Criminal Justice

Response

To people with mental illness Arrested or incarcerated in Tennessee

Module 1
Introduction

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Tennessee Department of Mental Health and Developmental Disabilities
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Module One
Introduction

Length of Presentation: 30 minutes

Handouts and Materials

1-1 Criminalization of Mental Illness: The Problem
1-V Optional Video: ABC News: Jailed, but Mentally Ill
1-2 Criminal Justice/Mental Health Liaison Project Description
1-3 Optional: Criminal Justice Task Force Report: Mental Health and Criminal Justice in Tennessee, June 2000
1-4 Optional: 2003 Jail Report Summary
1-5 Title 33 statutory authority for mental health crisis management training
1-6 Response: What Do You Want to Know?

*[**Note to Instructor:** The purpose of this module is to give participants confidence that this training will help them in their work. This module is essential to lay a good foundation for the rest of the training session, but do not spend more than the specified time.]*

Objectives

- To discuss reasons for training;
- To give an overview of the history of mental health treatment,
- To learn about the Criminal Justice/ Mental Health Liaison project;
- To create an enjoyable learning setting;
- To find out what participants want to learn.

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DISCUSSION
Introduction

Who We Are: Instructor Introductions

- Name, background, education, work history, employer
- Roles and responsibilities
  - Duties;
  - Limitations.

Who Are You? Participant Introduction (omit if group is large)

- Name, position (rank if applicable),
- Length of time you have been on the job

Why Are We Doing This Training?

- Because people with mental illness are too often arrested and incarcerated due to untreated mental illness; and
- Because it's the law.

The Problem

[Refer to Handout 1-1: Criminalization of Mental Illness: The Problem]

- There are more than three times as many people with mental illness in the Tennessee county jails (18%) as in the general population (5%).
- Nationally almost a quarter (23.2%) of the jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of untreated mental illness.

Historical Background:

- 1700's to 1830's: Individuals with mental illness incarcerated in jails/ workhouses,
- Mid 1800's Dorothea Dix advocated for humane treatment of people with mental illness in asylums,
- 1950's peak of institutionalization, lives ruined, great expense to society.
- 1950's psychotropic medications became available to allow people with serious mental illness to function outside a hospital setting;
- 1960's community mental health centers established, only 25% of what was needed.
- 1970's consumer rights movement due to gross human rights violations in institutions (class action lawsuits resulting in patient/consumer rights),
- 1980's Community Support Services developed to help individuals with SPMI live and work in the community (case management and psychosocial rehabilitation that helps people with mental illness live independently through social skills training, and assistance with employment and housing);

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- Federal budget tightening resulted in lack of affordable housing, homelessness.
- 1990's Managed care/ cost containment, outcome emphasis. and 'Decade of the Brain,' increased research into new medications and effectiveness of community-based treatment.
- 2000's Increased knowledge base of evidence-based treatment, Newer, more effective medications,
- Economic downturn increases barriers to community mental health services,
- Inadequate community services + barriers to rapid assessment + hospitalization too expensive = increased incarceration.

Terms commonly used to refer to individuals with mental illness are consumers, clients, patients, service recipients. Children are referred to as children with SED (serious emotional disturbance).

[Optional Video: ABC News: Jailed, But Mentally Ill]

What are we doing about the problem?

Solution 1: Criminal Justice/Mental Health Liaison Project

[Refer to Handout 1-2: Criminal Justice/ Mental Health Liaison Project]

- Mission: To work collaboratively to improve the functioning of the criminal justice and mental health service delivery systems on behalf of individuals with mental illness who interact with the criminal justice system. The target population is adults with serious mental illness who are incarcerated, or at risk of incarceration.
- Staff: 16 liaisons covering 21 counties;
- CJ/MH liaison duties:
  - Decriminalize mental illness by fostering collaboration between criminal justice and mental health organizations;
  - Divert people with mental illness from arrest and incarceration to treatment and rehabilitation, where appropriate;
  - Assess service needs of offenders/inmates suspected of having mental illness;
  - Intervene when issues arise concerning inmates with mental illness;
  - Link jail inmates to family, friends and other supports where appropriate;
  - Link inmates with mental illness scheduled for release to community services and supports.

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Solution 2: Consumer Advocacy
- Assistance to consumers who are incarcerated;
- Education of consumers regarding the criminal justice system.

Solution 3: System Changes;
[Optional: Refer to Handout 1-3: Criminal Justice Task Force Report; and Handout 1-4: Jail Report Summary.]

- Change TennCare eligibility policy: suspension rather than termination upon incarceration, expedited enrollment upon release;
- Develop more appropriate modes of transportation;
- Facilitate use of best practices for criminal justice intervention with people who have mental illness;
- Facilitate use of best practices for prescription and maintenance of psychiatric medication for jail inmates;
- Facilitate better working relationships between crisis response services, law enforcement and jails;

Solution 4: Increase knowledge and skill of criminal justice personnel
- How to recognize mental illness;
- How to recognize malingering;
- How to respond to people whose behavior is disordered:
    - Confused;
    - Fearful;
    - Manipulative;
    - Aggressive;
    - Suicidal;
- How to get help for people with serious mental illness; and
    - Co-occurring disorders of substance abuse or mental retardation

Solution 5: Increase knowledge and skill of mental health personnel
- The criminal justice process;
    - Arrest;
    - Adjudication;
    - Incarceration;
    - Probation/parole;
- Suggested best practices for individuals at risk of arrest and incarceration;
- Continuity of care for individuals with mental illness who are incarcerated.

