be allayed with sound information made widely available, as well as extended treatment by a careful application of the MDMI construct.

Third, barriers inherent within the mental health system exist. For example, whether for fear of lawsuits or avoidance of cumbersome legal prerequisites, some psychiatrists hesitate to utilize effective measures, such as injectable medication, and inpatient or outpatient commitments. The urgency inherent in an MDMI designation would help alleviate these concerns and facilitate immediate treatment.

Fourth, psychotropic medications have serious side effects so must carefully be balanced and monitored by the court's team to prevent patients from unilaterally discontinuing their medications and doctor visits.

Public information about mental illness must be freed from inaccuracies. For example, rather than comparing mental illness to other diseases such as diabetes or cancer, spokespersons need to emphasize that these diseases are similar in that no one wishes for them, nor are they the patients' fault, but they must add that diseases of the brain may cause different complications in the sufferer, often resulting in misperceptions of reality, hallucinations, and sometimes harm to self or others, requiring monitoring and treatment.

Fifth, legislators and psychiatrists who are subject to intense agenda-group pressure avoid public comment, debating behind the scenes. Their own agenda on mental health remains largely obscured.[9] The views and interests are so charged with emotion that, but for the occasional unsung hero, there exists no principal advocate or leader in any venue. Special advocate groups comprised of the parents of mentally ill individuals and the end stakeholders in the status quo can monopolize debate by focusing on their families' welfare, not public safety. Public safety advocates, on the other hand, often focus only on sanctions and incarceration. These problems, and society's aversion to mental illness issues, have inhibited change. I am proposing legislative reforms that are necessary, compassionate, and safe. This decade of tragedy underscores the need for greater public awareness and action.

In the '60s this country hospitalized 600,000 mentally ill patients but now provides beds to fewer than 40,000.[10] With this discharge rate more than 90 percent, often

without an enforceable treatment plan, who should be surprised by today's tragic headlines? Effectively, there exists a revolving-door system now run by psychiatrists, created by the Legislature, and maintained by ministerial judges.[11] One dangerously mentally ill person can easily cost millions of dollars cycling through a lifetime of commitments. If we dedicated with similar fervor the same amount of resources that we currently use to fight terrorism, we would be well on our way to better helping the mentally ill and making this country far safer. For example, while body scans and removal of shoes by millions may be necessary to deter one terrorist, similar monies could be effectively spent on awareness campaigns, treatments, and programs for mental illness, aimed at the MDMI, the prime resource users.

We can certainly agree that in every group, there exist individuals who monopolize our care, resources, and attention because of an identified propensity for violence. This is no less true for the mentally ill, and thus we should consider identifying and distinguishing them from those 80 percent or greater who are nonviolent. We need the public to know the MDMI term beyond its present limited use within state hospital systems. A bright line rule might not be the easiest of solutions; however, doctors and judges must identify telltale signs of serious and imminent harm to self or others. The single most important predictor of violent behavior is a history of violent behavior.[12] We must begin a discussion and create a workable matrix that identifies the violently mentally ill. If doctors are required to complete a risk analysis, on the record for the court, behaviors cannot be ignored. For example, social media posts levying threats against the public are one warning sign—and should be taken seriously. Another key indicator is a history of acting upon delusions, threats, and refusing medication. Grave decompensation coupled with command hallucinations to kill and records of escalating violent acts naturally are the predictors of violence. Once a person is identified as MDMI, then cooperative, closed-loop information sharing by the courts, police, and doctors would help each system better deal with problems when they arise.[13]

Public information about mental illness must be freed from inaccuracies. For example, rather than comparing mental illness to other diseases such as diabetes or cancer, spokespersons need to emphasize that these diseases are similar in that no one wishes for them, nor are they the patients' fault, but they must add that diseases of the brain may cause different complications in the sufferer, often resulting in misperceptions of reality, hallucinations, and sometimes harm to self or others, requiring monitoring and treatment. Also, the National Alliance on Mental Illness (NAMI) features an instructive statement: "treating individuals with major psychiatric disorders markedly reduces episodes of violent behavior."[14] The types of treatment mentioned by NAMI include IOPC, conservatorships, and conditional release.[15] I would add that inpatient hospitalizations and compelled medications, when appropriate, are also integral to recovery.

Advocacy groups are fond of mentioning that the overall likelihood of violence in individuals with mental illnesses is low. However, one Finnish study in 1996 reported that having schizophrenia increased the likelihood of homicidal recidivism in individuals more than 25 times the average for the normal population.[16] Advocacy groups will also note that "the amount of violence committed by people with schizophrenia is small, and only 1 percent of the U.S. population has schizophrenia … By comparison 2 percent of the U.S. general population without psychiatric disorders engages in any violent behavior in any one year period."[17] Rather than focus on defending all individuals with mental illnesses, these statistics bear out the very premise of my proposal, that the MDMI are in fact an identifiable group.

Indeed, I support advocacy for the mentally ill, until it infringes on the public's corresponding right to safety. The two are not mutually exclusive. I think we can all agree that freedom without treatment translates to freedom to be miserably ill, often homeless, and a danger to all. For example, those dangerously ill with anosognosia[18] often cannot function without intense inpatient treatment, enforced medication, and extended commitments. Naturally, if psychiatrists are empowered to direct injectable medications, this power must be balanced by the patient's needs, family input, medical peer review, and finally, discretionary judicial oversight.

Mentally ill individuals are also statistically at a vastly higher risk as victims of a crime, suicide, and homelessness, all contributing to the stigma.[19] Alcohol and drug abuse is a common form of self-medication to many who suffer from mental illness, and compounds the problem.[20]

The behaviors of these unfortunate and neglected individuals are a partial result of their release from full-time care since the '60s, society's slowness to embrace these widespread effective reforms,[21] and our current "no plan" releases. As a result of these failures and the existing stigma, many patients with diagnosable disorders are unlikely to independently seek help.

