

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**

Table of Contents

Executive Summary	i
Director's Overview	v
Introduction	1
Agenda Day One.....	3
Presentation Overview	5
Policy Research Associates Presentation	7
Regional Group Breakout – Day One.....	15
Summary of Highlights of Regional Group Work.....	16
Workshop Day Two Summary.....	23
Summary of Regional Priorities for Action Planning.....	23
Summary: Conclusions and Recommendations.....	24
Closing	29
References.....	30

Attachments

- Attachment 1: Agenda
- Attachment 2: Regional Workshop Group Notes
- Attachment 3: Action Planning Matrixes, Regional and State Groups
- Attachment 4: Characteristics of Consumers with Criminal Justice Encounters
- Attachment 5: Standardized Model for Substance Abusing Offenders: A Historical Perspective and Plan for the Future
- Attachment 6: Behavioral Health Jail Diversion Program of Lancaster County
- Attachment 7: Douglas County, Nebraska: Mental Health Diversion Program
- Attachment 8: Hidden Cost of Homelessness – Lincoln, NE
- Attachment 9: Sequential Intercepts for Change: Criminal Justice – Mental Health Partnerships
- Attachment 10: GAINS Re-Entry Checklist for Inmates Identified with Mental Health Service Needs
- Attachment 11: Emergency System Process
- Attachment 12: The EPC Crisis
- Attachment 13: Brief Jail Mental Health Screen
- Attachment 14: Nebraska DHHS Strategic Planning Workshop, Contact Information
- Attachment 15: The New Veterans Court Helps Vets in Trouble Get Back on Track

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 5th and 6th 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 5th and 6th 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.

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Attachment 1
Workshop Agenda

Agenda (as of November 28, 2007) For
Strategic Planning Workshop on Transforming Services for Persons with
Mental Illness in Contact with the Criminal Justice System”

Country Inns and Suites, 5353 N 27th St, Lincoln, Nebraska

December 5, 2007 (Day 1)

9:00 AM Start / Sequential Intercept Workshop

- Introductions / Overview of Two Days (5 minutes)
- Opening Remarks (10 minutes)
Robert Houston, Director, NE Department of Correctional Services
Scot Adams, Director, NE Division of Behavioral Health
- National Overview and the “Sequential Intercepts for Change: Criminal Justice – Mental Health Partnerships” and the Kentucky Jail Crisis Program (Dan Abreu and Connie Milligan) (75 minutes)

Break (10:30 – 10:45)

- Presentation by Shinobu Watanabe-Galloway, Ph.D. (Epidemiology Department, College of Public Health, University of Nebraska Medical Center) on preliminary findings data from NE Department of Correctional Services and DHHS (10 minutes)
- Deb Minardi, Office of Probation Administration – Day Reporting System (20 minutes)
- Travis Parker, Behavioral Health Jail Diversion Program of Lancaster County (10 minutes)
- John Sheehan, Douglas County Mental Health Diversion program (10 minutes)
- Jean Chicoine – NE Homeless Assistance Program (10 minutes)
- Discussion / Q&A on morning session (15 minutes)

Lunch (working lunch Noon to 1:00 p.m.)

Video “Howie the Harp” about Forensic Peer Support in NYC (about 20 minutes)

1:00 PM / Six Regional Breakout Groups (state representatives asked to distribute themselves among regional groups).

- Overview of the afternoon and charge to the breakout groups (Dan Abreu)
- Strengths – The group will identify current strengths within their Region (e.g., programs along the Intercept and other initiatives)
- Gaps - The group will identify current gaps and areas of need along the Intercept model.

(Break around 2:15)

- Prioritizing Gaps – The group will begin to prioritize gaps
- Large group and report out

5:00 End of Day

December 6, 2007 – Start at 8:30 AM

- 8:30 – 8:35 Overview of the morning (Dan Abreau)
- 8:35 – 9:00 Mark DeKraai – Next Steps – the implementation of the Nebraska Justice-Mental Health System Collaboration Planning Project grant from the Office of Justice Programs – U.S. DOJ
- 9:00 – 10:00 Six Regional Breakout Groups – Develop an action plan to address the priorities developed from Day 1 – each group will meet to develop local level priorities and next steps based on the previous day’s discussion.