The Law

Tennessee Code Annotated, Title 33, the mental health code, requires the Tennessee Department of Mental Health and Developmental Disabilities to offer training to law enforcement officers who provide transportation for involuntary

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emergency commitment be trained in mental illness and crisis management. Criminal justice/ mental health liaisons conduct training on a quarterly basis, also inviting police, correctional officers, probation officers and other criminal justice personnel.
[Refer to Handout 1-5: Title 33: The Law]

***Response*: What Do You Need to Know?**
[Time allotment: 10 minutes]

[Instructor note: *Ask participants what they would like to gain from the training. Write responses on a marker board or flip chart.*

[If participants mention a topic that will not be covered, tell them so and the reasons why. Distribute handout or resource contact information on topic if available.]

[Optional: Give everyone who responds a small reward. Choices:
Small candy (hard candy, gum, etc.)
Playing card (class will play a hand of poker at the end of the training)
Raffle ticket (prizes to be awarded at the end of training).]

References
Council of State Governments (2002) *The Consensus Project.* Washington, DC: Council of State Governments.

Diehl and Hiland, (2003) *Survey of County Jails in Tennessee: Four Years Later*, Nashville, TN: Tennessee Department of Mental Health and Developmental Disabilities.

Tennessee Department of Mental Health and Developmental Disabilities (June, 2000) Mental Health and Criminal Justice in Tennessee. Nashville: TDMHDD.

(2001) Tennessee Code Annotated: Title 33, Section 33-6-901, special provisions for mental health transportation.

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Handout 1-1
Criminalization of Mental Illness: The Problem

There are more than three times as many people with mental illness in the Tennessee county jails (18%)[1] as in the general population (5%)[2] (Kessler et al, 1999). Nationally almost a quarter (23.2%) of the jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of untreated mental illness (Ditton, 1999)[3].

Reprinted from The Criminal Justice/Mental Health Consensus Project: (www.consensusproject.org. June 2002)

Of the 10 million people booked into U.S. jails in 1997, at least 700,000 had a serious mental illness; approximately three-quarters of those individuals had a co-occurring substance abuse disorder.[3] A study conducted in New York State found that men involved in the public mental health system over a five-year period were four times as likely to be incarcerated as men in the general population; for women, the ratio was six to one.[4]

Impact of the Problem on People and Systems

How elected officials and the public understand mental illness as it relates to the criminal justice system often is informed by newspaper and television headlines, which typically focus only on the most egregious manifestations of the problem: a screwdriver-wielding woman with mental illness shot dead by officers who subsequently tell of being frightened and confused themselves; a crime victim outraged that, before assaulting her, a person with a history of untreated mental illness bounced between community mental health centers, state hospitals, and the local jail.

Although these tragedies sometimes drive policymaking, they are not the cases involving mental illness most familiar to police officers, prosecutors, defense attorneys, judges, corrections administrators, parole and probation officers, and other criminal justice personnel. These criminal justice practitioners are all too familiar with the following scenarios:

- A police officer returns countless times to a house or street corner in response to a call for assistance involving the same person with a history of mental illness; each time, the officer is unable to link the person to treatment.
- Month after month, a prosecutor charges the same person with committing a different public nuisance crime, and, each time, the defendant with mental illness pleads guilty to time served.
- Jail and prison administrators watch their systems swell with these individuals, who spin through the revolving door of the institution. Corrections officials' job is to keep these inmates alive, even if that means isolating them in administrative segregation with no outside contact for

[1] Diehl, S. & Hiland, E. (2003) *A Survey of County Jails in Tennessee: Four Years Later.* Nashville: Tennessee Department of Mental Health and Developmental Disabilities.

[2] Kessler, RC (1999) *A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness,* In Mental Health United States 1999, *Manderscheid, RW and Henderson MJ eds., Rockville, MD, Center for Mental Health Services.*

[3] *Ditton, PM (1999)* Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers. *Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.*

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weeks on end. When the release date comes around, freedom for many prisoners is only temporary, unless they are among the few for whom reentry has meant planning and linkage with community supports.

- A parole officer already struggling with an overwhelming caseload is assigned an individual with mental illness released from prison; the officer receives only limited support from the community-based mental health program. The parolee is rearrested and returned to prison when he commits a new crime - urinating on a street corner and making lewd gestures to frightened people passing by - displaying in public the symptoms of his untreated mental illness.

Each of these situations frustrates criminal justice officials; they know they are failing the person who suffers from mental illness and his or her loved ones. Encounters between people with mental illness and law enforcement sometimes end in violence, jeopardizing the safety of consumers and officers. Once incarcerated, people with mental illness become especially vulnerable to assault or other forms of intimidation by predatory inmates.[5] People with mental illness also tend to decompensate in prisons and jails - environments that exacerbate the symptoms of mental illness - and there they are at especial risk of harming themselves or others. Upon their return to the communities they left behind during their incarceration, they discover that their criminal records have, in many cases, made it even harder to obtain access to treatment.

