

# Nebraska

**Transforming Services for Persons  
with Mental Illness in Contact with the Criminal Justice System**

**ACTION:**

**Criminal Justice Mental Health Strategic Planning  
Workshop Report (from December 5 and 6, 2007)  
Lincoln, NE**

**Report by  
Policy Research Associates  
January 28, 2008**

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## Executive Summary

The incarceration of people with mental illness in Nebraska's correctional facilities is a continuing issue of concern. Technical assistance from Policy Research Associates (PRA) based in Delmar, New York, was sought by the Division of Behavioral Health to examine the current policies and make recommendations for transformation. The ongoing collaboration between the Division of Behavioral Health and the Nebraska Department of Correctional Services has prompted legislative action that is exploring the interface between mental health and criminal justice. Legislative Bill 669 (Adopt the Nebraska Behavioral Health Jail Diversion Planning and Coordination Advisory Council Act) spurred Legislative Resolution 99 which approved an interim study to examine the policies related to the incarceration of persons with mental illness in Nebraska correctional facilities. The technical assistance from PRA was designed to further this exploration. The workshop and PRA's detailed report is intended to offer summary recommendations to address these issues to the Nebraska Legislature's Judiciary Committee for consideration in the 2008 legislative session.

### Program Structure

PRA helped structure a two-day workshop on December 5 and 6, 2007 in Lincoln, NE. The participants included the various state and local stakeholders concerned with the issues surrounding the incarceration of people with mental illness. The workshops included presentations from some of Nebraska's leaders in research and service delivery in this arena. They included:

- Shinobu Watanabe-Galloway, Ph.D., from the College of Public Health at the University of Nebraska Medical Center, presented the preliminary findings from a data match between the Department of Correctional Services and the DHHS as part of an ongoing assessment of mental health needs in DOCS.
- Deb Minardi, from the Office of Probation Administration, presented an overview of the standardized model of substance abusing offenders, which is reducing recidivism.
- Travis Parker, Director of the Behavioral Health Jail Diversion Program in Lancaster County, presented on the impact of this successful diversion program in Lincoln, NE.
- John Sheehan, Director of the Douglas County Mental Health Diversion program, presented on the effectiveness of aggressive outreach and case management on reducing jail time and recidivism.
- Jean Chicoine, Director of the Nebraska Homeless Assistance Program, presented a fascinating cost analysis of the high utilizers of homeless emergency services which shows that supportive housing reduces the cost of homeless services by 71%.

PRA workshops on both days were structured around imparting state and national information on the scope of the problem and the solutions that best work to keep people out of the criminal justice system. The presentations and discussion were organized around the "Sequential Intercept Model," which is a schematic view of the various agencies consumers typically interface with as they move from community-based services into the criminal justice system. PRA presented information about the best practice programs from across the nation that provide services at each intercept. The participants were divided into six regional focus groups and were led through tasks to identify each region's strengths, gaps in services and priorities for addressing the needs of people with mental illness in the criminal justice system. They prioritized their top three issues for action and developed corresponding action steps. The

results of the regional groups' work is summarized below and detailed in the technical report. In addition, PRA analyzed the information and offered recommendations, which are condensed below.

## Nebraska Region's Priorities for Change

1. Information sharing: A seamless mechanism for sharing information and enhancing communication needs to be developed for those clients that move through multiple service delivery system. (Region 3, 5 and the state group)
2. Re-entry: Create mechanisms to enhance and coordinate an individual's re-entry and connection back to the community. (Region 3, 4 and the state group)
3. Medications: People need access to medication during incarceration and after re-entry to prevent relapse. (Region 1, 3 and 6)
4. Screening Instruments: Jails need consistent screening instruments that will assist in the identification of risk and need related to mental illness and substance abuse. (Regions 1 and 2)
5. Jail Diversion: Jail Diversion programs need to be funded. The successful one in Lancaster County needs sustainable funding and could be a model for possible expansion to other regions. The Behavioral Health Jail Diversion Program in Douglas County is another highly successful model that could be replicated. (Regions 5 and 3)
6. Housing: Affordable housing needs to be funded. ( Region 5 and 6)
7. Forensic Peer Support: Forensic Peer Support is a highly successful model that needs to be developed. ( Region 1)
8. Training for Jail Staff: Standardized mental health training for jail officers needs to be developed. ( Region 2)
9. In-Custody Treatment: Mental Health and substance abuse treatment needs to be developed and offered to people in custody. ( Region 4)

## PRA's Recommendations for Consideration

1. Enhance the Emergency Management System and/or Local Crisis Response Teams (LCRT) role to effectively interface with other consumer involved agencies for diversion efforts, with funding to offset expanded responsibilities.
2. Provide statewide Crisis Intervention Team training for Law Enforcement officers and make clear linkages with the LCRT with expanded capacity where appropriate.
3. Expand or improve access to crisis stabilization beds as needed with improved coordination with law enforcement officers.
4. Establish a statewide committee to focus on persons with mental illness in the criminal justice system. This committee could be subsumed within the Community Corrections Council.
5. Each Regional Behavioral Health Authority should insure the stakeholder groups attending the workshop follow up on the action plans they developed and establish Regional Planning Committees that report to a state level oversight committee that coordinates statewide efforts.
6. Increase resources to the local community mental health system to provide diversion and re-entry services through the use of Forensic Intensive Case Management.
7. Increase jail diversion at post-arrest across the state.
8. Implement standardized screening instruments in the jails that prompt referrals for services and explore funding options for services and medications in the jails.

9. Expand or increase trauma informed care and gender specific treatment capacity in the prisons and jails.
10. Re-entry planning and services need to be systematically provided prior to release from jails and prisons.
11. Expand affordable housing.
12. Information sharing across all systems of care needs to be enhanced.
13. Expand Nebraska's extensive efforts on consumer involvement to the criminal justice areas with a forensic focus to include: a) participation in all state and local planning efforts, b) Forensic Peer Support and c) training and employment for Forensic Peer Specialists.
14. Expand efforts on planning and service delivery to include veterans in the justice system.

The details of these recommendations and the information about the priority issues from Nebraska's regional focus groups can be reviewed in PRA's technical report.

## Director's Overview

**Scot L. Adams, Ph.D., Director**

**Division of Behavioral Health, Nebraska Department of Health and Human Services**

On December 5 and 6, 2007, we were introduced to the use the Criminal Justice Sequential Intercept Model to complete a strategic planning process. The idea was that there should be a type of Behavioral Health intervention at each step of the criminal justice process. The efforts of the workshop participants over the day and a half helped to develop a long-term vision for the area of criminal justice and behavioral health over the next five years.

I see this work as a natural extension of what the state started in 2004 with Nebraska Behavioral Health Reform. Under Behavioral Health Reform, we have been developing community based services that are closer to a consumer's family and community and that better meet their needs, redefining the role of state Regional Centers, and much more.

Behavioral Health Reform includes the idea that mental health services and substance abuse treatment need to be consumer and family-centered. They should also increase consumers' abilities to successfully manage life's challenges, facilitate recovery and build resilience. When the necessary supports and services are available, a consumer can thrive in the community. Without them, it is possible that a person could end up in the criminal justice system. I do not believe that the criminal justice system is the best place to serve most people with behavioral health problems.

All of this leads me to believe we are ripe for the conversation now in Nebraska. I want to especially thank our partners who provided the financial support to make this event possible:

- The Nebraska Supreme Court Office of Probation Administration
- The Department of Correctional Services
- The Nebraska Homeless Assistance Program
- Federal Center for Mental Health Services, via
  - National Technical Assistance Center and the National Association of State Mental Health Program Directors
  - New Freedom Initiative State Coalitions To Promote Community-Based Care

I also want to thank the Community Corrections Council, the six Regional Behavioral Health Authorities and all our other partners in this endeavor.

The December 5<sup>th</sup> and 6<sup>th</sup> workshop offered a rich agenda that included local, state and national perspectives. We've assembled good people with great talent. I was gratified at the tremendous turnout. Only good things can happen as a result of the work on those two days.

The goal for the December 5<sup>th</sup> and 6<sup>th</sup> workshop was to have a report completed by Policy Research Associates for the 2008 Legislative session. This report meets those requirements.

We are working with our criminal justice and mental health partners to decrease criminal justice system involvement for people with behavioral health problems in Nebraska. I know we will build upon our strengths and keep moving forward together to transform services for persons with mental illness in contact with the criminal justice system.