The basic mental health laws in this country have not undergone dramatic change since the '60s. Attempts at legislative reform have brought mixed results.[22] We must reform the judge-created gatekeeper rule for involuntary commitment that requires one to be a very serious danger to self or others, and which for evidence is entirely reliant on the subjective judgment of psychiatrists. If a team can grasp an individual's violence risk potential and identify the MDMI earlier, effective treatment will result. Allowing the mentally ill to choose the timing and duration of treatment when they are incapable of doing so is inhumane. Legislation I have drafted and proposed in cooperation with former state Sen. Jeff Wentworth, now a judge, includes requirements to:

1. Fingerprint every patient committed who has been identified as MDMI. Closed-loop identification could better prepare emergency rooms or first responders in serving these individuals. The police now have hand-held fingerprint identifiers with instant results.
2. Establish DNA mouth swabbing for the MDMI, with restricted access to this information.[23] Ironically, such an approach may defend against a false accusation.
3. As in California, require all psychiatrists to report patients who make credible threats to kill.[24] Doctors should ask those patients who, what, where, when, and why and then report this information to the appropriate local law enforcement.
4. No one identified as MDMI should be allowed to own weapons. Stringent screening processes should have access to the MDMI database. Before the present system was implemented,[25] the mentally ill could walk out of the hospital after discharge to a gun shop, lie on all of the forms (because mental health history could not then be verified), and wait the required time for their gun and ammo.[26] Our system should also enable immediate state action for families of the mentally ill who cannot effectively disarm them. Additionally, law enforcement should be well aware of an individual's MDMI status upon their arrival.
5. All persons involuntarily committed will need a Social Security payee until they stabilize.
6. The MDMI who suffer from homicidal command hallucinations must be identified on a national level. In addition, after initial screening, if diagnosed as MDMI, their inpatient treatment must be long and intense. If released as outpatients, current technology should be used to monitor their whereabouts. Similar precautionary, intense follow-up programs as are used with chronic pedophiles released from prison could be used.
7. Juveniles diagnosed with mental illness identified as MDMI deserve a plan and must be monitored longer. In Texas in 2010, youth completing the Texas Youth Commission's Mental Health Treatment Program demonstrated a reduction in risk by 38 percent for rearrest for a felony or misdemeanor and a reduction by 89 percent for re-incarceration when compared to those who did not.[27] Adults deserve a similar program, with emphasis on intense supervision for medication compliance.
8. Mentally ill patients in major cities who are frequently hospitalized, jailed, or detoxed need to be identified and then institutionalized and given free medication upon their release. Studies show that this system could save communities millions.[28] The present "least restrictive setting" must give way to more controlled monitoring and enforced medication.[29] For example, one violent patient in San Antonio, Texas, still in her 20s, was committed 81 times involuntarily. She generated endless hand-wringing meetings amongst naive professionals. What rational system would release her?
9. Finally, we need specialized criminal mental health courts for sufferers committing crimes. These courts currently exist in 43 states.[30] The approximately 300 mental health courts in the United States divert qualifying offenders from the mainstream criminal justice system.[31] These courts must have a role in labeling the MDMI within constitutional limits.

Sadly, in jurisdictions without mental health courts or reasonable commitment processes, many acute-care, violent patients are allowed to depart from hospital confinement after two weeks of treatment with a handful of medications, which they could disregard, and seek a shelter or bridge underpass or land in jail.[32] But the cost of care of the incarcerated mentally ill eclipses the cost of maintaining the general prison population without serious mental illnesses or co-occurring disorders. It has been estimated that mentally ill inmates cost $130 a day to incarcerate rather than $80;[33] or about $400 to $500 per day in a state psychiatric facility.[34] Costs can easily top $2.5 million for a lifetime of care.[35]

In 1968, while I was working for legal aid, a client called while he was traveling to the LBJ ranch and said, "I need to kill Lyndon Johnson because he raped my daughter." I had him removed by the civil mental health

unit and reported to Secret Service. He called the next day and said, "Do you know where I am? I am in a mental institution." Decades later, I found myself calling the same mental health docket he cycled through. One day, two convicted pedophiles appeared for release. One was walking a child off school grounds when stopped and the other was at a school performing a dangerous act. Neither knew the children. I could not sleep if I signed their releases. But the doctors concluded that they were no longer a danger once medicated, so they were released without my order. I resigned that duty and now advocate for this legislation. Mental illness and violence will continue its costly toll worldwide; however, embracing effective reforms will help eliminate the suffering and costs and address the needs of each individual. **TBJ**