Criminal justice officials may lose sight, however, of the lives these individuals lead. These are sons and daughters, fathers and mothers, who struggle daily to fend off symptoms of mental illness. Without adequate treatment, their disease may disable them significantly. Some experience delusions and may be convinced that strangers are planning to attack them. In other cases, depression immobilizes them; overcome with a sense of hopelessness, their physical strength deteriorates. Many of them are people who've spent years trying to mask torments or hallucinations with alcohol or any street drug they could scrape together enough money to buy and now are dependent on these substances to avoid withdrawal states and further decompensation. Often, their exhausted families have run out of the funds and emotional resources to take care of them.

Sometimes, when the criminal justice and mental health systems let someone with mental illness fall through the cracks, a stranger is harmed and justifiably motivated to demand accountability from the person with the mental illness and the public health system that failed. More often, when a person with a mental illness does assault someone, the victim is a family member, friend, or acquaintance.[6] Whether relatives or strangers, the victims are usually left to make sense of the baffling interface between the criminal justice system and the mental health system.[7]

The current situation not only exacts a significant toll on the lives of people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system. Police departments dedicate thousands of hours each year transporting people with mental illness to hospitals and community mental health centers where staff often are unable to admit the individual or quickly return him to the streets. Judges, prosecutors, and defense attorneys race through backlogged dockets, disposing of most cases in minutes, but find that the symptoms and behaviors of the growing numbers of defendants with mental illness who appear in their courtrooms cannot be processed as quickly. On any given day, the Los Angeles County Jail holds as many as 3,300 individuals with mental illness - more than any state hospital or mental health institution in the United States.[8] Without adequate planning to transition inmates with mental illness back into the community, many will quickly return to jail or prison; recidivism rates for inmates with mental illness can reach over 70 percent in some jurisdictions.[9]

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Every criminal justice professional would agree that the system has inherited a problem of enormous scope and complexity. Police, courts, and corrections officials feel they're boxed in. Resources are stretched to the limit: they're tight on money and even tighter on time. Under the circumstances, many have tried to find a way to serve people with mental illness more efficiently. But with limited options and resources, especially in rural areas, many criminal justice practitioners are frustrated because they know what they're doing isn't enough.

Origins of the Problem

Understanding why this problem has become so acute in recent years requires some familiarity with the dramatic shifts in mental health and criminal justice policy over the course of recent decades.

Few institutions have attempted so complete a change over the previous 35 years as has the nation's public mental health system. Once based exclusively on institutional care and isolation, the system has shifted its emphasis almost entirely to the provision of community-based support for individuals with mental illness. In 1955, state mental hospital populations peaked at a combined 559,000 people; in 1999 this number totaled fewer than 80,000.[10] There are many reasons for this change; fiscal reality, political realignment, philosophical shifts, and medical advances, in no particular order, have all played a part. These forces and others have converged to create a reality that few could have envisioned when the Community Mental Health Centers Act was signed into law in 1964.[11]

For many clients who utilize this system, successful community integration has indeed been achieved. Reliable data on the success of community mental health are difficult to find, but anecdotal experience shows that many people with active or past diagnoses of mental illness live and work "normally" in communities across the country. Their very success in achieving recovery helps them to mix unremarkably with their families, neighbors, and coworkers.

The mental health system today has powerful and effective medications and rehabilitation models with which to work. The professionals in the system know much about how to meet the needs of the people it is meant to serve. The problem comes, however, in the ability of the system's intended clientele to access its services and, often, in the system's ability to make these services accessible. The existing mental health system bypasses, overlooks, or turns away far too many potential clients. Many people the system might serve are too disabled, fearful, or deluded to make and keep appointments at mental health centers. Others simply never make contact and are camped under highway overpasses, huddled on heating grates, or shuffling with grocery carts on city streets.

The lack of affordable, practicable housing options for individuals with mental illness compounds the difficulty of providing successful treatment. Without housing that is integrated with mental health, substance abuse, employment, and other services, many people with mental illness end up homeless, disconnected from community supports, and thus more likely to decompensate and become involved with the criminal justice system. Most studies estimate that at least 20 to 25 percent of the single adult homeless population suffers from some severe and persistent mental illness.[12]

It is against this backdrop that officials in the criminal justice system have in recent years encountered people with mental illness with increasing frequency. Because of sensational news headlines or other sources that stigmatize mental illness, some criminal justice professionals may be prone to making the incorrect assumption - which most of the public makes - that mental illness by definition incorporates violent behavior.[13] They may respond to situations on the street, in a courtroom, or at a parole board hearing on the basis of common but erroneous perceptions. In such instances, police, judges, and releasing authorities may be especially wary about releasing people with mental illness into the community.