# Nebraska:

## Strategic Analysis Workshop for Transforming Services for Persons with Mental Illness in the Criminal Justice System

### Introduction

The Nebraska Division of Behavioral Health sought technical assistance in the area of criminal justice and mental health partnerships from Policy Research Associates (PRA) from Delmar, New York. PRA understands that the impetus for this assistance is based on several factors. As indicated in a letter from Scot L. Adams, Ph. D., Director of the Division of Behavioral Health in the Nebraska Department of Health and Human Services, there has been an ongoing partnership between the Division of Behavioral Health and the Nebraska Department of Correctional Services that has prompted legislative action to further explore the interface between mental health and criminal justice. More specifically, Legislative Bill 669 (Adopt the Nebraska Behavioral Health Jail Diversion Planning and Coordination Advisory Council Act) spurred Legislative Resolution 99 (LR 99) which approved an interim study to examine the policies related to the incarceration of persons with mental illness in Nebraska correctional facilities. Several successful programs in Nebraska addressing these issues are operating on soft money. The Lancaster County Behavioral Health Jail Diversion Program and the Douglas County Mental Health Diversion Program are showing positive outcomes and would like to continue and possibly expand their services. The technical assistance and ensuing report is needed by the various stakeholders for submission to the Nebraska Legislature's Judiciary Committee for the 2008 legislative session.

PRA has been providing research, training and technical assistance on the issues related to the interface between mental health and criminal justice since 1987. PRA is a national leader in policy evaluation and formation to promote the transformation of systems of care to provide more seamless, recovery oriented and consumer driven services that reduce contact with the criminal justice system. PRA's work is informed by The National GAINS Center, which is operated by PRA. The National GAINS Center has been funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) since 1995 to provide technical assistance to and serve as a catalyst for change for states and communities to improve mental health and criminal justice collaboration for justice involved persons with co-occurring disorders. To this end, the Strategic Analysis Workshop is designed to help states:

- Identify a target population for intervention based on both clinical criteria and criminal justice criteria
- Understand the characteristics and service needs of the target population
- Understand the criminal justice supervision options
- Use the Sequential Intercept Model as a framework to design and prioritize state facilitated or state led interventions
- Model best practices for service, collaboration, coordination, and legislation in place in other states and jurisdictions

- Assess available criminal justice and mental health data as it pertains to development of diversion and reentry programs
- Assess gaps and strengths in areas of services and programs, agency coordination and collaboration and policy and legislation
- Prioritize gaps and develop a plan of Action

PRA's technical assistance to the state of Nebraska was developed to meet these goals in a day and a half workshop. The agenda, developed in collaboration with Jim Harvey, Quality Improvement Coordinator for Nebraska's Department for Health and Human Services, Division of Behavioral Health, sought to highlight the excellent research and diversion work that is being provided in the state and the gaps in services that need to be filled. PRA provided background information on the scope of the problem, highlighted some of the best-practice programs in the nation, and conducted a series of group process workshops to elicit specific information on Nebraska's issues for people with mental illness who enter the criminal justice system. The goal of the group process was to determine the strengths of the current service delivery system and then determine the gaps in those resources as it relates to increasing diversion opportunities. The fifty-nine attendees invited included representation across the state from the following stakeholders: Legislature, The Division of Behavioral Health, Division of Children and Family Services, Protection and Safety Administrators, Nebraska Homeless Assistance Program, The Department of Correctional Services, The Community Correction Council, The Office of Probation Administration, The Crime Commission and The Department of Vocational Rehabilitation, the National Alliance on Mental Illness and consumer representatives from each region.

The following is a review of the agenda for the Strategic Analysis Workshop. Please see **Attachment 1** for a copy of the full agenda.

# Nebraska Strategic Analysis Workshop

## Agenda Day One

On December 5, 2007, the Strategic Analysis Workshop provided an overview of the scope of the problem for people with mental illness in the criminal justice system in Nebraska and nationwide. Opening remarks were made by Robert Houston, Director, NE Department of Correctional Services and Scot Adams, Ph.D., Director of the Division of Behavioral Health in the Department of Health and Human Services. The PRA consultants provided an overview of national research and Nebraska data. The “Sequential Intercept Model” was used to explain the path people with mental illness take through the criminal justice system and to highlight best practice programs. Presentations were made by Nebraskan researchers and program administrators who are addressing issues in this field. They included:

- Shinobu Watanabe-Galloway, Ph.D. from the College of Public Health at the University of Nebraska Medical Center presented the preliminary findings from a data match between the Department of Correctional Services and the DHHS a part of an ongoing assessment of mental health needs in DOCS.
- Deb Minardi, from the Office of Probation Administration presented an overview of the standardized model of substance abusing offenders, which is reducing recidivism.
- Travis Parker, Director of the Behavioral Health Jail Diversion Program in Lancaster County presented on the impact of this successful diversion program in Lincoln, NE.
- John Sheehan, Director of the Douglas County Mental Health Diversion program presented on the effectiveness of aggressive outreach and case management on reducing jail time and recidivism.
- Jean Chicoine, Director of the Nebraska Homeless Assistance Program presented a fascinating cost analysis of the high utilizers of homeless emergency services. Her data indicated that providing supportive housing to persons who cycle among shelters, jails and hospitals could potentially reduce expenditures up to 71%.

A working lunch included a video and discussion about the Howie the Harp program in New York City. This program trains and supports forensic peer specialists to become competitively employed in the human services field.

The afternoon’s focus was on a group exercise, broken out by the six geographical regions, to identify each region’s strengths, gaps and priorities for addressing the needs of people with mental illness in the criminal justice system. This exercise utilized the Sequential Intercept Model and PRA’s Strategic Analysis Workbook Guide as a conceptual framework for identifying the strengths and gaps in services in each state region. Each regional group was asked to prioritize their gaps for further action planning. The day concluded with a report from each group on the strengths and gaps in their services and the priorities that were identified for further action. Please see **Attachment 2** for each region’s group report.

## Agenda Day Two

On December 6, 2007, the group convened to hear the plans for the work product from the Strategic Analysis Workshop and to further analyze the priorities that were identified in workshop day one. The group heard from Mark DeKraai about the implementation of the

Nebraska Criminal Justice-Mental Health Collaboration planning grant from the Office of Justice Programs. The participants then broke into regional groups to discuss the regional identified priorities. By utilizing an Action Planning Matrix, top priorities were given action steps along with an identified responsible party and time frames. “Quick fixes” were also identified for prompt action within each region. Quick fixes may not have been among the top priorities but were gaps or problems that regions identified that could be remedied quickly with few resources and would improve coordination or delivery of services.

Regional priorities that were determined to be state level issues were identified. These were prioritized and action steps were developed by a group of state level participants. Please see **Attachment 3** for the Action Planning Matrixes from each region and the state level group.

## Presentation Overview

Shinobu Watanabe-Galloway, Ph.D.  
Epidemiology Department, College of Public Health  
University of NE Medical Center

Dr. Watanabe-Galloway presented her findings from a follow up study on adults being discharged from the Regional Center units being downsized, along with the Regional Center short term care unit and Community Transition Program. One focus of the study was to determine if any of those discharged would interface with the Department of Corrections. By using data matches between the Department of Correctional Services (NDCS) and the Department of Health and Human Services (DHHS) data, she examined those consumers who were discharged in the 2 ½ year and a half period prior to June 30, 2007. In that time there were 1,004 consumers who entered the follow-up system. Of that group, there were 38 who had a match with the NDCS database. The data revealed that 33 or 86.8% were imprisoned at some point after discharge from the regional centers. 22 of the 38 persons matched met criteria for 3 diagnostic categories: Serious mental illness/low functioning, substance abuse related disorder and personality disorder. In addition, a significant portion had multiple offenses.

Please see **Attachment 4** for more details.

Deb Minardi  
Deputy Administrator  
Office of Probation Administration

A presentation by Deb Minardi from the Office of Probation Administration explained the operation and impact of the Standardized Model for Substance Abusing Offenders. The goals of the program, to provide substance abuse treatment and reduce recidivism, include consistent screening, assessment for risk of re-offending, coordination of information sharing between the judiciary, probation and other providers and the integration of substance abuse treatment with other offender accountability. To achieve this, the Justice Department provides screening and risk assessment components that lead to evaluations and treatment by substance abuse professionals. This leads to the integration of standardized levels of supervision and treatment in the disposition or sentencing phase utilized by Judges, justice agencies and behavioral health. Over 500-600 providers have been trained and are registered to provide the screening, which requires extensive training and continuing education. The standardized reporting format is ensuring consistency across the state. As Deb reported, “the standardized model is about making a connection between reducing recidivism, treatment and public safety.”

Please see **Attachment 5** for more details.

Travis Parker, M.S., L.M.H.P., C.P.C.  
Program Director, Behavioral Health Jail Diversion Program of Lancaster County, Community Mental Health Center of Lancaster County

The Behavioral Health Jail Diversion Program in Lancaster County was the first of its kind in the state and has been a model for other Counties and for the state of Iowa. This program seeks to divert from jail 60-75 persons a year with severe and persistent mental illness (SPMI) and co-occurring substance abuse disorders who have misdemeanors or felony level offenses. The program involves identification of appropriate candidates in jail, engaging them in a treatment program that is approved by the courts and attorneys, and maintaining them in needed services through a Forensic Intensive Case Manager. The outcome data looks good. This program was funded through grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) Targeted Capacity Expansion Jail Diversion Grant (TCE). At this time, there is no sustainable funding for this program. Today, the program is funded through a combination of Lancaster County funds and a grant from the Bureau of Justice Assistance (BJA), US Department of Justice ending June 30, 2009.