NOTES

1. During the writing of this paper, another commuter-train pushing death occurred in Los Angeles, California, perpetrated by a person long known to be mentally ill who reportedly was not taking her medication.
2. E. Fuller Torrey, The Insanity Offense 167. (W.W. Norton & Company, Inc., 2012).
3. *Id.* at 22.
4. My colleague Judge Spencer wisely appointed Oscar Kazen as a civil associate judge, as the statute places mental health administration solely with her.
5. Bexar County also has several county-city funded programs that provide treatment and ongoing services for individuals suffering from mental illness and/or substance abuse issues that are in crisis. The Restoration Center Addiction Services has saved the county approximately $50 million over five years, and the count of homeless people living downtown has been reduced by 60 percent. Leon Evans, President and C.E.O., Center for Health Care Services, Address to NAMI National Conference, San Antonio, Tex. (June 28, 2013).
6. *See* Torrey, *supra* note 2, at 118-120, reporting that in one study, 21 out of 65 patients released from an Ohio state psychiatric hospital were arrested within six months of release; psychotropic medication had been prescribed upon their discharge, but the residents failed to take their medication. Another study of almost 2,000 individuals with schizophrenia demonstrated that those who were nonadherent with medications were twice as likely to commit violent acts and also twice as likely to be arrested, rehospitalized, or victimized by criminal acts.
7. *See, e.g.*, Helen Dermatis, Ph.D., et al, Schizophrenic Patients and Cocaine Use: Antecedents to Hospitalization and Course of Treatment, Substance Abuse, Vol. 19, No. 4, 169 (1998), *available at* http://link.springer.com/article/10.1023%2FA%3A1021477312621#page-1.
8. *See* Torrey, *supra* note 2, at 147.
9. Both the legal field and psychiatry attempt to predict behavior, and they are subjective, inexact disciplines. As an example, it was not until 1973 that psychiatrists voted to remove homosexuality as a psychiatric disorder in the DSM rubric.
10. *See* Diseases of the Mind: Highlights of American Psychiatry Through 1900, U.S. National Library of Medicine, National Institutes of Health, *available at* http://www.nlm.nih.gov/hmd/diseases/early.html; *see also* Sue Abderholden, Changes in Mental Health System, Council on Crime and Justice, *available at* http://www.crimeandjustice.org/councilinfo.cfm?pID=55.
11. *See* Torrey, *supra* note 2, at 222.
12. *Id.* at 157.
13. Every policeman's car computer should alert when law enforcement is sent to an incident by a known perpetrator.
14. *See* New Study Confirms Treatment Reduces Violence in Individuals with Major Psychiatric Disorders by Half, NAMI website, (May 14, 1998). *available at* http://www.nami.org/Content/ContentGroups/Press_Room1/1998/May_1998/New_Study_Confirms_Treatment_Reduces_Violence_in_Individuals_with_Major_Psychiatric_Disorders_by_Hal.htm
15. *See* Ken Duckworth, M.D., The Virginia Tech Tragedy: Distinguishing Mental Illness from Violence, NAMI website, (April 18, 2007), *available at* http://www.nami.org/Content/ContentGroups/Press_Room1/20076/April6/The_Virginia_Tech_Tragedy_Distinguishing_Mental_Illness_from_Violence.htm.
16. Torrey, *supra* note 2, at 157.
17. *See* Duckworth, *supra* note 15.
18. Defined as a lack of awareness of one's mental illness.
19. *See* Torrey, *supra* note 2, at 164.
20. *See, e.g.*, Dermatis *supra* note 7, at 169.
21. *See, e.g.*, Duckworth, *supra* note 15.
22. *See, e.g.*, Kristen Beronia, et al, U.S. Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans, Department of Health and Human Services website, *available at* http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm#content; *see also* California's Lanterman-Petris-Short Act, Cal. Welf & Inst. Code, sec. 5000 et seq., July 1, 1972.
23. Indeed, the U.S. Supreme Court on June 3, 2013, upheld the police practice of taking DNA samples from people who have been arrested but not convicted of a crime, ruling that it amounts to the 21st century version of fingerprinting.
24. *See* Mental Health Professionals' Duty to Protect/Warn, National Conference of State Legislatures website, (January 2013), *available at* http://www.ncsl.org/issues-research/health/mental-health-professionals-duty-to-warn.aspx; *see also Tarasoff v. The Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976).
25. *See* 18 U.S.C. § 922(d), relating to restrictions on previously committed persons to access to firearms.
26. *But see* Tex. Gov't Code §411.172, relating to restrictions in Texas on concealed weapons carried by previously committed persons.
27. Texas Youth Commission, 2010 Annual Review of Agency, Treatment Effectiveness, (Dec. 2010), *available at* http://www.tjjd.texas.gov/about/Annual_Treatment_Effectiveness_Review2010.pdf.
28. *See, e.g.*, Allen J. Frances, M.D., Prison or Treatment for the Mentally Ill, Psychology Today (March 2013), *available at* http://www.psychologytoday.com/blog/saving-normal/201303/prison-or-treatment-the-mentally-ill; *see also* Kirk Mitchell, Drug aid program benefits mentally ill prisoners, Denverpost.com (2009) *available at* http://www.denverpost.com/breakingnews/ci_13284304?source=rss.
29. I am suggesting a more controlled, family atmosphere for psychiatric institutions, with modern treatments.
30. E. Lea Johnston, Theorizing Mental Health Courts, 89 Wash. U.L. Rev. 519 (2012).
31. *Id.* at 519, 521.
32. The number of jail admissions involving people with SMIs (serious mental illnesses) has been estimated to be around 804,000 annually, and these individuals tend to stay incarcerated longer than "others charged with similar crimes." *See* Dale E. McNiel, Ph.D. & Renee L. Binder, M.D., *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 Am. J. Psychiatry 1395 (2007). The most common SMIs in the prison population include schizophrenia, bipolar disorder, and major depression, and these illnesses are classified by the American Psychiatric Association in a DSM-IV-TR rubric. *See also* Psychiatric Disorders; Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), All Psyche Online, http://allpsych.com/disorders/dsm.html.
33. C.M. Miller & A. Fantz, Special "psych" jails planned, Miami Herald (Nov. 2007) *available at* http://consensusproject.org/media/special_psych_jails_planned_1. The article cites that some reasons for the higher cost include increased activity in the courts, increased need for evaluations by social workers and physicians, and costs of medications administered. In regard to recidivism, a 2010 study of the Los Angeles County Jail showed that 90 percent of mentally ill inmates are repeat offenders, with 31 percent having been incarcerated 10 or more times. *See also* E.F. Torrey, et al., More Mentally Ill Persons are in Jail and Prisons than Hospitals: A Survey of the States, Treatment Advocacy Center and National Sheriffs Association (2010).
34. *See* Torrey, *supra* note 2, at 90.
35. Figures based on best estimate as stated in e-mail exchange by Associate Judge Lin Morrisett, Tarrant County, Tex., and using per diem state hospital figures of the San Antonio State Hospital (June 5, 2013).

TOM RICKHOFF

is a 1969 graduate of St. Mary's University School of Law, served in the Vietnam War, and later became a military judge. He served as a district judge in Bexar County for three terms and as a justice on the 4th Court of Appeals. He currently presides as judge of Probate Court Number Two, Bexar County.

ELLEN PATTERSON

is a third-year law student at St. Mary's University School of Law. She earned her B.A. from the University of Texas at Austin in 1996, worked with disabled children in San Antonio, and then earned her master's degree in mathematics from the University of Texas at San Antonio in 2010.

Bexar County Specialty Court Resolution
Bexar County Commissioners Court

This resolution is adopted by Bexar County Commissioners Court pursuant to Senate Bill 462 passed during the Regular 83rd Legislative Session which requires that a resolution be passed declaring the establishment of the specialty court program.

BE IT RESOLVED THAT Bexar County Commissioners Court, the Bexar County Criminal and Civil District Courts, the Bexar County Courts-At-Law; and the 4th Court of Appeals found it in the best interest of the citizens of BEXAR COUNTY to create the following specialty courts:

- Bexar County Adult Drug Court (Misdemeanor) on October 1, 2001 by Bexar County Courts-At-Law and the Bexar County Commissioners Court on January 29, 2003;
- Bexar County Adult Drug Court (Felony) was established by the Criminal District Courts on January 1, 2004;
- Bexar County Co-Occurring Disorder Program (CORE) was established the Criminal District Courts on October 1, 2009;
- Bexar County Family Drug Court was established by the 225th District Court of Bexar County on June 19, 2002;
- Bexar County Mental Health Court/Initiative was established by the Bexar County Commissioners Court on October 1, 2009;
- Bexar County Veterans Treatment Court was established by the Bexar County Commissioners Court and the Bexar County Courts-At-Law on February 9, 2010;
- Bexar County Felony and Misdemeanor Re-Entry Courts was established by the Criminal District Courts, the Bexar County Courts-At-Law, and the Bexar County Commissioners Court on June 8, 2010; and
- Bexar County Misdemeanor DWI Court was established by the Bexar County Commissioners Court on April 23, 2013.

Esperanza Court A/K/A Prostitution Prevention Program established 11/5/2014

Signed this 4th day of February 2014.

NELSON W. WOLFF
County Judge

SERGIO "CHICO" RODRIGUEZ
Commissioner, Precinct 1

PAUL ELIZONDO
Commissioner, Precinct 2

KEVIN WOLFF
Commissioner, Precinct 3

TOMMY ADKISSON
Commissioner, Precinct 4

BEXAR COUNTY PUBLIC DEFENDER'S OFFICE

MICHAEL L. YOUNG
Chief Public Defender
RICHARD DULANY, JR.
BRIAN C. O'DONNELL
MICHAEL D. ROBBINS
AMIE R. SERRANO
Assistant Public Defenders

Paul Elizondo Tower
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San Antonio, Texas 78205

VERONICA MCDONALD, PARALEGAL
Office Supervisor

HERLINDA ESCAJEDA
Office Assistant IV
CYNTHIA M. BAVOUSETTE
Office Assistant III

FOR IMMEDIATE RELEASE: June 5, 2015

Contact: Laura Jesse
210.787.9038/m

Grant will provide public defender to indigent mentally ill

The Texas Indigent Defense Commission unanimously approved a grant request from the Bexar County Public Defender's Office during a meeting in Austin on June 4. This multi-year grant will provide approximately $600,000 over four years to provide an attorney during the magistration process to indigent people suffering from mental illness who have been arrested in Bexar County.