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Violence and Mental Illness
Popular beliefs about violence and mental illness do not jibe with reality. The results of several recent, large-scale research projects conclude that only a weak statistical association between mental disorder and violence exists.[14] Serious violence by people with major mental disorders appears concentrated in a small fraction of the total number, and especially among those who use alcohol and other drugs and those without access to effective services.[15] Indeed, the vast majority of people with mental illness are not violent; they are more likely to be victims of crime than they are likely to harm others.[16]

Compounding the problems stemming from the stigma associated with mental illness, changes to criminal justice policies during the course of the last two decades have prolonged the involvement of people with mental illness in the criminal justice system. For example, in response to community or government leaders' demands to increase quality of life and to reduce crime and fear of crime, many police departments have instituted "zero tolerance" policies, arresting people committing offenses such as loitering, urinating in public, and disturbing the peace.[17] Many individuals netted as a result of these tactics were people demonstrating in public the symptoms of untreated mental illness. The majority of these people also have a co-occurring substance abuse problem. As legislatures have increased the length of prison sentences (and frequently made them mandatory) for the possession or sale of some illegal substances, growing numbers of people with mental illness have been incarcerated - and for longer periods of time.

Already overcrowded and overburdened, prisons and jails typically are without the resources to ensure the availability of effective mental health treatment and appropriate medications. In these cases, a person with mental illness is likely to decompensate, exacerbating the symptoms of his or her mental illness. As a result, the person may act out and fail to follow prison rules, which in turn extends the period of incarceration for the individual. For these reasons, people with mental illness tend to stay in jail or prison considerably longer than other general population inmates. For example, on Riker's Island, New York City's largest jail, the average stay for all inmates is 42 days, but it is 215 days for people with mental illness.[18]

Inmates with a mental illness who leave prison or jail are typically provided with just a short (two weeks or less) supply of medications and enough money to take a one-way trip on public transportation. Without housing, linkage to a community-based mental health treatment program, or other much-needed services, the person typically returns to the type of behavior that originally contributed to his or her incarceration.

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[1] R. C. Kessler, et al., "A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness," In *Mental Health United States 1999*, edited by R.W. Manderscheid and M.J. Henderson, Rockville, MD, Center for Mental Health Services.

[2] Paula. M. Ditton, *Mental Health Treatment of Inmates and Probationers*, Bureau of Justice Statistics, U.S. Department of Justice, July 1999. The prevalence statistic for mental illness in U.S. jails and prisons was gathered through a combination of inmate self-reporting and past mental health treatment history. Inmates in the sample qualified as having a mental illness if they met one of the following two criteria: "They reported a current mental or emotional condition, or they reported an overnight stay in a mental hospital or treatment program." To account for inmate underreporting of their mental health problems, admission to a mental hospital was included as a measure of mental illness. Ten percent of inmates reported a current mental condition and an additional six percent did not report a condition but had stayed overnight in a mental hospital or treatment program.

[3] Linda Teplin and Karen Abram, "Co-Occurring Disorders among Mentally Ill Jail Detainees: Implications for Public Policy," *American Psychologist* 46:10, 1036-45.
[4] Judith F. Cox, Pamela C. Morschauser, Steven Banks, James L. Stone, "A Five-Year Population Study of Persons Involved in the Mental Health and Local Correctional Systems," *Journal of Behavioral Health Services & Research* 28:2 May 2001, 177-87. This study used data from the mental health and criminal justice systems of 25 upstate New York counties. The study defines individuals who have been in the public mental health system as having been in a state-run psychiatric inpatient facility or a local psychiatric inpatient facility, or having received mental health services from a local, general hospital using Medicaid coverage. Incarceration was defined as having spent at least one night in jail during the five-year study period.
[5] See testimony of Reginald Wilkinson, then vice president, Association of State Correctional Administrators and director, Ohio Department of Rehabilitation and Correction, before the House Judiciary Committee, Subcommittee on Crime, Terrorism and Homeland Security, oversight hearing on "The Impact of the Mentally Ill on the Criminal Justice System," September 21, 2000, available at: www.house.gov/judiciary/wilk0921.htm .
[6] Ditton, *Mental Health and Treatment*, 4. More than 60 percent of the victims of violent crimes committed by state prisoners with mental illness were known to the offenders.
[7] People with mental illness who themselves are the victims of a crime are a notable subset of this population. While especially in need of support services, they in particular suffer from insufficient coordination between criminal justice and mental health systems. Although some recommendations in this report address this population, the issue of victims with mental illness is generally beyond the scope of this report.
[8] *Sacramento Bee*, "Treatment Not Jail: A Plan to Rebuild Community Mental Health," March 17, 1999.
[9] Lois A. Ventura, Charlene A. Cassel, Joseph E. Jacoby, Bu Huang, "Case Management and Recidivism of Mentally Ill Persons Released From Jail," *Psychiatric Services* 49:10, Oct. 1998, 1330-37. This study examined the effect of community case management on recidivism for jail detainees who have mental illness. The study followed releasees for 36 months. Within the 36 months, 188 of 261 subjects (72 percent) were rearrested.
[10] T.A. Kupers, *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It*, San Francisco, Jossey-Bass Publishers, 1999.
[11] The public, the media, and even some in the criminal justice and mental health system, suggest that there is a causal connection between the dramatic reduction in the number of people in mental health institutions and the extraordinary growth of the prison and jail population. Some present two straight-line graphs to illustrate the point, implying that the very same people who used to be in mental health institutions are now in prison or jail. In fact, no study has proven that there has been a transition of this population from one institution to another. Indeed, while the gross number of people with mental illness incarcerated has increased significantly in recent years, there is no evidence that the *percentage* of people in prison or jail who have a mental illness is any greater than it was 35 years ago when the *Community Mental Health Centers Act* was passed. See Henry J. Steadman, et al., "The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968-1978," *Journal of Criminal Law & Criminology*, 75:2, 1984, pp. 474-90.