(Break around 10:00)

- Large Group:
 - o Regions report back to the Large group
 - o Identify the critical State areas needing to be addressed with discussion on how they could be addressed (such as areas for State policy change needed to facilitate local level changes)

Noon – Adjourn

Attachment 2

Regional Workshop Group Notes

Nebraska's Regional Strength and Gap Analysis

December 5, 2007

Workshop Group Notes

Region One - Strength and Gap Analysis

Sue Adams – Facilitator

Intercept 1: The Community and Law Enforcement

Strengths

- Trainings-(specially trained officers) in Scottsbluff/Gering
- Using screening tools, interviews, proper techniques, intervening with mental health consumers, symptom recognition
- Positive relationships with law enforcement
- Meet with, participate in meetings together
- Best availability at hospitals
- Good communication with law enforcement; attend LCRT meetings
- Local Crisis Response Teams in most areas
- Accessed by law enforcement for on-site behavioral health ax.
- Police awareness of WRAP training
- Consumer training on WRAP
- Clinicians using WRAP and CS following up in emergencies
- LCRT-provides alternatives to EPC and calls in ECS for immediate linkages to services
- Familiarity with local families and local resources
- LCRT consumers involvement/input

Gaps

- Need continuous training for officers
- Data-information from law enforcement re: calls involving behavioral health
- Lack of behavioral health professionals for LCRT in Sydney
- Not much “depth” in law enforcement dept
- EPC transport may deplete the force
- Privacy policies prohibits law enforcement from knowing when consumers re-enter system-prepared interventions with appropriate resources

Intercept 2: Initial Detention and Initial Court Hearing

Strengths

- Behavioral health records are available when requested

Gaps

- Training for attorney’s on accessing behavioral health services for clients
- No jail diversion program

Intercept 3: Courts and Jails

Strengths

- Scottsbluff Co.-Mental health, substance abuse treatment available in the jails and medical management
- Kimball, Cheyenne Co.-Substance abuse treatment in jail
- LCRT ax available on request to other jails
- Physical healthcare available in jail in Scottsbluff Co. on-site
- -Scottsbluff Co. bi-monthly meetings with county corrections officer, community health and community behavioral health provides to review provision of services/continuity of care post release
- Post-booking screening (behavioral health as well as medical)
- Drug Courts-Adult and juvenile, family, DWI court

Gaps

- Need to introduce standardized use of screening instruments
- Services available across region
- Funding for medication while incarcerated
- Funding for treatment while incarcerated

Intercept 4: Re-Entry

Strengths

- Before release, packet to fill out for pre-admission for treatment services, appointments made
- Referral by jail staff includes vocational rehabilitation, community health resources
- Some counties call PMHC or others directly to make appointments-continuity of care
- Start 12 step in jail; encourage transition to community 12 step program
- If already enrolled in community support, that support continues upon release (continuity of care)

Gaps

- Access to ECS prior to release
- Access to peer support specialists prior to release
- Lack of communication from prisons-re: re-entry into community
- Funding to acquire identification documents for inmates
- -policy change to access entitlements, treatment
- Re-enrollment for prisoners in Medicaid and other benefits

Intercept 5: Probation and Parole and the Community

Strengths

- Combined treatment update meetings between behavioral health and probation (monthly and phone prn)
- -client specific-sanctioning options to avoid revoking probation if appropriate
- Criminal justice voucher program
 - Housing voucher

- Transitional employment
- Supported employment
- Community support and ECS, all counties covered
- Redirection groups
- Peer Support

Gaps

- Lack of access to meds (money)
- -access to legal distribution site
- Lack of legal follow-up for court ordered outpatient
- Decreased housing
- Decreased peer support specialists
- Decrease number of employers who are willing to hire

Region Two - Strength and Gap Analysis
Denise-Facilitator
Deanna-Recorder
Corey-Reporter

Intercept 1 Community and Law Enforcement

Strengths

- Emergency Support Program (funded by LB1083)
 - 24 hour emergency line for justice
 - One person on phone (EPC's and hospitalization)
 - Behavioral Health Crisis Line is separate from the Justice Emergency Line
 - 24 hour triage on-site
 - Therapist (by phone and in person) to jail or other facility
 - Community support through system for emergencies
 - Behavioral health willing to help law enforcement (good relationships)
- Region 2: 17 counties in Mid-Nebraska
- Great Plains Center

Gaps

- Behavioral Health training for law enforcement
- Detox
- Medication availability and monitoring
- Repeat justice and behavioral health consumers

Intercept 2: Initial Detention and Initial Court Hearing

Strengths

- 24 hour triage on-site
- Therapist (by phone and in person) to jail or other facility
- Community support through system for emergencies