No county in Texas currently provides indigent clients with counsel at the initial magistration hearing.

"By having Assistant Public Defenders from our office represent indigent defendants at magistration, Bexar County will be leading the state and the nation on this critical issue," said Bexar County Chief Public Defender Michael Young. "The need to provide an attorney to persons suffering from mental illness is especially critical for this vulnerable population."

Texas law requires that every person arrested be taken before a magistrate judge within 48 hours of their arrest to be informed of the charges against them and their rights, and to determine if the person qualifies for a court-appointed attorney. The judge then sets the bond amount. If the person arrested qualifies for a court-appointed lawyer, the process still takes several days before this person will ever meet with their attorney. The magistration process also is when arrestees are screened for participation in jail diversion programs.

- more -

“I’d like to commend Bexar County for being the first jurisdiction in the state to provide access to defense counsel at a person’s first appearance before a magistrate when critical mental health diversion decisions are made,” said Jim Bethke, executive director of the Texas Indigent Defense Commission.

Advocates and conservative groups alike have identified the need for Texas counties to provide representation of indigent arrestees during the magistration process. The Texas Public Policy Foundation, a conservative think tank, pointed out this need in an article published in April. In March, the Constitution Project issued a national report with similar findings.

“This is one more positive step toward properly caring for the mentally ill population who all too often end up in the criminal justice system,” County Judge Nelson Wolff said. “We’ve been working since the early 2000s to establish programs that will help keep the mentally ill out of our jail and provide them with the treatment they need.”

The Texas Indigent Defense Commission has distributed funds to Texas counties since 2002 to support effective programs that protect the rights of accused persons who cannot afford to hire a lawyer. In addition to competitive discretionary grants to fund new, innovative programs, the Commission provides formula grant funding to counties in compliance with the requirements of the Fair Defense Act of 2001 based on population and indigent defense expenditures. More information is available at http://www.txcourts.gov/tidc/.

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Huffington Post

San Antonio's Sheriff Personal Fight to Fix Broken System

Posted: 08/11/2015 2:44 pm EDT Updated: 08/11/2015 2:59 pm EDT
http://www.huffingtonpost.com/the-stepping-up-initiative/san-antonio-sheriffs-pers_b_7967304.html

My brother was bipolar. This was in the 1960s and 1970s before we knew what lithium was or how to control chemical imbalances. He spent that time in and out of mental institutions. I saw firsthand the challenges of a family dealing with mental illness at a time when it was pushed under the rug and was seen as an embarrassment. So it's always been important to me.

My father was a minister and counselor and my life experiences helped prepare me to have a sensitivity to mental health issues.

Today, I am the sheriff of Bexar County, Texas, which includes the city of San Antonio, and is home to the Bexar County Adult Detention Center, the 16th largest jail in the nation. Of the 4,000 incarcerated in our jail, more than 800 are being treated for some type of mental illness.

The nation's jails have become de facto mental institutions, where law enforcement is increasingly relied upon to deal with individuals who are suffering from mental health issues. Bexar County spends $2.2 million annually on psychotropic drugs to treat people with mental illnesses in our jail, nearly 60 percent whom have been arrested five times or more.

In 2009, our Mental Health Unit--composed of 15 deputies--received Crisis Intervention Training (CIT) to teach officers how to properly recognize and de-escalate a mental health crisis. Prior to that, law enforcement officers used physical force taking into custody individuals in mental health crises at least 50 times annually. In the more than five years since the training, our department has only used force three times.

If that is not evidence-based proof that CIT training is essential. I don't know what is.

Other initiatives that Bexar County has undertaken include the Misdemeanor Mental Health Court, which has shown a low recidivism rate (17 percent) since 2008 for people participating in the court. Another initiative aims to perform mental health screenings on every person arrested in Bexar County. Mental Health Screenings and Assessments have expanded from Monday-Friday, 8 a.m. to 5 p.m. to seven days a week to include evenings. The goal is to identify individuals with mental illness and safely divert them to a mental health treatment program in the community... before they are incarcerated.

It's important not just to our nation and our counties but across the board to address these challenges. Think of how many people we impact everyday who could be productive citizens if given the right help.

Susan Pamerleau is the sheriff of Bexar County (San Antonio), TX.

The New York Times http://nyti.ms/1l5elE6

The Opinion Pages | OP-ED CONTRIBUTOR

Where Police Violence Encounters Mental Illness

By MATTHEW EPPERSON JAN. 13, 2016

NEARLY 20 years ago, I was a social worker in a county jail where I first began to understand just how frequently the police deal with people with mental illnesses. Run-ins with the police were a regular occurrence for many of my clients, with officers often knowing them by name. They were overwhelmingly poor, and poor people with mental illnesses are also likely to experience homelessness and substance abuse — issues that place them at increased risk of police contact and incarceration.

All too often, those interactions can end in violence and death, as was the case with 19-year-old Quintonio LeGrier, who was shot and killed by a Chicago police officer last month. Responding to a 911 call made by Mr. LeGrier's father, officers found Mr. LeGrier wielding a baseball bat, and one officer quickly opened fire.

This was not Mr. LeGrier's first encounter with law enforcement. He'd had several confrontations with the police at the university he'd attended in recent months — at least one of these incidents involved officers' guns being drawn. His experience bears a striking resemblance to that of one of my former clients who was a college student in the late 1990s and who had several tense exchanges with the police as his symptoms worsened.

What's remarkable is that, even about 20 years later, the police remain the primary responders to mental health crises like these. According to data compiled by

The Washington Post, of nearly 1,000 people shot and killed by police officers in the United States in 2015, 25 percent displayed signs of mental illness. And about 14 percent of individuals in American jails and prisons have a serious mental illness, which means that, for most officers, interacting with individuals with mental illness is an almost daily occurrence.

There are two simultaneous national crises — one of police violence and the other of inadequate mental health treatment — and we are making a mistake if we focus blame only on the police. They have become, by default, the way in which our society chooses to deal with people with mental illness in crisis, particularly in poor and minority communities. We need also to address the declining state of mental health services across the country.

Right now, we are moving in the opposite direction. Between 2009 and 2011, Mr. LeGrier's home state, Illinois, eliminated more than $113 million in community mental health treatment services. In Chicago, the number of public mental health clinics was cut in half — to 6 from 12 — in 2012 as a cost-saving measure. Illinois's path follows the national trend of funding cuts for mental health services. And of course these cutbacks primarily affect people living in poverty, who are already at heightened risk of suffering from mental illnesses.