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[12] Paul Koegel, et al., "The Causes of Homelessness," in *Homelessness in America*, 1996, Oryx Press.However, according to the Federal Task Force on Homelessness and Severe Mental Illness, only approximately 5 percent of people with severe mental illness are homeless on a given day. Federal Task Force on Homelessness and Severe Mental Illness, 1992, *Outcasts On Main Street: A Report of the Federal Task Force on Homelessness and Severe Mental Illness*, Washington, D.C., GPO. For more information on homelessness and mental illness see A.D. Lezak and E. Edgar, *Preventing Homelessness Among People with Severe Mental Illness*, Rockville, MD, Center for Mental Health Services, 1999 and The National Resource Center on Homelessness and Mental Illness, *National Organizations Concerned with Mental Health, Housing, and Homelessness*, Delmar, NY, 2001, available at: www.nrchmi.com
[13] U.S. Surgeon General, *Mental Health: A Report of the Surgeon General*, 1999, Available at: www.surgeongeneral.gov.
[14] Ibid.
[15] H. Steadman, E. Mulvey, J. Monahan, P Robbins, P. Applebaum,, T. Grisso, L. Roth, and E. Silver, "Violence by People Discharged From Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods. *Archives of General Psychiatry* 55, 1998, 393-401. See also K.T. Meuser, et. al., "Trauma and Post-Traumatic Stress Disorder in Severe Mental Illness," *Journal of Consulting and Clinical Psychology* 66:3, 1998, 493-99.
[16] Virginia Hiday, Marvin S. Swartz, Jeffery W. Swanson, Randy Borum, and H. Ryan Wagner, "Criminal Victimization of Persons with Severe Mental Illness," *Psychiatric Services* 50, 1998, pp. 62-68. This study tracked 331 involuntary mental health outpatients. The rate of nonviolent victimization for the study cohort (22.4 percent) was similar to that in the general population (22.1 percent). The rate of violent criminal victimization, however, was two and a half times greater than in the general population - 8.1 percent compared to 3.1 percent. In multivariate analysis, substance use and transient living conditions were strong predictors of criminal victimization.
[17] Ditton, *Mental Health and Treatment*, 4. According to the Bureau of Justice Statistics, over one-quarter of the inmates with mental illness in local jails were incarcerated for a public order offense.
[18] Fox Butterfield, "Prisons Replace Hospitals fro the Nation's Mentally Ill," *New York Times*, March 5, 1998, A1. Refers to testimony of Dr. Arthur Lynch, director of Mental Health Services for the NYC Health and Hospitals Corporation, before the Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse Service (April 22, 1998).

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Handout 1-2
Criminal Justice/Mental Health Liaison Project

Overview

The CJ/MH Liaison Project is a community project that examines the issues affecting adults with serious mental illness who are involved in the criminal justice system. The purpose of the project is to facilitate communication/coordination between the community, the criminal justice and the mental health systems to achieve common goals; to support the establishment of services that would promote diversion activities; and provide liaison activities for adults with serious mental illness who are incarcerated or at risk of incarceration.

System Issues

The CJ/MH Liaison projects are charged with examining the issues affecting adults with serious mental illness who are involved in the criminal justice system or at risk of involvement and to facilitate communication and coordination of activities between the community, criminal justice and mental health systems. The success of the projects depends greatly on community support and the willingness of communities to work collaboratively to improve the functioning of the criminal justice and mental health service delivery systems.

The intent is for the CJ/MH liaison to provide services or facilitate the provision of services at all levels of the criminal justice process from arrest to probation.
These services may include:

Early Identification and Continuity of Care: daily/regular contact with arresting agency or jail to identify mental health consumers known to the mental health system and those who may be exhibiting symptoms and require further assessment. Assist jail personnel in establishing viable mental health care for the consumer.

Release Planning and Follow-up: develop and coordinate release planning with the consumer and mental health provider. Follow-up to assure service plan was executed.

Consultation with Court Officials: provide recommendations concerning the mental health needs of a consumer, assist with the development of a release or sentencing plan, make recommendations on when and what mental health assessments may be appropriate, work with probation/parole to establish an appropriate community mental health plan.

Training and Education: provide specific training opportunities for criminal justice personnel and mental health personnel and be available to provide or facilitate information and training activities when requested by either system.

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Handout 1-3
Criminal Justice Task Force Report:
Mental Health and Criminal Justice in Tennessee
Summary, June 2000

The Criminal Justice Task Force provided an opportunity for key stakeholders to examine issues involved when a person with mental illness interacts with the criminal justice system. Members of the Task Force worked together to promote a better understanding of the needs and rights of persons with mental illness when they interface with the Criminal Justice System.