Please see **Attachment 6** for more details.

John Sheehan

Douglas County Mental Health Diversion Program  
Douglas County Mental Health Center, Omaha, Nebraska

The Douglas County Mental Health Diversion Program in Omaha, Nebraska was established in April 2006 supported by funding from the Alegent Health Community Benefit Trust (a local non-profit agency). Approximately \$216,000 was provided for each of three years to fund three staff members and associated costs. This post-booking program diverts some persons with mental illness, who are arrested from the traditional justice system into intensive case management services designed to help them establish independent living skills, manage their mental illness and reduce their contacts with the criminal justice system. The first 18 months have seen 52 total participants with 41 successfully completing the program. Consumer, prosecutor, defender, mental health provider, and judge must all concur with the diversion decision and each client spends 6-9 months in the program. An advisory committee of community-wide agencies was established and meets regularly to provide advice on program management. The program is being evaluated by the University of Nebraska Medical Center to determine cost-effectiveness and document changes in the use of emergency services and incarcerations by participants. Ten of 11 objectives established for the program have been achieved—most with far more positive results than expected.

Please see **Attachment 7** for more details.

Jean Chicoine.

NE Homeless Assistance Program Specialist

Jean Chicoine, NE Homeless Assistance Program Specialist, presented the results of a one year study, conducted by Lincoln's Continuum of Care, Long-Term & Discharge Planning Committee on high utilizers of emergency services for homeless people in Nebraska. This cost analysis revealed some startling results. The twenty-seven highest utilizers of Nebraska's array of emergency services for those that are homeless cost \$25,943 per person. If these people had been provided with supportive housing the expense per person would have been \$7,344, for a savings of \$18,599 or a 71.7% reduction. For the twenty-seven people studied, that would have been an annual savings of \$502,173.

Please see **Attachment 8** for more details.

# Policy Research Associates Presentation

Dan Abreu, MS, CRC, LMHC and Connie Milligan, MSW, LCSW

## Introduction

The increase in the number of persons with mental illness in the criminal justice system is well documented. Since the late 1960's when deinstitutionalization began, the community criminal justice system and behavioral health and social services agencies have sought to develop appropriate responses and interventions to effectively provide for a life of recovery in the community. But the reality is that service delivery systems have not been able to adequately meet all needs and some people are spending more time in jail and prison rather than community treatment. This trans-institutionalization takes place against a backdrop of "get tough on crime" and the "war on drugs" legislation and policies, along with the underfunding of many states' community mental health services and a continuing push to reduce state inpatient psychiatric bed capacity. In addition, headlines of violent crime involving persons with mental illness increased suspiciousness and fear of justice-involved persons with mental illness.

## Prevalence

Various studies place the prevalence rates of persons with mental illness in the justice system from 8% to over 50%. Discussion of these rates is important to better understand the target population and develop targeted strategies for intervention. In September, 2006 the Bureau of Justice Statistics (BJS) issued a report based on self report to a questionnaire listing a number of mental health symptoms, e.g. "have persistent anger or irritability" (BJS, 2006). If a respondent answered yes to any of the symptoms then the respondent was considered to have "a mental health problem". The positive response rate was over 60%. In 1999 the BJS issued another report on mental health prevalence. This time the self report survey asked, "have you ever had treatment for an emotional condition" or "have you ever had an overnight stay in a mental hospital?" This survey reported a prevalence rate of 16% (BJS, 1999). In 2002, Linda Teplin, studying inmates held in the booking area of Cook County Jail in Chicago, found a 12% prevalence of serious mental illness in women and 6.4% prevalence for men, using the Structured Interview for DSM Disorders (SCID) (Teplin, 2002). The Teplin research is regarded by GAINS as the most rigorous study of prevalence for SMI. The 1999 BJS survey reporting 16 % prevalence for any mental illness represents a fair estimate of prevalence when compared to statistical reports reviewed from individual states.

## Impetus for Change

There is an impetus for change, however, developing across the country. Many states, as a result of jail and prison overcrowding, have begun to develop strategies to develop diversion strategies and improve reentry programs to reduce recidivism. (CSG, 2002). Throughout the nation, newspaper headlines report on inadequate jail mental health services and care ("Mentally Ill in Jail Too Long, Lawsuit Charges" Austin American Statesman, 2/15/07; "Officials Clash Over Mentally Ill in Florida Jails" New York Times, 11/15/06; "State Standoff on Mentally Ill" Denver Post, 12/5/06; "Legal Limbo" the Seattle Stranger, 12/14/06; "Locked in Suffering" Kentucky Courier-Journal Feb 2002). Lawsuits challenging adequacy of care in jails and lack of discharge planning services have also begun to emerge. (Brad H v. New York City)

Funding initiatives for diversion and intervention have developed in several agencies. The Federal government is providing grant funding through BJA and SAMHSA to stimulate development of diversion programs and other programs for justice involved person with co-occurring disorders. The National Association of Counties (NACo) is also providing grant funding for counties to plan, develop or improve diversion programs. The National Alliance on Mental Illness has stimulated development of Police Crisis Intervention Teams in communities around the country. Lastly, states seem to have reached incarceration saturation. In addition to prison and jail overcrowding issues, states are beginning to question over-reliance on incarceration and are bolstered by emerging research on the effectiveness of diversion programs and reentry programs

## Population Characteristics

To intervene effectively, it is important to understand the characteristics of the population:

- Over 70% will have a co-occurring disorder, diagnosed with both a mental illness and substance abuse or substance dependence disorder. (Abram, K.M. and Teplin, L.A, 1991).
- Over 90% of the men and women with mental illness participating in a jail diversion program, will have a lifetime experience of trauma and over 50% of men and women report an episode of trauma within the year prior to arrest (unpublished TAPA evaluation data).
- Rates of homelessness and unemployment are higher for inmates with mental illness. (BJS, 1999).
- At time of arrest many persons with co-occurring disorder have not received any treatment in the year prior to arrest and it is unlikely that they have received integrated mental health substance abuse treatment.  
(<http://oas.samhsa.gov/NSDUH/2k5NSDUH/2k5results.htm#8.1.4>)

As a result of the multiple needs of the population, the fragmented systems of care and poor access to care, persons with co-occurring disorders tend to cycle from the streets, various treatment services, to shelters and to jail. A New York cost study (Culhane, Metraux, and Hadley, 2001) documented that it costs approximately \$36,000 a year for someone who cycles through various service providers, shelters, jails and prisons. A study by the Nebraska Coalition of Homelessness estimates that it costs \$7,443 (see **Attachment 8**) a year to house someone in a supportive housing bed, yet Nebraska, like most states, has a shortage of community residential beds. In other words, it costs more not to provide someone with coordinated and effective services.

Women have unique needs and it is important that programs and services be trauma informed and gender specific. For example, 74% of the women in NYS prisons report having 1 or more children (NYS, DOCS, 2005). New Hampshire passed legislation establishing the position of an administrator of women offenders and family services within the department of corrections and establishing an interagency coordinating council on women offenders (NH Senate Bill 262). In Nebraska, 56% of the women have an institutional length of stay of 18 months or less and 70% are released in 2 years or less. With the short LOS it is important to plan for reentry upon admission. In addition, the rate of prison incarceration for women is growing faster than for men. (NE DOCS, 2006). With the increase in female admissions it is important to examine female treatment and reentry issues.

A BJS report indicates that there were 140,000 veterans in state and federal prisons in 2003. Afghan and Iraqi war veterans accounted for 3.4% of the total number of veterans, up from 1.9% two years earlier (BJS, 2007). Levels of trauma, and post traumatic stress disorder in Afghan/Iraqi war veterans have been well documented in news headlines. In order to promptly and effectively engage veterans into service, it is important to establish screening methods so that Afghan/Iraqi war veterans can be identified and referred for institutional services and community services upon release. Collaboration with the Veterans Administration and veterans groups is essential.

## Sequential Intercept Model

People with mental illness, who come in contact with the criminal justice system, cycle through it in predictable ways. A visual and conceptual model of this process has been developed by Patricia A. Griffin Ph.D. and Mark Munetz M.D. (2006). The Sequential Intercept Model highlights the concept that at any juncture in the criminal justice system there is opportunity to “intercept” with diversion. The use of this model is helpful to identify the points of intervention where people can access treatment services so jail or prison can be avoided or diverted. (See **Attachment 9**)

The tasks of diversion are common, regardless of the entity providing the service. It involves knowing who is eligible for the service, screening and assessing their needs, engaging them in a services plan, negotiating the terms of services and linking them to those services. The ability to link with service and reduce recidivism back into the criminal justice system is the ultimate, universal outcome.