So that leaves the police as our de facto front line. To date, the dominant police model has been the Crisis Intervention Team (C.I.T.), which provides training on responding to mental health emergencies. Current research is as yet inconclusive on whether this training actually reduces the use of force, and police departments struggle with training and dispatching trained officers to the right calls. About 15 percent of Chicago police officers are C.I.T. trained, while experts recommend training for at least 25 percent.

But training alone will not solve the problem of police violence against people with mental illnesses. A few cities, like San Antonio, have made strides in building a better system by integrating mental health services with law enforcement. We need to invest more broadly in a mental health crisis system to work in conjunction with the police.

For example, in domestic disturbance cases like Mr. LeGrier's, a triage mental health worker could quickly gather pertinent information, assess risk of harm and engage family members as part of a coordinated effort. A crisis team could respond to the call, with police assistance if needed, to determine the safest and most clinically appropriate disposition. A responsive system would have suitable support available, such as a triage center or respite beds to provide urgent services, which would offer a clinically driven alternative to the more typical choices of jail, the emergency room or the morgue.

This is tricky terrain — even promising new approaches won't completely eliminate fraught interactions between the police and people with mental illnesses, or the chance of violence on either side. But they provide a wider and more fitting array of responses that could go a long way to averting future violence or incarceration. They certainly would have helped many of the clients I worked with in jail.

We also need to wrestle with our own complicated attitude toward people with mental illness. Mr. LeGrier's death is a rare case of national attention being paid to a person with mental illness being gunned down by the police, perhaps because a bystander, Bettie Jones, was also killed. Just 10 days after the shooting of Michael Brown in Ferguson, Mo., and only a few miles away, a young man with mental illness named Kajieme Powell was fatally shot by the police in St. Louis. Mr. Brown's death incited widespread protests, but despite the fact that Mr. Powell's shooting was actually captured on video, his senseless death went largely unnoticed.

If we are to prevent future tragedies, then we should be ready to invest in a more responsive mental-health system and relieve the police of the burden of being the primary, and often sole, responders. For the sake of individuals like Quintonio LeGrier, Kajieme Powell and many of the clients I've served, I hope we are.

Matthew Epperson is an assistant professor at the University of Chicago School of Social Service Administration.

Follow The New York Times Opinion section on Facebook and Twitter, and sign up for the Opinion Today newsletter.

A version of this op-ed appears in print on January 13, 2016, on page A21 of the New York edition with the headline: Pitting the Police Against the Mentally Ill.

RIVARD REPORT
Urban. Independent. All About San Antonio.

Haven for Hope Jail Outreach Program: 'It's an Opportunity'

CAMILLE GARCIA on 19 January, 2016 at 20:37

The mural outside Haven for Hope. Photo by Camille Garcia.

When Joel Torres found himself in jail again, he ran out of excuses to continue on the same path. When he wasn't serving time for his crimes, he was on the street without a job or a place to live.

"This isn't who I am, who I am reflecting outside to everyone else," Torres said. "On paper I just look like a criminal and inside I knew I really want to help people and help myself."

After serving his most recent jail sentence, Torres made a change. He accepted the help he was being offered by Haven for Hope to start anew. Torres agreed to be admitted into Haven's Jail Outreach Program.

A small group of current and veteran participants, as well as those who work behind the scenes, gathered Tuesday at the homelessness resource center and shelter to celebrate the outreach program's one year anniversary.

The program helps homeless individuals get back on their feet when they are released from the Bexar County Jail. The program provides free aid and therapy to those inmates with physical or mental health issues including addiction. Its staff works to find jobs and housing for its clients, in the meantime providing food and a place to stay in the Haven for Hope's large facility in the near Westside.

Haven for Hope. Photo courtesy of the Kronkosky Foundation.

"The year has been successful," said Steven Aidala, Jail Outreach peer support lead. In the past six months about 25 people have successfully left the program and are living independently while another 10 are living with family members.
The aim of the program is just that: to give homeless individuals with criminal backgrounds a chance to reintegrate into society, a process that is often difficult to achieve alone, especially for someone with a mental illness or addiction.

Torres received several forms of support through the program including counseling and new clothes for job interviews. "They had every tool in the shed for me," he said.
He now lives in his own apartment and has a full-time job.

It is cases like Torres' that make all of the work worth it, said Family Violence Court Judge Crystal Chandler, who plays a hand in the selection of inmates who are admitted to the program.

“This is an ideal situation. You want to see people who are taking advantage of opportunities that are out there for them and turning their lives around, that’s how you want the system to work,” Chandler said.

But not every inmate is initially eligible to join the program, she added. They first need to be eligible for a personal recognizance bond, or PR bond, which is granted after the review of an inmate’s case and criminal history is completed. If, after review, they are ineligible for the bond, then they may have the opportunity for a Haven for Hope case worker to speak to the judge on their behalf to allow them to enter the program.

“(A case worker) with pretrial services will go to the jail and interview them … and they’ll put together a report for me to read and can educate me and say ‘Judge, I think this person would be a great candidate for this program,'” Chandler said.
Michael Cardona, a current program participant, was hopeless at the end of his jail term, he said. He wanted the judge presiding over his case to let him stay in jail since he had nowhere else to go. After hearing about the outreach program, he decided to give it a try.

“I came to Haven and was just totally happy with all the help I’ve received since I’ve been here,” Cardona said, who started the program in July 2015. “There’s a bunch of different programs here that I’ve utilized.”

Since opening in April 2010, Haven for Hope has provided care and guidance for more than 2,500 homeless people in Bexar County. The Jail Outreach Program is just one of many programs offered there that works to positively affect and change the lives of the City’s homeless.

Bexar County Director for Judicial Services Mike Lozito said the program is a step toward putting an end to a never ending cycle of jail time.

“We looked at the homeless situation downtown,” he said. “A lot of these people serve time and get out but don’t have any services to help them. We thought about what we needed to do because some of these people have up to six arrests a year, and sometimes it’s just for sleeping in front of a building.”
Since the program started, Lozito said, 70% of participants remain in the program.

Haven is hoping to fine tune the program in its next year and keep in touch with its “graduates.”

“We hope to keep a good level of communication and stay involved with folks in whatever way we can,” Aidala said.

Though he has graduated from the Jail Outreach Program, Torres said he’s proud to share his story with others and to be part of the Haven for Hope community as an alumni.

“This isn’t a homeless shelter,” he said. “It’s a program, it’s an opportunity.”