The members of the Task Force recognize that each Tennessee community, urban and non-urban, is unique and has varied characteristics that need to be addressed. It was determined that the most effective manner in which to begin work on the problem was to facilitate the education of and communication between key statewide and community stakeholders.

The programs that the Task Force reviewed and that have been successfully implemented are those that have leaders who view mental illness as a community issue and who work together by devoting time, energy, and pooling of resources to develop services appropriate for each community.

The Task Force identified components that can be developed and implemented to meet the needs of local communities throughout the state. The components include facilitation, education and training, and community support.

- Facilitation is the process of developing and maintaining relationships between the criminal justice and mental health service systems to ensure they work together to achieve common goals. This process can be accomplished through a designated facilitator, sometimes referred to as a "boundary spanner".
- Education and training are the necessary building blocks to develop working relationships. Education provides the foundation from which communication and understanding are built; training activities must be relevant and ongoing.
- Community support is the willingness of communities to accept responsibility and work collaboratively to improve the functioning of the criminal justice and mental health service delivery systems on behalf of individuals with mental illness who interact with the Tennessee criminal justice system.

The Criminal Justice Task Force hereby submits the following report with recommendations about the needs of offenders with mental illness in the Tennessee Criminal Justice System.

Handout 1-2
Criminal Justice Task Force Report

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TASK FORCE PROCESS

During a series of monthly meetings, members of the Task Force were provided individual presentations about programs that have been implemented in Tennessee and other states. The members also shared with one another numerous articles, periodicals, and other written material about programs and models of programs that address the criminal justice system and mental health issues.

The members then reviewed the Tennessee system and how the criminal justice and mental health systems are currently interacting as well as the inadequacies of the system. The recommendations were developed from this extensive review of the mental health and criminal justice systems in Tennessee and other states.

ELEMENTS

Themes and elements emerged from the presentations that are characteristic of model programs.

I. Boundary Spanner

The first element is the need for each defined geographical area to have an individual who is responsible for coordinating and facilitating relationships between judicial, correctional and mental health providers. This was presented as an essential component for bringing the appropriate people together to develop a program to benefit the community and its needs for persons with mental illness involved in the criminal justice system. This individual, who is referred to as a "boundary spanner", is defined as someone who navigates between the different systems and agencies to achieve common goals.

II. Diversion Services

The second element is providing diversion services in communities. Many different types of diversion programs provide alternatives to individuals with mental illness from enduring unnecessary incarceration. Diversion services may be designed for both pre-booking and post-booking phases.

A. Pre-booking

The following pre-booking services are examples from the Task Force presentations and review of the literature.

1. Single Port of Entry
   A single port of entry provides an alternative for individuals who are suspected of having a mental health problem, but who have engaged in, or have propensity to engage in inappropriate or criminal behaviors as defined by state law and implemented by the local law enforcement agency. This type of diversion allows the law enforcement agency to immediately access (7 days a week, 24 hours a day) a mental health evaluation to determine the most appropriate treatment resource and avoid booking the individual to a jail. A single port of entry can divert an individual from the criminal justice system and, therefore, promote the decriminalization of mental illness.

Handout 1-2
Criminal Justice Task Force Report

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2. Specialized Team Approach
   A specialized team is comprised of trained law enforcement agents who are able to address mental health issues in the community. The officers are trained to determine when diversion is appropriate and have the option to divert individuals for mental health evaluation and referral to community resources before booking.

B. Post-booking

Post-booking is offered once the individual is incarcerated. The following are examples of post-booking diversion services.

1. Mental Health Court
   The first mental health court was developed in Broward County, Florida, in an effort to reduce the number of people with mental illnesses in jail and reduce the amount of time they spent in jail. This service model was created by a task force that used a community-based approach to address a broad set of issues involving persons with mental illness in the justice system with non-violent misdemeanor offenses. The Broward County Mental Health Court model has gained national attention for its success and is being replicated in other states.
2. Pre-trial Services
   Pre-trial services are an alternative to bonding and incarceration in which individuals are released on their own recognizance and diverted to appropriate treatment services rather than held in jail. Pre-trial services can be delivered by case managers with diverse skills who obtain mental health evaluations, negotiate treatment plans, link with community resources, and consult with the courts for rapid release to community services, rather than incarcerate an individual who has serious mental illness.

III. Mental Health Services During Incarceration

The third element is the provision of mental health services during incarceration. A successful model must emphasize early identification, evaluation and stabilization of mental health symptoms and coordination of treatment services. Model jail programs demonstrate that case management is an effective means for implementing these activities. An individual with mental health skills and knowledge of criminal justice systems can also provide valuable training for jail personnel. As noted in one presentation, having this type of mental health worker available in the jail is a win-win situation for all parties involved.

The Task Force identified the following additional components as important for jail programs.

- Contracting with or employing a psychiatrist of physician with psychiatric expertise, a physician assistant with psychiatric expertise, or an advanced practice psychiatric nurse to perform assessments for medication and treatment needs.
- Written policies and standards that address suicide prevention.
- Separate holding areas or facilities for individuals with mental illness who are vulnerable and/or experiencing acute symptoms.