The Sequential Intercept Model provides a template for discussion and exploration of the innovative work that is being done across the country to provide diversion. Each intercept involves different community agencies that have a significant role in identifying people with mental illness and linking to them to services designed specifically to respond to their identified needs. It is important to note, justice agencies whose primary role has little to do with the treatment of mental illness now are addressing the needs of people whose symptoms are not stable. Heroic efforts are seen at every juncture.

This workshop provided a review of the intercepts and the types of diversion and services that can be provided. Several examples of model programs already exist in Nebraska. The following review of each intercept includes a notation of those that are currently in operation in Nebraska.

### INTERCEPT 1 --- Community and Law Enforcement

People with mental illness, who are not stabilized by the treatment offerings of their community, often have their first contact with the justice system through law enforcement personnel. Police departments across the country are forced to address the issues of people with mental illness because they are usually the first line of intervention. Not only are they called if someone becomes dangerous to others, they are also the identified point of intervention when a person is dangerous to themselves. Most state civil commitment procedures involve the use of police and sheriff officers to seek, secure and transport people to a safe location for further assessment and evaluation for services. It is within this context that people can be taken to jail if their behavior is aggressive, there is no other safe place or

they are involved in criminal behavior. It is no surprise that some of the first innovative diversion work was developed by police officers trying to provide a better public service.

The Police Crisis Intervention Team (CIT) concept was developed by Major Sam Cochran of the Memphis Police Department. His intent was to provide training (40 hours) on symptoms of mental illness and local community resources so officers would be able to provide options other than jail for people in crisis. Police departments across the nation have been implementing this successful program because it provides needed information and resources. Officers are more quickly able to identify a person with mental illness and link them to services, thus avoiding and reducing jail time. The most successful programs hand-off an identified person to local treatment providers who are located at emergency rooms or triage centers. Diversion at this intercept can offer tremendous cost savings or cost offset to a community by reducing the time of officers' involvement and reducing use of jail and court resources. Nebraska has one CIT program in Omaha.

Another development along with CIT has been the use of mental health professionals to work side by side or within police departments. When police officers have this resource, it often ensures that the outcome for the individual will include services, not jail. In Framingham, MA clinicians are based at the police headquarters and respond telephonically to requests for assistance. In Nebraska, in Region 1, the mental health crisis line is frequently used in this manner.

Mental Health Crisis Lines and mobile crisis response teams (CRT) have developed excellent capacity to respond to individuals in distress who have been identified by police officers. Across Nebraska, there is evidence that CRT works hand in glove to provide services to people who have been brought to emergency rooms for evaluations by police officers. When indicated, this allows a person to receive mental health treatment, through emergency services or civil commitment, rather than through court involvement.

## INTERCEPT 2 --- Initial Detention and Initial Court Hearing

The next point of interception involves diversion options that are offered after arrest. This can include services that are organized in jails, within the initial court hearing process and by outside entities that work with all the service providers that interface at this juncture. Despite communities' efforts to keep people in treatment or to divert them from jail through an interface between law enforcement and mental health, people continue to be arrested in high numbers, often with low level charges.

Jails and prisons have been called the "new asylums" and thus have become the unintended champions of diversion because of the influx of people with mental illness in their facilities. (PBS special "The New Asylums" 2005) This trend has serious consequences for all involved. Individuals with mental illness experience untold suffering, suicide rates in jails have escalated, (A. Ivanoff and L. Hayes, 2002) and local and state municipalities have had negative outcomes in law suits based on jails being "deliberately indifferent" to inmate needs.

Studies on the suicide rates in jails are alarming. According to Lindsay Hayes, Project Director of the National Center on Institutions and Alternatives and national expert on jail suicide, the rate in jails has been nine times higher than in the general population (L. Hayes and E. Blaauw 2002). This rate has gone down in recent years to several times higher with the implementation of good screening and follow-up procedures (L. Hayes, 2005). Nevertheless, a 2002 study of suicide in US jails, conducted by the Bureau of Justice, shows that small jails with under 50 beds have a suicide rate of 155 per 100,000 inmates, as opposed to 32 per 100,000 in jails with over 1,500 beds (BJS, 2005). The implication of this is sobering. In rural areas, where resources are scarce, people with mental illness in detention often experience inappropriate or inadequate care with terrible outcomes.

When an individual is brought to jail, the jail becomes the responsible party with constitutional mandates to provide safe, secure and reasonable treatment. Jails ensure that services are structured around a person's needs by providing a screening of risk and needs during the booking process. When a person flags with mental health problems or suicidal thinking there is typically follow-up to manage the risk and to organize an appropriate mental health or medical response. In rural areas, this can be difficult to organize in a timely manner and at best is done by medical staff who have limited involvement with the facility.

In Kentucky, the high rate of suicide in their mostly rural jails, prompted a newspaper exposé aptly entitled "Locked In Suffering" (J. Adams, Courier Journal, 2002). The legislature responded to this report by funding four hours of mental health training. This training was well received, but Jail Administrators indicated that mental health services were the essential need. This prompted the development of a statewide 800 line Telephonic Triage program to assess and respond to mental health risk. This program, The Mental Health Crisis Network, which is funded through legislative action with a five dollar increase in court cost, is providing a network of services through the Community Mental Health Centers of the state. It includes four components: 1) screening instruments for the arresting officer and jail booking officer 2) telephonic triage by a Licensed Mental Health Professional of people who flag with mental health risk factors 3) follow up jail management protocols that corresponds to the level of risk to keep the person safe and secure and 4) face to face follow up services by the local Mental Health Center for people who are high risk.

The Mental Health Crisis Network has made significant impact after three years of implementation and over 28,000 services. There has been an 84% reduction in the suicide rate and 14% of people have been identified for diversion. Diversion takes place when the mental health professional provides face to face services, files petitions for a person to be placed in a hospital or works with the attorney and judge to have charges dropped and the person released. Other professionals, including Judges, pretrial officials, attorneys, hospitals and substance abuse treatment facilities are using the information to assist people in diversion from jail. This "handshake between jails and mental health" has prompted cross training across both systems of care so that the delivery of services is more fluid and consumer sensitive. (C. Milligan and R. Sabbatine, 2006 and publication expected in *American Jails*, Jan. 08)

There are other model programs that offer diversion at this intercept. They include programs that provide mental health workers in the courts to identify screen and refer people for services during the initial court hearing. The mental health staff can be employed either by the court or by the local mental health system and in some cases, funding is used by both parties to provide this service.

The Jail Diversion program that operates in Lincoln, Nebraska is a good example. Here mental health workers, employed by the Community Mental Health Center of Lancaster County, work with the courts to offer diversion. The point of entry into the program can come from defense attorneys, judges, or prosecuting attorneys, who make recommendations for referral into the program. The individual is offered treatment options as a condition of release during the Court's initial arraignment hearing. Release conditions are in effect as long as the person is attending the treatment program. The outcomes of this program have been excellent, with reduced recidivism and renewed involvement in treatment. This program is an example of diversion that could easily be replicated throughout the state.

### INTERCEPT 3 --- Courts and Jails

When diversion has not been possible through law enforcement referral or a post arrest diversion at the initial court hearing, the courts and the jails get involved. The jails have had to develop a number of treatment options to provide safe and secure housing, while the courts have initiated mental health dockets, or problem solving courts that attempt to use the leverage of the court to address the needs of people with mental illness.

Across the nation, jails are being trained to provide a system of classification, offered through the National Institute of Corrections, to identify people's risk and needs so that the appropriate housing and services can be provided. (<http://www.nicic.org/Features/Training/>) A good classification system in a jail can reduce the suffering for people with mental illness and can link people to good quality treatment during incarceration so re-entry to the community is less debilitating. While some of the Nebraska jails are offering this, there is wide variability in access to treatment. Some regions are able to access services from the local mental health centers, others are not and have contracts with local providers or offer limited services through their medical provider.

In facilities across the nation, access to medications is limited in jails, which can exacerbate the symptoms of a person with mental illness. This trend is related to restrictions in access to medication by jail administrative policies, by lack of medical providers and of course, the escalating costs of medications. Not surprisingly, this was noted as a problem in Nebraska jails.

Mental Health Courts can provide sanctions, both positive and negative, as incentives to connect people with mental illness to treatment providers and programs. According to the National GAINS Center, there are currently around 130 courts that offer this service. The research on mental health courts has been variable. Early studies suggest that non-punitive approaches and non-coercive sanctions are preferred by mental health courts, but further research on the effectiveness of these approaches is needed. (Griffin, Steadman, Petrila, 2002). A recent study of the Mental Health Court in Allegheny County, PA has shown that this strategy can be effective when there are good linkages with local mental health providers and services. (Rand Corporation, 2007.)