BEXAR COUNTY SHERIFF'S OFFICE
ARREST & BOOKING SHEET

Offense Case #	Master Incident #	Date of Occurrence	Time of Occurrence	Arresting Agency ORI
				TX0150000

ARRESTED PERSON INFORMATION

Name (Last, First, Middle)	Race	Sex	Height	Weight	Hair	Eyes	CIJS SID #	CIJS SPN #
								N/A

Address	Unit Type	Unit #	Complexion	Build	Date of Birth	Age

City	State	Zip Code	Primary Phone #	Secondary Phone #	Driver's License #	State

Aliases / Nicknames / Maiden Name	Place of Birth	Citizenship	Social Security #

Scars, Marks, Tattoos, Amputations	Miscellaneous Number(s)

Occupation	Employer	Student	School	Education Level
		☐ Yes ☐ No		

Emergency Contact (Last, First)	Address	City	State	Zip Code

OFFENSE CODE	CHARGE DESCRIPTION	WARRANT #	WARRANT TYPE	ISSUED BY

ARREST DETAILS

Location of Arrest	Date of Arrest	Time of Arrest	District / RA

Condition of Prisoner	Special Needs	Disposition

Operate Vehicle	VIN or License Plate	Make	Model	Year	Color	Hazardous Material
☐ Yes ☐ No						☐ Yes ☐ No

Vehicle Impounded	Location	Phone #
☐ Yes ☐ No		

Property in Property Room	Location	Phone #
☐ Yes ☐ No		

VICTIM NOTIFICATION

Victim Notification Phone #	VINE PIN #	Victim Declines Notification	Comments
		☐ Yes ☐ No	

FACTS OF ARREST

Arresting Agency	Address	City	State	Zip Code
BEXAR COUNTY SHERIFF'S OFFICE	200 N. COMAL	SAN ANTONIO	TX	78207

Complainant / Victim Name	Address	City	State	Zip Code
			TX	

Witness Name	Address	City	State	Zip Code
			TX	

Badge	Arresting Officer 1	Badge	Arresting Officer 2	Badge	Transporting Officer	Badge	Approving Officer

Mental Health Diversion Questions

1. Have you ever been diagnosed as having a mental illness by a doctor or a mental health professional? (Check 1) YES ☐ NO ☐

2. Have you ever or are currently taking any medications for mental illness? (Check 1) YES ☐ NO ☐

3. Have you ever tried to kill yourself? (Check 1) YES ☐ NO ☐

4. Do you currently have thoughts of killing yourself? (Check 1) YES ☐ NO ☐

***These questions are to be asked to arrested person as by required by SAPD procedure 601, and a Directive issued by the Bexar County Sheriff's Office.

TEXAS STATE of MIND
THE MEADOWS MENTAL HEALTH POLICY INSTITUTE

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS
Collaborative Approaches to Public Safety

Bexar County Smart Justice

Redesigning a Local Justice System to Divert People with Mental Illnesses to Community Treatment

A key goal of the Smart Justice initiative of the Meadows Mental Health Policy Institute (MMHPI) is to reduce the number of people with mental illnesses in county jails in Texas by identifying and diverting as many as safely possible to community treatment. MMHPI has partnered in Texas with the Council of State Governments Justice Center (CSGJC) to work on transforming local justice systems to achieve this goal. MMHPI provides high-quality, nonpartisan, and objective policy research and development to improve mental health services in Texas (texasstateofmind.org). The CSGJC is a nonpartisan national organization that assists state and local officials in improving justice policies (csgjusticecenter.org/about-jc/).

Approximately 17 percent of adults entering jails and state prisons have a serious mental health illness. The jail cost for individuals with mental illnesses in Texas is estimated at over $450 million annually.[1] Individuals with untreated mental health and substance use disorders are 8 times more likely to be incarcerated, often due to lack of access to appropriate crisis services and ongoing care (see figure 1).

The **Meadows Mental Health Policy Institute** Smart Justice Initiative is directed at reducing the number of people with mental illnesses in Texas county jails by safely diverting people to community treatment.

The Institute has partnered with the **Council of State Governments Justice Center** and **Bexar County** officials to work on transforming their local justice system to reduce the number of people who have mental illnesses in jail and increase the effectiveness of community treatment for justice-involved individuals.

Bexar County leaders have adopted key recommendations developed by local officials working with MMHPI and CSGJC and are in the process of designing and implementing these strategies.

Local justice systems are overseen by an array of independent elected officials: county commissioners, district and county judges, sheriffs, district attorneys, county clerks, mayors, and city councils. Local mental health authorities, hospital districts, and private mental health and substance abuse providers using public and private funds manage the local community behavioral health system. With such a large number of varied interests and oversight structures involved, changing the path of mentally ill persons from the police or jail to community treatment is a complex undertaking.

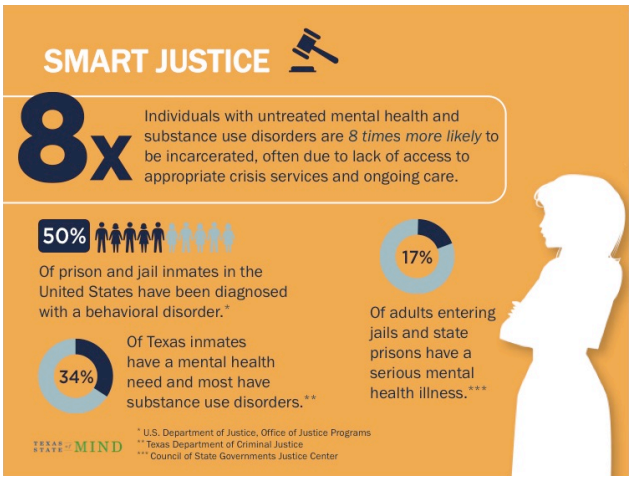


Figure 1. Smart Justice Mental Health Landscape, MMHPI

TEXAS STATE of MIND
THE MEADOWS MENTAL HEALTH POLICY INSTITUTE

JUSTICE CENTER
THE COUNCIL OF STATE GOVERNMENTS
Collaborative Approaches to Public Safety

Bexar County Smart Justice

MMHPI and CSG Justice Center have partnered with Bexar County officials to work on transforming their local justice system to reduce the number of people with mental illnesses in the jail and increase the effectiveness of community treatment for these individuals. In 2014 the work team completed an in-depth review of the county's pretrial processes and examined mental health diversion practices. The research team also conducted data analyses on the flow of populations booked into the Bexar County justice system and related recidivism rates. This phase of the project was financed by Bexar County, the U.S. Department of Justice's Bureau of Justice Assistance, and the Jacob Valeria Langeloth Foundation.

The Results of the Analysis Showed:

- **Major bottlenecks in the booking after arrest processes in the county**. Bottlenecks are partly driven by an obsolete booking facility (referred to as the Central Magistration Facility or CMAG) that negatively affects staffs' ability to effectively conduct mental health screening and assessments;

- **Low number of diversions to treatment**. Of the 7,216 people with mental illnesses who were eligible for diversion and booked after arrest into the system between April 2014 and February 2015, only 2,170 received a mental health assessment and only 125 were diverted to community treatment.