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- Treatment programs for convicted individuals with substance abuse disorders or other co-occurring disorders.
- A process for quick identification of individuals needing forensic evaluations and expedited court orders to prevent delays and possible deterioration in mental status.

IV. Release Planning

The fourth element is linking offenders to mental health and community services on release from jail or prison. Strong evidence in the literature indicates that many offenders with mental illness continue to offend and return to jail because of lack of participation in community services on release. Release planning is the assessment and planning for services required to assist the individual with successful community living. Community resources that should be in place before release are adequate housing, mental health services, assertive case management, availability of medication, income or insurance to pay for medications and treatment, psychosocial services, and needed social supports and assistance.

Strong collaboration among the criminal justice system, mental health providers, probation and parole, and community services can reduce the revolving door syndrome and decrease the number of individuals with mental illnesses in jails.

CRIMINAL JUSTICE TASK FORCE RECOMMENDATIONS

Mental Health Recommendations

❖ The Task Force recommends that the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) establish a priority statement recognizing that persons with serious mental illnesses who are involved in the criminal justice system have equal access to mental health services.

❖ The Task Force recommends that the Tennessee Mental Health Planning Council develop a position statement which promotes access to treatment for persons with serious mental illnesses who are involved in the criminal justice system.

❖ The Task Force recommends that TDMHDD seek funding for the development, implementation, and monitoring of pilot projects that can be replicated to meet the needs of local communities statewide. The pilot projects should include, but not be limited to, the following: Single Port of Entry, Boundary Spanners, Pre-trial and Post-trial Case Management services, and Mental Health Courts.

❖ The Task Force recommends that Crisis Response Services develop a policy requiring crisis responders to provide the same level of service to persons with mental illnesses who are involved with law enforcement or correctional personnel as it provides to all other persons who are experiencing mental health crises.

❖ The Task Force recommends that TDMHDD through office of Housing, Planning and Development work toward increasing appropriate housing options for persons with mental illnesses who have had involvement with the criminal justice system.

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Criminal Justice Recommendations

- The Task Force recommends legislation to give an appropriate agency the authority to develop and enforce standards that would ensure that persons with serious mental illnesses as well as co-occurring disorders are provided care and treatment resources while incarcerated.

  The Task Force makes note that the Tennessee Corrections Institute is the only entity in the state that is responsible for certifying jails. If a jail is decertified, there are virtually no consequences or corrective actions that can be taken to improve the jail. Additionally, the standards do not adequately address mental health issues that should be specified as other chronic mental illnesses.

- The Task Force recommends that regardless of legislation, the Tennessee Correctional Institute in conjunction with the Division of Mental Health Services and the Department of Correction, develop and monitor standards that require documentation of release planning for person with serious mental illnesses or co-occurring disorders who are released or transferred from jails to the Department of Correction, probation and parole, or community based corrections. Release planning standards should include information to ensure continuity of care and treatment.

- The Task Force recommends that community correctional facilities use a standardized mental health assessment and screening tool, which includes procedures for suicide assessment and prevention and provides appropriate housing for special needs detainees.

Training Recommendations

- The Task Force recommends that members from each of the following entities receive specialized multidisciplinary training:
  - Criminal Justice System as defined in this report.
  - Case management and mental health treatment providers.

The multidisciplinary training curriculum should encompass at a minimum the following basic areas:

  - Basics of psychopharmacology,
  - Mental Health crisis non-violent and de-escalation interventions,
  - Symptom recognition and differentiation of mental illness and mental retardation,
  - Judicial process,
  - Substance abuse disorders,
  - Confidentiality,
  - Mental health resource identification, service eligibility standards, commitment standards, and mandatory outpatient treatment.

It is further recommended that the multidisciplinary training curriculum be provided as a part of the core training and reinforced through in-service training.

- The Task Force recommends that resources are made available to coordinate and approve the development and delivery of specialized training for the Tennessee Peace Officers Standards and Training (POST) commission and the Tennessee Correctional Institute (TCI).
- The Task Force recommends that community mental health agencies identify personnel who can receive specialized training and education on the criminal justice system.

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System Recommendations

- The Task Force recommends that individuals receiving TennCare benefits who enter the criminal justice system be identified and not disenrolled from TennCare. A mechanism for suspending and then reinstating benefits upon release to the community should be implemented.

- The Task Force recommends that the Bureau of TennCare develop an expedited application process for eligible persons with serious mental illness who are incarcerated to ensure benefits may be accessed quickly upon release.

- The Task Force recommends that the Title 33 Commission recommendations be accepted and signed into law. The Commission was appointed by Governor Sundquist to conduct a thorough review of Title 33 and give recommendations for revision of the law. Many of the recommendations are pertinent to the issues and discussions of the Task Force. Recommendations include: a philosophy that promotes community based services for persons with mental illness and accountability to the public; a 24 –72 hour observation service for individuals with mental illness who are experiencing severe impairment; the permission to transport people for involuntary hospitalization by alternative transporting agents; a requirement that the Department of Mental Health and Developmental Disabilities set basic quality standards to people with mental illness.