An option for both courts and jails is the use of data connectivity to identify a person with mental illness and link them to their current or past treatment provider. While there appear to be many barriers to sharing information, several states have enacted legislative mandates to ensure it happens. This is being successfully done in Texas and in Connecticut. In a GAINS Center brief by John Petrila, JD, "Dispelling the Myths about Information Sharing between the

Mental Health and Criminal Justice Systems” the feasibility of additional information sharing between mental health and criminal justice is described. (GAINS Center, February, 2007)

#### INTERCEPT 4 --- Reentry

Reentry planning is the least practiced service in jails and prisons (Steadman and Veysey, 1997). Recent research and events have highlighted the importance of reentry planning. Is it too dramatic to say that reentry planning is a matter of life and death? A study of 30,237 inmates released from Washington state prisons, found that the mortality rates were 3.5 times higher than the general population and 12.7 times higher within the first two weeks of release. (New England Journal of Medicine, 2007). This study highlights the importance of good reentry planning especially with a population (persons with SMI), that has a mortality rate 4.9% higher than the general population. (“Morbidity and Mortality in People with Serious Mental Illness”, NASMHPD, 2006)

Is there a right to reentry planning? In 2002, *Brad H v. City of New York*, a class action, was filed by 5 inmates released from Riker’s Island Jail in NYC alleging that the City violated state mental hygiene law and NYS Office of Mental Health regulations in releasing inmates with mental illness from jail without discharge planning services. In July of 2000, the NYS Supreme Court ordered NYC to provide adequate discharge planning for the class and a settlement agreement was signed April 2, 2003 mandating treatment referrals, sufficient medication upon release and access to entitlements.

Stigma is a significant factor in reentry planning. In New York, agency cross training was a significant factor in reducing stigma and improving access to community services. The strategy with the most impact in reducing stigma, however, was the involvement of forensic peer specialists both as trainers and service providers working in reentry and community programs.

There are other barriers to effective reentry planning, requiring collaboration among many community and state agencies. In most communities, Medicaid is terminated after 30 days of incarceration. As a result, persons are not eligible for Medicaid upon release, making it difficult to obtain community treatment services and pay for needed medication. Housing beds are in short supply. Transition case management services are not available and existing case management services are not funded to engage consumers prior to release to insure a smooth community transition. Under-funded community services lack capacity to respond in a timely way to recently released consumers resulting in delays of several weeks to obtain appointments with psychiatrists so that medications can be continued. Many jails and prison lack the service capacity to provide reentry services. Lastly, perceived obstacles to sharing of information can also be a barrier to effective reentry planning.

While these barriers are significant, states and communities have begun to develop strategies to insure continuity of care upon release. New York recently passed legislation which requires that Medicaid be suspended, not terminated, upon incarceration. New York enacted in 1999 a Medicaid Grant Program (MGP) for jail and prison releases. The MGP program provides insurance coverage upon release until a Medicaid determination is made. In 2007 Alaska passed APIC legislation which requires state and local collaboration around reentry planning and provides transition funds for persons with SMI to provide transportation back to the home community, fund treatment services until Medicaid is restored, pay for medications etc. Texas

changed legislation to allow information sharing among criminal justice and behavioral health agencies.

The GAINS Center developed the APIC (Assess, Plan, Identify, Coordinate) model to assist communities in developing a planning model for reentry. The model identifies ten service domains to consider when developing reentry plans. A reentry checklist form was also developed to be used for reentry referrals. (see **Attachment 10**)

#### INTERCEPT 5 --- Probation/Parole

In Nebraska, there are about 2 ½ times as many persons on probation and parole as there are in jail and prison (BJS, 2006; NE DOCS, 2006). Typically probation and parole agencies have a difficult time accessing mental health services. Many probation and parole agencies have developed dedicated mental health caseloads characterized by smaller caseloads and trained officers.

Due to under funded community service systems, some probation and parole agencies are funding mental health services, thereby developing a parallel treatment system or funding treatment slots with existing providers. The quality of mental health services for probation and parolees is also an issue. In 2005 and 2006, the GAINS Center conducted a series of Expert Panels on mental health Evidence Based Practices (EBP's) and how those practices are utilized with justice involved population. In summary, with the exception of Forensic Assertive Community Treatment (FACT) and Forensic Intensive Case Management (FICM), there is little research on use of EBP's with justice involved persons with mental illness. FACT and FICM are equally effective with this population. Since FICM is a less expensive intervention, FACT should be reserved for persons with the highest need and lowest level of functioning. In addition, some states and communities are including cognitive behavioral treatment interventions to the service package to address criminal behaviors. Promising practices include the use of Forensic Peer Specialists to work with the reentry population.

## Regional Group Breakout – Day One

After the morning presentations, the participants from across the state spent the afternoon session meeting in regional groups. They were given a structured task to explore their areas' strengths, gaps in services and opportunities for change to address the needs of people with mental illness in the criminal justice system. They prioritized their top three issues that they want to target for change. Each group was also encouraged to identify those things that could be a quick fix, meaning it did not need additional funding or action at the state level to accomplish the change.

A few groups commented that they did not have full representation from the various interest groups with investment in the issues of people with mental illness in the criminal justice system. As a consequence, it was noted that the regional group reports may not provide a comprehensive perspective on the resources and gaps in services. The dialog in each region, though, did generate interest in developing regional planning groups that would meet to continue the discussion and planning that was initiated in the workshops.

## Summary of Highlights of Regional Group Work

Each region's strengths and gaps have been selected, summarized and grouped around the Sequential Intercepts from the region's flip chart notes. A listing of priority issues and quick fixes for each region is also included. For a comprehensive listing of each region's notes, please see **Attachment 2**.

## Region I:

### Strengths

- Intercept I: The interface between mental health and law enforcement includes cross training, Crisis Response Teams that interact with law enforcement, good communication, regular meetings, and sharing of mental health records when requested. WRAP training is given to police and consumers.
- Intercept II: Post arrest mental health screening is available when someone enters jail
- Intercept III: In detention facilities, mental health and substance abuse treatment is available in Scottsbluff; substance abuse treatment is available in Kimball and Cheyenne Co. There is drug court, family court and DWI court available.
- Intercept IV: The jails have some strong pre-release planning programs that provide referrals to community agencies, with linkages to treatment providers that ensure continuity of care.
- Intercept V: Behavioral Health and Probation have combined treatment meetings on shared clients with client specific sanction programs that help reduce probation revocation.
- There is a criminal justice voucher program.

### Gaps

- Intercept I: Law enforcement officers need ongoing training, Sydney lacks enough LCRT personnel, there is a need for more trained officers especially to assist with transport and there is a lack of information when consumers re-enter the system.
- Intercept II: There are no post-arrest jail diversion programs and attorneys need training on behavioral health issues.
- Intercept III: In jail, there is a lack of standardized screening instruments and funding for treatment service. Treatment in jail is not consistently available across the region.
- Intercept IV: At release there is limited access to ECS prior to release, no access to SSI/SSDI benefits, and a lack of communication from prison to reentry into community.
- Intercept V: Once in the community, there is limited access to medications, legal follow-up, housing, peer support and limited employment options.

### PRIORITIES

1. Provide access to peer support prior to release from incarceration.
2. Provide greater access to medication.
3. Develop a jail diversion program.

### QUICK FIXES

1. ECS contact prior to release from incarceration
2. Provide standardized screening instruments for post-booking at the jail.

### POLICY/LEGISLATIVE RECOMMENDATIONS

1. Reinstate rather than reapply for Medicaid at the time of release from incarceration

## Region II

### Strengths

- Intercept I and II: Funding of the Emergency Support Program (LB 108) has enhanced the relationship between behavioral health and law enforcement. There is a separate behavioral health crisis line and one for justice that has 24 hour triage. This provides support in the community and on-site response for the jails.
- Intercept II and IV: There is a Drug Court, a Reporting Center, the Great Plains Center and Homeless shelters that all provide support to people with mental illness that interface with the criminal justice system.
- Excellent cross system relationships were noted that foster good collaboration and planning.

### Gaps

- Intercept I: There is a lack of behavioral health training for law enforcement, limited detox beds and limited medication availability and monitoring.
- Intercept II and III: The jails have limited access to medication and treatment.
- Intercept IV: There is a lack of screening at homeless shelters.
- Across the system: There are people who repeatedly cycle through all the systems of care, highlighting the need for cross system data matching and communication.
- Forensic Peer Specialists could be used at every juncture.