Gaps

- Justice System players using existing resources creatively
- Increased need for behavioral health peer involvement
- Medication availability and monitoring
- Repeat justice and behavioral health consumers

Intercept 3 Courts and Jails

Strengths

- Drug Court
- Justice System players using existing resources creatively

Gaps

- Medication availability and monitoring
- Repeat justice and behavioral health consumers

- Increased need for behavioral health peer involvement

Intercept 4: Re-Entry

Strengths

- Reporting Center (Probation and Goodwill, other services)
- Great Plains Center
- Homeless shelters

Gaps

- Screening at homeless shelters
- Medication availability and monitoring
- Repeat justice and behavioral health consumers
- Increased need for behavioral health peer involvement

Intercept 5: Probation and Parole and the Community

Strengths

- None documented

Gaps

- Need Screening at homeless shelters
- Medication availability and monitoring
- Repeat justice and behavioral health consumers
- Increased need for behavioral health peer involvement

Relationships that Facilitate Planning

1. Emergency Support Program
 - Phone
 - In person
 - Follow-up
 - Peer support
 - Great Plains Hospital EPC
 Peer support
2. Emergency Support Program follow-up
Peer support
3. Drug Court (Midwest)
Peer support
4. Reporting Venter (Lexington), new resource
Peer support
5. Gap-

Summary of Gaps

- Frequent Flyers or Revolving Door
 - Are some of these avoiding extended screening/processing in mental health/substance abuse system due to increase criminal justice involvement?

- Do we need mental health unit/program that specializes in this population modeled after the probation specialized substance abuse supervision?
- No “hammer” related to mental health compliance on probation or diversion
- Lots of anecdotal information-need to know more about this population-better data system to know about this group (statistics)
- Training for law enforcement
- Not just for new officers-need for working officers (veterans)-on mental health identification and intervention
- Medication
- Pre-sentenced medications are covered and post conviction are not covered
- Monitoring and Encouragement (medication and service compliance)
- Availability of medications and monitoring must be joined
- They have to be developed together
- Homeless
- Shelters can use more training in screening/intervention with mental health
- Justice system players-could use some assistance in thinking outside the box
- To take advantage of existing resources to ‘prevent’ emergencies

Other Issues

1. At what point in the system is peer involvement most effective and appropriate?
2. Mental health screening process needs consideration in local jails
3. Veterans services- is it a gap in local areas?
4. What are the privacy barriers in health and justice system-training needed
5. Substance abuse education availability

Region Three - Strength and Gap Analysis

Sheri Dawson - Facilitator

Intercept 1. Law Enforcement and the Community

Strengths - Summary

- Crisis Response Teams work with law enforcement and go to jail
- Triage Center in Grand Island available resource to law enforcement
- Central phone number for law enforcement and others to use/available EPC
- City/County based referrals and resources
- Telephonic Triage or face to face evaluations
- Relationships are collaborative
- Hastings law enforcement training, openness

Strengths – Detail

Crisis Response Teams

- Cover 75% of Region
- Mental Health Professionals
- Go to jail, receptive to help
- Work at training law enforcement (ongoing)
- Positive relationships in region with each other
- Hastings Law Enforcement open to training on behavioral health
- Recognition repeat/cycle thru system means we can help know their needs WRAP training, peer involvement, law enforcement aware of plans, ask about plan
- 6 Peer Support Specialist across region (only 1 funded by region)
- Provider commitment
- Law Enforcement asking about service (eg. ECS worker) will engage that provider
- Crisis stabilization option/know who to call

Triage Center—24/7 in Grand Island

- Central phone number, law enforcement et other to use (not if clear EPC)
- Location based options and referrals
- Telephonic triage or face-to-face

Gaps

- Transportation (secure transport, help families) address impact on law enforcement
- Inability to gather mental health commitment information (avoid EPC if know person on out patient commitment)

Intercept 2. Initial Detention and Initial Court Hearing

Strengths

- Coordination, cooperation between most counties, providers
- Emergency BH meetings include public defenders
- Post-booking screen/evaluation and communication with provider

Gaps

- Increase judges awareness of crime and behavioral health needs

Intercept 3. Courts and Jails

Strengths

- County Substance Abuse Drug Courts (4 counties) for adult substance abuse, felony
- Access to timely treatment (targeted funding to serve justice population)
- Building on success for family court
- Target justice population for funding

Gaps

- Implement family drug court identify/find funding for family et expand courts
- Judge training-need working relationship to identify strategies for an individual
- Lack of assessment to help judges meet needs
- -save jail time