- **Inability to meet the spirit of Texas law.** Deficient screening, assessment, and diversion protocols for people with mental illnesses do not meet the magistration (preliminary hearing to decide to release a person on pretrial supervision or bond) and diversion requirements under Texas Code of Criminal Procedures, Article 16.22 and 17.032;

- **Limited pretrial supervision strategies.** People with mental illnesses who are on pretrial supervision are not properly identified for special conditions of supervision or for effective connections to treatment;

- **Shortage or inadequate use of limited behavioral health treatment services and poorly developed protocols to divert persons to treatment from the CMAG facility and jail.** In 2013, the University Health System, the county hospital providing treatment services in the Bexar County jail, only diverted 51 out of more than 2,500 people with mental illnesses in the county jail population to community treatment; and,

- **High recidivism rates for people with mental illnesses.** Over 50 percent of the jail population classified as having a mental illness has been arrested six or more times previously.

The Bexar County Commissioners Court approved the implementation of recommendations to improve these processes in January 2014. Phase II of the project started in August 2014 with MMHPI and CSGJC providing technical assistance to county officials to assist in the implementation of recommendations.

Bexar County Smart Justice

Milestones Achieved

Local officials created an Executive Committee, chaired by County Judge Wolff and co-chaired by Sheriff Pamerleau, to guide the initiative. Various inter-agency groups were created to design implementation plans. Phase II has been funded by the county and by MMHPI. Important milestones that have been achieved include:

- The county has allocated $2.9 million for needed renovations to the CMAG facility in its 2015 budget, and architecture plans are underway with the goal of maximizing space to facilitate expanded mental health screening and assessment.

- The county created a Public Defender Office and, with state funding assistance from the State Indigent Defense Commission, and local funding, defense lawyers with a mental health specialization will be representing persons with mental illness at the magistration process to advocate for pretrial release from the jail to community treatment.

- A local agreement has been established to create new processes to allow city and county law enforcement officials to increase the number of people with mental illnesses who are diverted to treatment before booking into the justice system.

- In partnership with Methodist Healthcare Ministries of South Texas (MHM), in Fall 2015, MMHPI will begin a comprehensive performance assessment of Bexar County mental health systems that should identify opportunities to improve mental health services, including how to better engage in treatment services with people who have mental illnesses who are involved with the criminal justice system.

Bexar County leaders are making a public commitment to address the issues raised by CSGJC and MMHPI. County and city officials created a new Criminal Justice Coordinating Council, co-chaired by the Mayor of San Antonio and the County Judge. Members include the County Sheriff, the San Antonio Police Chief, and the city and county managers. This council met for the first time on April 28, 2015. The Mayor and County Judge directed the focus of the conversation to addressing the "long-running issues regarding early screening of arrestees for possible referral to diversion programs and substance abuse treatment."[2]

Subsequently, a supportive editorial by the San-Antonio Express News was published stating:

"We applaud the effort by city and council officials to tackle shared problems in the criminal justice system by creating the Bexar County/San Antonio Criminal Justice Coordinating Council. The move was long overdue."[3]

Next Steps

The District Attorney and the Public Defender Office in late April 2015 also signed a memorandum-of-understanding in which they formalized discussions "regarding a mechanism to facilitate the use of existing resources for the treatment and supervision of arrestees processed through the Central Magistration System (CMAG)." They agreed that Bexar County "must comply with Texas Code of Criminal Procedure Art. 17.032 if a qualifying arrestee is believed to suffer from mental illness." [4]

Finally, the judges overseeing the magistration system, in an application for state indigent defense grant funds, agreed to increase the number of people with mental illnesses diverted from booking to treatment from 6 percent of arrestees to 30 percent, (an increase of over 1,500 additional diversions from the justice system to treatment).[5] The funds requested would be directed at establishing a mental health public defender program that, working with the magistrates and district attorney, will support defense services aimed at advocating for people with mental illnesses who qualify for diversion to treatment. The Public Defender Mental Health Unit should be operational starting in September 2015.

Challenging work lies ahead to complete Phase 3 of the Bexar County Smart Justice project, MMHPI and the CSGJC seek philanthropic support for the following:

- Fund a process review design for a central behavioral assessment center to better identify treatment needs of persons entering the justice system.
- Use the MHM assessment to develop strategies to better leverage community treatment capacity for managing and increasing diversion and overall treatment referrals from the justice system.
- Continue funding the MMHPI and CSGJC technical assistance needed by local officials to sustain the system transformation efforts over the next three years.

More challenging work is ahead. The judicial branch now needs proof that the new processes to be put in place can be effective in identifying the best population in need of treatment, and that the treatment is effective in reducing recidivism. The CSGJC and the MMHPI will continue to partner with local officials to assist in achieving these goals.

1 *MMHPI and the Texas Conference of Urban Counties, Texas Mental Health Landscape, http://www.texasstateofmind.org*

2 *http://www.expressnews.com/news/local/article/City-county-to-collaborate-on-criminal-justice-6229750.php*

3 *http://www.expressnews.com/opinion/editorials/article/Joint-city-county-justice-effort-welcome-6258907.php*

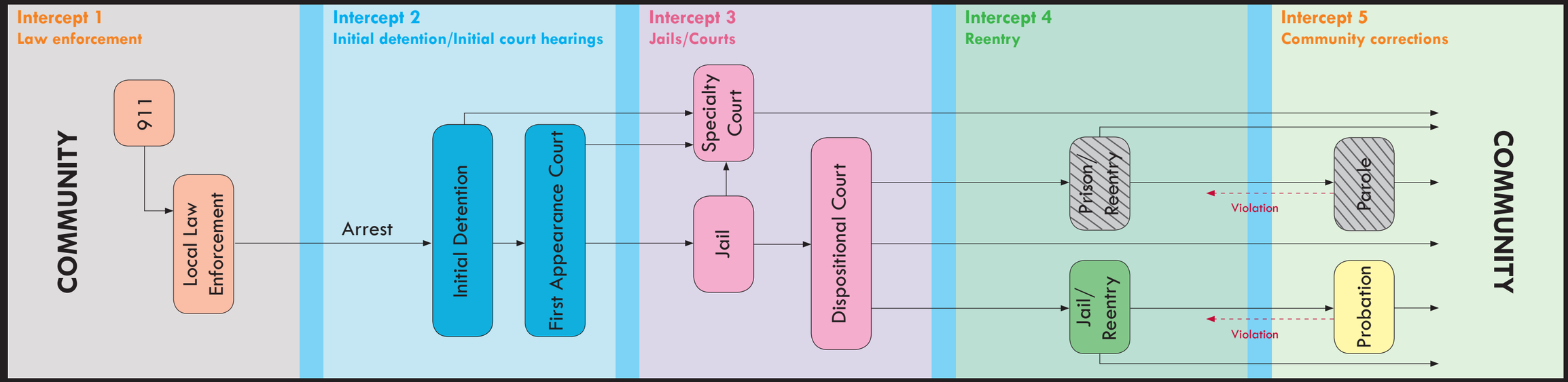
4 *April 30, 2015, Memorandum-of-Understanding signed by Nicholas "Nico" LaHood with the Public Defender of Bexar County, Michael Young.*