### PRIORITIES

1. Detox services are needed.
2. Law enforcement needs standard training (expanded from local models) in MH and substance abuse identification and intervention.
3. Curriculum and funding (state assistance) for jail and officers – local can do much of this.
4. Increase knowledge of available resources and develop creative use of resources by justice system players.
5. Need to address compliance and monitoring the needs of highly involved, repeat justice/behavioral health customers, e.g. specialty supervision units or expertise available on the local level.

### QUICK FIXES

1. Peer involvement (need state support)
2. Law enforcement training can be done at local level (and has been done)
3. Justice system players – outreach can be made locally
4. Local jail screening instrument can be introduced

## Region III

### Strengths

- Intercept I: Emergency System Specialist is a resource and the mental health's Crisis Response Teams interface well with law enforcement. Relationships are collaborative, there is phone and face to face evaluation service availability and there is cross training across systems.
- Intercept II and III: There are Substance Abuse/Drug Courts in four counties.
- Intercept IV; Targeted funding provides rapid access to treatment for people in the justice system. Judges understand people's treatment needs and jail and emergency community support workers collaborate on treatment plans.
- Intercept V: For people re-entering the community from incarceration there is housing, supportive employment services, and collaborative relationships between probation and service providers. In addition there is some medication assistance and specialized SA service officers.

### Gaps

- There is a demand for services that exceeds the region's capacity to provide. This includes problems with appropriate outpatient treatment services, medication management and intensive outpatient services.
- While there are good emergency response services and law enforcement training, comments noted that these appear "to be underutilized with limited receptivity to collaboration and change".
- There are gaps in information sharing across the system.
- There is limited access to entitlements, reentry and medications.

### PRIORITIES

1. Develop and implement reentry system (Intercept 4)
2. Funding to meet service needs
3. Sharing of information among all systems
4. Access to meds/develop med program

### QUICK FIXES

1. Implement screenings throughout model and provide training for screening
2. Collaboration with judges/system similar to work with juveniles that's been in place
3. Identify Judge training and provide it in their annual training
4. Law enforcement training
5. Work regarding discharges

In addition, Region Three participants listed possible legislative action, policy needs and program collaboration that would enhance services to this population. Please see the write up in **Attachment 2** for their full report.

## Region IV

### Strengths:

- Intercept I: Crisis Response Teams throughout the region include training of law enforcement and good community support.
- Intercept II: There is a mental health contact person for each jail and in some jails medications are provided.
- Intercept III: Judges are knowledgeable about the needs of this population and order mental health and substance abuse evaluations as needed. Drug Court and Family Courts are available.
- Intercept IV: Eligibility determination for Medicaid/Medicare is done prior to a person's release from incarceration and transition planning is done from state correctional facilities. There is good case planning for probation.

### Gaps

- Intercept I: There is inconsistent use of Crisis Response Teams, transportation issues, inconsistent communication, lack of cross training and in general the use of jails as a human services agency.
- Intercept II: In the jails there is a lack of consistent screening and intervention, limited collaboration and a lack of diversion opportunities. Jails lack psychological services, medications and individualized program.
- Intercept III: In court there is inconsistent sentencing, based on the court's knowledge of a person. There is little collaboration with the four Native American tribes in this region.
- Intercept IV: At re-entry, there is a lack of transition planning including obtaining eligibility for SSI/SSDI and medication. There is not a cross-walk of identification between mental health and probation and parole so collaboration on treatment can be done and limited follow up for support and treatment services.

### PRIORITIES

1. Develop mental health and substance abuse treatment accessibility for persons who are incarcerated.
2. Develop transition planning for re-entry (to include services, meds, et al.).
3. Develop consistency and use of CRT across the region(s).

## Region V

### Strengths

- Intercept I: Crisis Response Teams cover the sixteen counties; there is case management support, and an 800 number that is utilized by police departments for mental health information and access to treatment beds.
- Intercept II: The Lancaster County Jail Diversion Program provides post arrest diversion. There are community meetings and education of Judges.
- Intercept III: There are drug and family court and pretrial release programs within community corrections.
- Intercept IV: DCS offers programs that help people who are re-entering the community which are offered along with mental health and substance abuse treatment.
- Intercept V: Probation and parole provides substance abuse supervision, a voucher program, reporting centers that offer employment and life skill training classes, behavioral health services and specialized parole officer training in the Lincoln area. The state Community Corrections Council is seen as a resource to help solve some of the identified gaps in services.

### Gaps

- Intercept I: Law enforcement personnel lack transportation for the EPC, with a 200% over capacity in the CSH. Local mental health programs are under-funded and at or beyond capacity. The rural programs lack understanding of behavioral health emergencies. There are information transfer gaps across the system.
- Intercept II and III: Programs that do exist in jail do not have sustainable funding and limited capacities. There is limited transportation for work release, limited housing and voucher availability.
- Intercept IV: There is no discharge planning in the region's jails which creates disconnects in obtaining eligibility for Medicaid/Medicare.
- Intercept V: Overall there is a lack of funding for services, which includes treatment, housing, supportive employment and discharge medications. The community corrections council only provides services for felony offenders.

### PRIORITIES

1. Information should follow a person through all 5 intercepts – Regional Health Information Organization System.
2. Missing a Targeted Adult Services Coordination Program for Lincoln Police Department Housing – Supported Housing for probationers/parolees.
3. Sustainable funding for jail diversion.

## Region VI

### Strengths

- Intercept I: The services include a CIT team within the Omaha police department with interface with a Crisis Response Team.
- Intercept II: Within the jails, there are screening for mental illness and screening for the Diversion Program in addition to vocational rehabilitation in house.
- Intercept III: There are mental health courts, existing diversion programs and interagency collaboration.
- Intercept IV and V: There is a day reporting location that offers services for people on probation. A management information system is integrated. Probation has specialized case loads.
- There is good consumer involvement and support from NAMI especially for the diversion programs and for the WRAP program.

### Gaps

- Intercept I: Law enforcement lacks transportation. There are issues with safe keeper evaluator capacity, information gaps between agencies and the communities' lack of understanding of the emergency system.
- Intercept II: The lack of sustainable funding for the Jail Diversion program is a problem that could have great consequences soon, and this service is not available in other parts of the state.
- Intercept III: Within the jails, there is limited substance abuse or mental health treatment and transportation to work release. There are also limited specialty courts.
- Intercept V: When a person leaves jail, there are no discharge planners, SSI/SSDI benefits are terminated and not promptly reinstated; and there is lack of sex offender treatment, and employment training.
- Intercept VI: Probation and parole also has limited funding for housing, treatment resources and supportive employment. People have limited access to medication upon release and there is a shortage of psychiatric care.

### PRIORITIES

1. Improve housing for people with mental illness involved in justice.
2. Improve access to medication.

### QUICK FIXES

1. Look at expanding existing Transitional Team at R6 to include pretrial, children and family services (children and family services use MOU if need be).
2. Discuss Medicaid coverage issue with Medicaid.
3. Each system should document its resources/services and share.

## Workshop Day Two Summary

The focus of the second day of the Strategic Planning Workshop was on the development of an **Action Plan** for each of the region's top three priorities. The workshop participants worked in their regional groups to analyze the priorities for change that had been identified the day before. Utilizing an Action Planning Matrix supplied by PRA, the regional groups identified the steps to accomplish the identified priorities for change, and then identified who would be responsible for taking the action and a time frame for accomplishing the task. Each group's completed Action Matrix is included in **Attachment 3**.

### Summary of Regional Priorities for Action Planning

Across the state, there are a number of similar issues that were identified as priorities for action and change. While the voting process made the ranking of the top three priorities different, they were identified in each region as a gap in service or as a priority for change. The following shows the voting and ranking of those top three priorities.

a) Priority issues identified by **three regions**:

- Information sharing: A seamless mechanism for sharing information and enhancing communication needs to be developed for those clients that move through multiple service delivery system. (Region 3, 5 and the state group)
- Re-entry: Create mechanisms to enhance and coordinate an individual's reentry and connection back to the community. (Region 3, 4 and the state group)
- Medications: People need access to medication during incarceration and after re-entry to prevent relapse. (Region 1, 3 and 6)

b) Priority issues identified by **two regions**:

- Screening Instruments: Jails need consistent screening instruments that will assist in the identification of risk and need related to mental illness and substance abuse (Regions 1 and 2)
- Jail Diversion: Jail Diversion programs need to be funded. The successful one in Lancaster County needs sustainable funding and could be a model for possible expansion to other regions. The Behavioral Health Jail Diversion Program in Douglas County is another highly successful model that could be replicated. ( Regions 5 and 3)
- Housing: Affordable housing needs to be funded ( Region 5 and 6)

3. Priority issues identified by **one region**:

- Forensic Peer Support: Forensic Peer Support is a highly successful model that needs to be developed ( Region 1).
- Training for Jail Staff: Standardized mental health training for jail officers needs to be developed ( Region 2).
- In-Custody Treatment: Mental Health and substance abuse treatment needs to be developed and offered to people in custody ( Region 4).