Handout 1-2
Criminal Justice Task Force Report

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Handout 1-4
A Survey of County Jails in Tennessee, Four Years Later:
A Descriptive Study of Services to People with Mental Illness and Substance Abuse Problems

Executive Summary

There are more than three times as many people with mental illness in the Tennessee county jails (18%) as in the general population (5%) (Kessler et al, 1999). Nationally almost a quarter (23.2%) of the jail inmates with mental illness are incarcerated for public order offenses that could be connected to symptoms of untreated mental illness (Ditton, 1999). This study, sponsored by the Tennessee Mental Health Planning and Planning Council, examines the number of county jail inmates with serious mental illness and substance abuse issues, services provided in the jails and in the community, and training of correctional personnel that interact with mentally ill inmates. The purpose is to determine what services and supports exist and what can be done through training and coordination to make better use of those resources.

The 2002 “Survey of County Jails” questionnaire was modeled on a previous study sponsored by the TennCare Partners Roundtable. Questionnaires were mailed to individuals designated by the Sheriff’s with instructions to review the questions and collect information. Telephone interviews were conducted over a two-month period with 179 respondents including Sheriff’s, jail administrators, correctional medical personnel and others representing jail systems from all of the 95 counties in Tennessee.

At the time of the survey an estimated 2509 inmates were diagnosed with mental illness representing 17.8% of the total inmate population, a slight decrease from 1998 but higher than national rates of mental illness in the jail and prison populations. One fifth (22%) of the total inmate population received psychiatric medication, 2% demonstrated suicidal thoughts, and 55% were estimated to have serious substance abuse problems.

More than two-thirds of the county jails offered mental health assessment, pastoral counseling and psychiatric medications. However, less than one quarter of the jails offered substance abuse counseling even though more than half of the inmates were thought to have serious substance use disorders.

The most common jail diversion and service linkage programs offered in the community included mobile crisis response teams, screening and evaluation clinicians medication evaluation, and post-booking diversion to mental health agencies. However, the services that received the highest satisfaction ratings were only available to a few communities. Those services included mental health court, specially trained police, 24-hour crisis triage centers, criminal justice/mental health liaison personnel and pre-trial diversion services. Cost of

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psychiatric medication was a major concern to jail administrators, who employed various strategies to control expenditures. Correctional staff from three fourths of the jails attended training programs on mental health topics. Training was conducted by the Tennessee Corrections Institute, criminal justice/mental health liaisons and mental health center staff.

Recommendations concern provision of prevention and early intervention services by mental health and criminal justice personnel, establishing best practices in more Tennessee communities and bringing mental health and substance abuse services to correctional facilities rather than transporting inmates to community agencies. Training programs should be developed and disseminated to mental health providers, criminal justice personnel, consumers and family members. The Criminal Justice/ Mental Health Task Force made recommendations in FY2000 for closing inter-system gaps that are still pertinent such as, implementing standards of care for incarcerated persons with mental illness, using collective bargaining to control medication costs, suspending rather than disenrolling TennCare beneficiaries with serious mental illness who enter the jails, expediting TennCare benefits upon release, and establishing transportation alternatives to Sheriff's' personnel when evaluating persons for civil commitment to Regional Mental Health Institutes.

Collaboration between the Tennessee criminal justice and mental health systems appears to be making headway. Previous efforts by the TennCare Partners Roundtable, the Criminal Justice/Mental Health Task Force and the Tennessee Mental Health Policy and Planning Council have illuminated the problem and established initiatives to resolve the problem of the criminalization of mental illness in Tennessee.

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Handout 1-5: The Law, Title 33
Special Provisions for Mental Health Transportation

The county sheriff provides transportation unless:

- A secondary transportation agent is named;
- A municipal law enforcement agency is designated by the sheriff;
- A person authorized under other provisions of the law is designated,
- One or more friends, neighbors, other mental health professionals familiar with the person, relatives of the person or a member of the clergy are willing to transport at their own expense.

However, to use transportation other than law enforcement, a physician or mandatory prescreening authority must evaluate and determine that the individual does not require physical restraint or vehicle security.

Secondary transportation agent shall be available 24/7.

Sheriff should consult with county executive or mayor before designating a secondary transportation agency.

Transportation of persons to be involuntarily hospitalized is the responsibility of the county in which the person is initially detained. The county of residence may be billed for transportation costs.

The Department of Mental Health and Developmental Disabilities shall provide training on mental health crisis management for transportation agents and sheriff's personnel.

If a mandatory prescreening agent, physician, or licensed psychologist determines that the person does not require physical restraint or vehicular security,

Then one or more reputable and trustworthy relatives or friends of the person who will assume responsibility for the person's safe deliverance may be allowed to transport the person to the hospital and do so at their own expense.

A person may be detained pending hospitalization in their home or in some suitable facility; however, not in a non-medical facility used for detention of persons charged with or convicted of criminal offenses.

A protocol is needed for each county to establish criteria to determine which individuals are transported by sheriff's personnel and which by a designated alternate agent.

Summarized from Chapter 6, Part 9: 33-6-901, a-b.

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