5 *Bexar County application for grant funds to the Texas Indigent Defense Commission, May 2015.*

Sequential Intercepts for Developing CJ–MH Partnerships

Action for System-Level Change

- Develop a comprehensive state plan for mental health/criminal justice collaboration
- Legislate task forces/commissions comprising mental health, substance abuse, criminal justice, and other stakeholders to legitimize addressing the issues
- Encourage and support collaboration among stakeholders through joint projects, blended funding, information sharing, and cross-training
- Institute statewide crisis intervention services, bringing together stakeholders from mental health, substance abuse, and criminal justice to prevent inappropriate involvement of persons with mental illness in the criminal justice system
- Take legislative action establishing jail diversion programs for people with mental illness
- Improve access to benefits through state-level change; allow retention of Medicaid/SSI by suspending rather than terminating benefits during incarceration; help people who lack benefits apply for same prior to release
- Make housing for persons with mental illness and criminal justice involvement a priority; remove constraints that exclude persons formerly incarcerated from housing or services
- Expand access to treatment; provide comprehensive and evidence-based services; integrate treatment of mental illness and substance use disorders
- Expand supportive services to sustain recovery efforts, such as supported housing, education and training, supportive employment, and peer advocacy
- Ensure constitutionally adequate services in jails and prisons for physical and mental health; individualize transition plans to support individuals in the community
- Ensure all systems and services are culturally competent, gender specific, and trauma informed – with specific interventions for women, men, and veterans



Action Steps for Service-Level Change at Each Intercept

- ***911:*** Train dispatchers to identify calls involving persons with mental illness and refer to designated, trained respondents
- ***Police:*** Train officers to respond to calls where mental illness may be a factor
- ***Documentation:*** Document police contacts with persons with mental illness
- ***Emergency/Crisis Response:*** Provide police-friendly drop off at local hospital, crisis unit, or triage center
- ***Follow Up:*** Provide service linkages and follow-up services to individuals who are not hospitalized and those leaving the hospital
- ***Evaluation:*** Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement

- ***Screening:*** Screen for mental illness at earliest opportunity; initiate process that identifies those eligible for diversion or needing treatment in jail; use validated, simple instrument or matching management information systems; screen at jail or at court by prosecution, defense, judge/court staff or service providers
- ***Pre-trial Diversion:*** Maximize opportunities for pretrial release and assist defendants with mental illness in complying with conditions of pretrial diversion
- ***Service Linkage:*** Link to comprehensive services, including care coordination, access to medication, integrated dual disorder treatment (IDDT) as appropriate, prompt access to benefits, health care, and housing; IDDT is an essential evidence-based practice (EBP)

- ***Screening:*** Inform diversion opportunities and need for treatment in jail with screening information from Intercept 2
- ***Court Coordination:*** Maximize potential for diversion in a mental health court or non-specialty court
- ***Service Linkage:*** Link to comprehensive services, including care coordination, access to medication, IDDT as appropriate, prompt access to benefits, health care, and housing
- ***Court Feedback:*** Monitor progress with scheduled appearances (typically directly by court); promote communication and information sharing between non-specialty courts and service providers by establishing clear policies and procedures
- ***Jail-Based Services:*** Provide services consistent with community and public health standards, including appropriate psychiatric medications; coordinate care with community providers

- ***Assess*** clinical and social needs and public safety risks; boundary spanner position (e.g., discharge coordinator, transition planner) can coordinate institutional with community mental health and community supervision agencies
- ***Plan*** for treatment and services that address needs; GAINS Reentry Checklist (available from http://www.gainscenter.samhsa.gov/html/resources/reentry.asp) documents treatment plan and communicates it to community providers and supervision agencies – domains include prompt access to medication, mental health and health services, benefits, and housing
- ***Identify*** required community and correctional programs responsible for post-release services; best practices include reach-in engagement and specialized case management teams
- ***Coordinate*** transition plans to avoid gaps in care with community-based services

- ***Screening:*** Screen all individuals under community supervision for mental illness and co-occurring substance use disorders; link to necessary services
- ***Maintain a Community of Care:*** Connect individuals to employment, including supportive employment; facilitate engagement in IDDT and supportive health services; link to housing; facilitate collaboration between community corrections and service providers; establish policies and procedures that promote communication and information sharing
- ***Implement a Supervision Strategy:*** Concentrate supervision immediately after release; adjust strategies as needs change; implement specialized caseloads and cross-systems training
- ***Graduated Responses & Modification of Conditions of Supervision:*** Ensure a range of options for community corrections officers to reinforce positive behavior and effectively address violations or noncompliance with conditions of release

The Sequential Intercept Model

Developed by Mark R. Munetz, MD, and Patricia A. Griffin, PhD, the Sequential Intercept Model provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with serious mental illness. Within the criminal justice system there are numerous intercept points — opportunities for linkage to services and for prevention of further penetration into the criminal justice system. Munetz and Griffin (2006) state:

> The Sequential Intercept Model … can help communities understand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time.

The Sequential Intercept Model has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pre-trial services, courts, jails, community corrections, housing, health, social services, and many others.

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Plan Health & Justice The Intercept

Three Major Responses for Every Community

Three Major Responses Are Needed:

1. **Diversion programs** to keep people with serious mental illness who do not need to be in the criminal justice system in the community.
2. **Institutional services** to provide constitutionally adequate services in correctional facilities for people with serious mental illness who need to be in the criminal justice system because of the severity of the crime.
3. **Reentry transition** programs to link people with serious mental illness to community-based services when they are discharged.

The Sequential Intercept Model has been used by numerous communities to help organize mental health service system transformation to meet the needs of people with mental illness involved with the criminal justice system. The model helps to assess where diversion activities may be developed, how institutions can better meet treatment needs, and when to begin activities to facilitate re-entry.

The GAINS Center

The CMHS National GAINS Center, a part of the CMHS Transformation Center, serves as a resource and technical assistance center for policy, planning, and coordination among the mental health, substance abuse, and criminal justice systems. The Center's initiatives focus on the transformation of local and state systems, jail diversion policy, and the documentation and promotion of evidence-based and promising practices in program development. The GAINS Center is funded by the Center for Mental Health Services and is operated by Policy Research Associates, Inc., of Delmar, NY.

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Developing a Comprehensive for Mental Criminal Collaboration: Sequential Model