The action steps that were identified to accomplish these priority issues can be found in the **Action Planning Matrix** completed by each region. See **Attachment 3**.

## Summary: Conclusions and Recommendations

PRA would like to offer the following observations and recommendations based on the strengths of Nebraska's current system, the gaps that were identified and the priorities for change.

The participants in the Nebraska Strategic Analysis Workshop exhibited a great interest and commitment to the issues facing people with mental illness who interface with the criminal justice system. They were able to quickly work collaboratively, despite, as was evidenced in several regions, people were meeting each other for the first time. This degree of interest and spirit of collaboration can be harnessed to generate significant change. The ideas that were developed in the Action Planning Matrix are excellent. These regional groups will hopefully continue to address the priority issues and quick fixes that were identified. It is with this background that PRA makes the following recommendations for your consideration.

### Summary of Recommendations

1. Enhance the Emergency Management System and/or Local Crisis Response Teams (LCRT) role to effectively interface with other consumer involved agencies for diversion efforts, possibly with funding to offset expanded responsibilities.

Across the state, the Emergency Management System process (through LB 108) with its interface between law enforcement and the LCRT was touted as an improved and effective system of services. The gaps in services that were identified in the regional workshops include cross training of law enforcement and jail personnel, sharing information, access to real time data about availability of crisis beds for consumers, and improving response to law enforcement when transporting consumers in crisis (See **Attachment 11** "Emergency System Process" for summary of current issues). If the Emergency Management System, the LCRT, or some designated agency is given additional authority as the coordinating body in emergency response, several of these problems could be addressed. Training could be formally developed and delivered for all concerned agencies, as it is currently being done in a few regions. The LCRT could coordinate referrals, keep daily tabs on bed availability and offer this to law enforcement through their 800 line. This would address some of the concerns expressed by law enforcement about the time it takes to find an emergency bed. With centralized referrals, the flow of information about consumers' needs could be more easily passed on to the next provider. This would be very helpful to jails and courts as well. Regional data from such a system would provide a state-wide picture of current needs and services.

2. Provide Crisis Intervention Team training for Law Enforcement officers across the state and make clear linkages with the LCRT to include expansion of LCRT where appropriate.

While CIT was cited as being helpful in Omaha, it is not available in other parts of the state and is not linked to community services. The whole community benefits when there are trained law enforcement officers who understand the signs and symptoms of mental illness and know how to make referrals and involve local community providers for the purpose of diversion. Already the good interface between law enforcement and the LCRT offers the opportunity for an enhanced and sophisticated statewide system, if officers are trained and involved in CIT. In particular, the Omaha CIT program would benefit from closer linkages to community

resources. This interface could potentially become a national “best practice” model of statewide coordinated services.

3. Expand or improve access to Crisis Stabilization beds as needed with improved coordination with law enforcement officers.

As noted in the document entitled The EPC Crisis – October 1, 2007 (See **Attachment 12**), there are current bed shortages that create problems for persons with mental illness in crisis. During the workshops, people across the state noted that finding beds is problematic when someone is in crisis. At this time, it falls on the law enforcement officials to search for a bed, which takes valuable patrol time and can be very disruptive for consumers in crisis. When there is a lack of inpatient beds, jails can become a default placement if there is a chargeable offense. It should be noted that Faith Regional Hospital in Norfolk expanded inpatient bed capacity on January 15, 2008 and Lasting Hope Recovery Center will open in April 2008. This expanded inpatient capacity should ease bed demand in neighboring regions.

PRA recommends legislative oversight that there be on going collaboration and coordination with law enforcement. Centralized coordination with the expansion of LCRT or EMS duties can ensure timely transport, effective utilization of crisis beds and the Regional Health Authority can develop a strategy to track bed availability and capacity issues. Crisis stabilization beds or crisis triage centers, are a critical component of the Memphis CIT model. The law enforcement/LCRT interface can be adapted in Nebraska to insure improved crisis response.

4. Establish a statewide committee to focus on persons with mental illness in the criminal justice system. This committee could be subsumed within the Community Corrections Council.

To enhance and coordinate regional efforts, it is recommended that a state level body or Oversight Committee be formalized and charged with specific goals to reduce consumers’ interface with the criminal justice system. Ideally, this Oversight Committee, or Commission would be legislatively mandated, include legislative representation and have representation from the highest level of relevant governmental and policy interest groups. The Oversight Committee would set goals, plan, coordinate and monitor the progress of the Regional Planning Committees so this issue receives the highest level of attention. The Texas Correctional Office on Offenders with Medical and Mental Impairments (TCOOMMI) is an example of a statewide coordinating body.

5. Each Regional Behavioral Health Authority should insure the stakeholder groups attending the workshop follow up on the actions plans they developed and establish Regional Planning Committees that report to a state level oversight committee that coordinates statewide efforts.

Regional groups, like those that met during the workshop, should be formally assembled and charged with a clear mission to further develop and work on the action steps that were identified. The regional groups should include broad representation as planned for this workshop. These groups can proceed with local efforts as outlined in each local Action Matrix. Local efforts can be reported to the state level group.

6. Increase resources to the local community mental health system to provide diversion and reentry services through the use of Forensic Intensive Case Management.

Forensic Intensive Case Management services are appropriate along the entire Sequential Intercept Model.

During the workshop, there were comments among participants that lack of resources for the community mental health system is a large problem that significantly contributes to people with mental illness entering the justice system. While this specific service recommendation was not listed as a priority by the regional groups, PRA recommends that increasing resources for community mental health services be a top priority.

Consumers have multiple services needs and personal demands upon reentry. Forensic case management is essential to help broker the multiple service systems that may be part of an individual's reentry plan. In addition, close coordination with probation and parole is required so the service and supervision is coordinated.

7. Increase capacity for jail diversion at post-arrest across the state.

There are only two post-arrest diversion options in the state, and this represents one of the significant gaps in services. The Behavioral Health Jail Diversion Program of Lancaster County is partially funded by federal grants and is a nationally recognized jail diversion program that is achieving good diversion results. (See **Attachment 6**). The Behavioral Health Jail Diversion program in Douglas County is achieving outstanding results. It has been privately funded and should be considered a model of services that could be replicated across the state (See **Attachment 7**). These programs need sustainable resources.

8. Implement standardized screening instruments in the jails that prompt referrals for services and explore increasing resources for services and medications in the jails.

Post-Custody Screening and access to services and medication during incarceration were noted as priority issues. Many of Nebraska jails are utilizing some form of screening, but it was noted that clear identification of mental health risk and needs is not consistently being done nor are there clear linkages to services. Introducing screening instruments to the jails statewide can be a "quick fix" with the use of forms that were shared in the meeting or can be obtained through the GAINS Center (See **Attachment 13**). Funding for services and for medication are recognized as more costly, long term issues. Utilizing "memorandum of agreements" for services with local providers is an option. As was presented in the meeting, there are models for statewide coordination of services through the community mental health system which can be explored. Kentucky has such a system and has also implemented a statewide pharmacy and ER benefits management program that has reduced the rate of medical expenses by millions of dollars. PRA would be happy to provide additional information on these resources.

9. Expand or increase trauma-informed care and gender-specific treatment capacity in the prisons and jails.

Incarceration creates trauma for most people, but especially for people with mental illness. In addition, many people bring a long history of trauma with them to jail. There is a new body of information on trauma that is designed specifically for justice service institutions. PRA

recommends that that the Department of Corrections review current programs and insure that new programs be gender specific and trauma informed. Jails should also review current screening, program and service practices.

The rate of an incarceration for women in Nebraska has increased dramatically and is the fastest growing population in the corrections system. PRA can provide information and training on how to be sensitive to the gender-specific needs of women.

10. Re-entry planning and services need to be systematically provided prior to release from jails and prisons.

Comprehensive reentry planning requires four components. Recommendations are listed below:

- Increase the capacity to identify and refer persons in need of reentry planning. Many jails have no or limited reentry planning services in place. Regions should survey their jails and provide training and coordination support to improve services. Prison and jail reentry staff may refer to the GAINS publication, “A Best Practice Approach to Community Reentry from Jails for Inmates with Co-occurring Disorders: The APIC Model.”
- Provide the person with access to a sufficient supply of medication upon release to last until follow-up services and additional medication can be arranged. Jails and prisons should review current policies to insure sufficient supplies of medication are available upon release. Actual medication can be dispensed to inmates or a prescription given to inmates or a combination. Since it is often difficult to obtain appointments with a psychiatrist post-release, up to a 30-day supply may be needed.
- Provide prompt access to Medicaid benefits and initiation or restoration of Social Security benefits. Medicaid benefits are crucial to obtaining medication upon release. Prescriptions given upon release cannot be filled unless Medicaid benefits are available. In addition, it is often difficult to receive mental health services without Medicaid coverage. At the local level, jails should work closely with the local Medicaid office to identify persons with existing Medicaid coverage so that coverage can be suspended rather than terminated. At the state level, the Department of Correctional Services should work with state Medicaid office to allow for application for benefits prior to release from prison. Some states (Texas, New York, Alaska) provide gap funding to pay for medications until persons are determined Medicaid eligible. During the workshop, participants questioned whether the provisions of LB 95 Section 83-380, which authorizes payment for medications when a treating physician determines that medication is necessary for the patient’s mental health, could be expanded to include persons with serious mental illness being released from jail or prison. This question merits further discussion.

11. Expand affordable housing.

There was considerable discussion during the workshop and in several regions about the importance of affordable and sustainable housing to decrease recidivism and provide the necessary supports for people with mental illness. The excellent presentation by Jean Chicoine on the “Hidden Costs of Homelessness - Lincoln NE” clearly supports this supposition. (see **Attachment 8**) The study illustrated that the cost of homelessness services exceeds that of supportive housing by 71%.

It is recommended that some of the suggestions that were developed by Regional Groups V and VI that are included in the Action Planning Matrix be explored to address this problem. Suggestions included the use of Forensic Case Managers to provide support, provide Rent-Wise education for renters, have discharge planners utilize websites to assist with housing plans and actually develop an affordable housing website. In addition, they recommended funding and policy strategies, such as Nebraska Housing Related Assistance Program, to work with the legislature to carve out dollars from the real estate stamp tax for housing and linking with Omaha's continuum on homelessness 10 year plan.

12. Information sharing across systems of care needs to be enhanced.

The ability to share information across all systems of care utilized by consumers with mental illness is essential for effective coordination and delivery of services. This issue was one of the top priorities for change in the state. There are several states (Texas and New York) that have enacted legislation to enable this process. In workshop discussion, there appeared to be confusion and possible barriers to sharing information between clinical providers and across agencies within the justice system. We would recommend a review of the current state's confidentiality statutes to determine if they inhibit the flow of information that ensures continuity of treatment. In Texas and New York new laws have been enacted that allow for more exchange of information for the purpose of promoting continuity of care and greater access to appropriate treatment. PRA can be a resource to provide those references and consultation on this needed transformation.

13. Expand Nebraska's extensive efforts on consumer involvement to the criminal justice areas with a forensic focus that includes: a) participation in all state and local planning efforts b) Forensic Peer Support and c) training and employment for Forensic Peer Specialists.

- The inclusion of forensic consumers in the planning process for change can enhance the success of the process. Consistent with the values expressed in the President's New Freedom Commission, consumers provide honest and needed feedback about the pros and cons of the operation of the current service delivery system and can offer practical solutions for change. It is recommended that they have a role in every regional planning committee and at any statewide group. We commend Nebraska for including 7 consumer participants in the workshop and encourage continued involvement as planning activities continue.
- Forensic Peer Support specifically for justice involved consumers works well because forensic peers often have different experiences and needs than people who have not been in the justice system. Peer support specific to justice involved persons might include activities such as social groups, community resource rooms, and working on a volunteer basis in jails or prisons to help with pre – release planning. For people addressing the sometimes overwhelming needs of re-entry, Forensic Peer Support can provide socialization and acclimation that is sensitive to the unique issues of community supervision and environmental adjustment. We also recommend expansion of the consumer delivered Wellness Recovery Action Plan (WRAP) training currently utilized in Region I, to other regions.

- Forensic Peer Specialists are paid paraprofessionals who work as part of a multi-disciplinary treatment team in a variety of treatment settings. They can provide in-reach to jails and prison and bridge services and support into the community. Training and employing Forensic Peer Specialists also provides a meaningful pathway to recovery for justice involved consumers.
- PRA can provide assistance to communities to identify and train a pool of consumers to participate in statewide and local mental health criminal justice planning activities. For further information, contact Jackie Massaro.

All these initiatives would dove-tail nicely with the work of Joel McCleary, the Administrator of the Office of Consumer Affairs within the DHHS.

14. Expand efforts on planning and service delivery to include veterans in the justice system.

The Veteran's Administration and Veterans groups should be included in planning committees. Justice agencies should enhance or update screening procedures to engage Afghan/Iraqi war veterans in trauma-informed services. Information sharing agreements between the Veterans Administration and behavioral health agencies should also be addressed. Training for law enforcement on PTSD and other veterans issues should be explored (see **Attachment 15**).

## Closing

PRA appreciated the opportunity to be involved in conducting the "Strategic Analysis Workshop on Transforming Services for Person with Mental Illness in Contact with the Criminal Justice System." We were impressed with the quality of the work being done and being planned in the State of Nebraska. There were many excellent ideas generated and great energy for accomplishing the needed changes at the interface between the mental health and criminal justice systems. These efforts will undoubtedly increase the functioning of consumers and reduce the amount of time people with mental illness stay in the criminal justice system. PRA welcomes the opportunity to offer any additional assistance in Nebraska's transformation process.

## References

- Abram, K.M. & Teplin, L.A. (1991). Co-Occurring Disorders Among Mentally Ill Jail Detainees. *American Psychologist*, 46 (10): 1036-1045.
- Adams, J. & Shipley, S. Locked in Suffering: Kentucky's Jails and the Mentally Ill. Four-part series, *Courier Journal* (Louisville, KY) Feb. 24-Mar., 3, 2002.
- Binswanger, I.A., Stern, M.F., Deyo, R.A., Heagerty, P.J., Cheadle, A., Elmore, J.G. & Koepsell, T.D. (2007). Release from Prison – A High Risk of Death for Former Inmates. *New England Journal of Medicine*, 356 (2): 157-165.
- Council of State Governments. Criminal Justice/Mental Health Consensus Project. New York: Council of State Governments. June 2002.
- Ditton, P.M. (1999). Mental Health and Treatment of Inmates and Probationers. Washington, DC, United States Department of Justice, Office of Justice Programs.
- Glaze, L.E., & Bonczar, T.P. (2006) Probation and Parole in the United States, 2005. Washington, DC, United States Department of Justice, Office of Justice Programs.
- Griffin, P.A., Steadman, H.J. & Petrila, J. (2002). The Use of Criminal Charges and Sanctions in Mental Health Courts. *Psychiatric Services*, 53 (10): 1285-1289.
- Ivanoff, A. & Hayes, L.M. (2002). Preventing, Managing, and Treating Suicidal Actions in High-Risk Offenders. *Jail Suicide/Mental Health Update*, 11 (2): 1-12.
- James, D.J. & Glaze, L.E. (2006). Mental Health Problems of Prison and Jail Inmates. Washington, DC, United States Department of Justice, Office of Justice Programs.
- Justice, Treatment and Cost: An Evaluation of the Fiscal Impact of Allegheny County Mental Health Court. Rand Corporation, 2007.
- Metraux, S., Culhane, D. & Hadley, T. (2001). The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Persons with Mental Illness in New York City. Philadelphia, PA: Center for Mental Health Policy and Services Research, University of Pennsylvania.
- Milligan, C. & Sabbatine, R. (2006). Calling for Help. *Behavioral Healthcare*. 27.
- Mumola, C.J. (2005). Suicide and Homicide in State Prisons and Local Jails. Washington, DC, United States Department of Justice, Office of Justice Programs.
- Munetz, M.R., & Griffin, P.A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services*, 57 (4): 544-549.
- Nebraska Department of Correctional Services, Planning, Research and Accreditation (2006). 32<sup>nd</sup> Annual Report and Statistical Summary.
- New Hampshire Senate Bill #262.

- Noonan, M.E., & Mumola, C.J. (2007). *Veterans in State and Federal Prison, 2004*. Washington, DC, United States Department of Justice, Office of Justice Programs.
- Parks, J., Svendsen, D., Singer, P., Foti, M.E. & Mauer, B. (2006). *Morbidity and Mortality in People with Serious Mental Illness*. National Association of the State Mental Health Program Directors Medical Directors Council (Alexandria, VA)
- Staley, E.M. (2005). *Research Highlight: Female Offenders 2003-2004*. New York State Department of Correctional Services, The Division of Program Planning, Research and Evaluation.
- Steadman, H.J. & Veysey, B. (1997). *Providing Services for Jail Inmates with Mental Disorders*. National Institute of Justice: Research in Brief.
- Substance Abuse and Mental Health Services Administration. (2006). *Results from the 2005 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.
- TAPA unpublished TCE data. Technical Assistance and Policy Analysis Center for Jail Diversion. Policy Research Associates. 345 Delaware Ave. Delmar, NY 12054
- Teplin, L.A. (1994). *Psychiatric and Substance Abuse Disorders Among Male Urban Jail Detainees*. *American Journal of Public Health*, 84 (2): 290-293.