Intercept 4. Re-Entry

Strengths

- Jail and Emergency community support workers collaborate on plans - Jail and ECS workers connect with plans
- Judges accept/understand treatment needs
- Awareness of judges' acceptance/willingness/see benefit of treatment

Gaps

- No case management to assist with planning
- No peer specialist with planning for individuals
- Lack of re-entry planning system/coordination

Intercept 5. Probation and Parole and the Community

Strengths

- Housing, providers, region, supportive employment, probation, etc. positive relationships to problem solve - Interface at work with ACT in Region 3
- Some medication assist for Board of Mental Health commitments - Make affordable - Make Connections
- Specialized SA service officers (SASS) (2 of them), Buffalo County - involve training -Specialized SA officers

Gaps

- Case management to get referrals clients working to ensure following plan for success
- Need more SASS officers

Throughout Model:

Strengths

- Region Emergency System Specialist as a resource

Gaps

- Demand exceeds services/funding (fulfill gaps)
- Out patient, medication management, IOP
- Case management throughout
- Gap in obtaining/sharing information
- Legal assistance to resolve issue
- Access meds (no entitlement), system not developed at this time
- Throughout model, underutilizing available resources and law enforcement training/receptive to collaboration/change in system

Region Four - Strength and Gap Analysis

Jean Chicoine - Facilitator

Intercept 1 Law Enforcement and the Community

Strengths

- Have CRT throughout region
- Community support in every county
- Initial training of law enforcement
- Good police incident documentation

Gaps

- Inconsistent use of CRT (easier, less time consuming to use hospital)
- Transportation (liability issues)
- Inconsistent communication across region between law enforcement and mental health (1)
- Lack of cross-training
- Use of jails as human services agency
- Delivery of services across large geographic areas

Intercept 2 Initial Detention and Initial Court Hearing

Strengths

- Every area/region has a contact number for persons in detention (for mental health)
- Some system is in place to provide meds when person is incarcerated

Gaps

- Lack of appropriate screening and intervention
- Lack of communication and collaboration between law enforcement and mental health (1)
- “Silos” in service delivery
- Lack of diversion opportunities across the state
- Too much reliance on self-reporting

Intercept 3 – Courts and Jails

Strengths

- Drug/specialty court
- Judges good about ordering mental health evaluations
- Assessments done (if mental health problem is identified)
- Court ordered evaluation and court ordered treatment for substance abuse
- Standardized substance abuse assessment tools

Gaps

- Lack of psychological services or substance abuse for incarcerated (service and meds)

- -(i.e. 6 for 22, counties) (those in jail, at jail site)
- Lack of individualized programming
- Few and inconsistent diversion programs
- Inconsistency in sentencing (based on familiarity of client)
- Collaboration of services with 4 Native American tribes in Nebraska

Intercept 4 Re-Entry

Strengths

- Medicaid/Medicare eligibility determination (in jail/prison)
- Transition plan for state correctional facilities

Gaps

- Lack of services and medication for re-entry period
- Pre-release eligibility for SSI/SSDI
- Lack of transition plan; especially for jails

Intercept 5 – Probation and Parole and the Community

Strengths

- Case planning done for probation (includes employment, accessing SSI/SSDI)

Gaps

- Lack of identification (any mental health provider) of probation/parolees in the mental health/substance abuse system (to direct to appropriate services)
- Lack of follow-up with newly released individuals (services, counseling, housing, employment)

Region Five - Strength and Gap Analysis

Intercept 1 Law Enforcement and the Community

Strengths

- No strengths data reported

Gaps

- Transportation for EPC
- DEC over 200% of capacity CSH
- Missing a TASC-like program for the Lincoln Police Department targeting persons EPC'd to crisis center for 2 or less days
- Rural providers not having a good understanding of the behavioral health emergency systems
- Information gap-transfer of mental health information with patient coming to the SOC when a person is on CSH status.

Opportunity

- Instead of transporting service recipients, transport staff

Intercept 2 Initial Detention and Initial Court Hearing

Strengths

- TASC program-assessments to county jails for persons with substance abuse and mental health problems who are at risk for EPC or transfer to DEC

Gaps

- Lack of integrated real time data/information-mental health/substance abuse histories
- Need accurate history information in a short period of time
- Services-Jail Diversion-might not be accessible to first time contacts-no mental health treatment, history, diagnosis, etc.
- Information/history needs to follow a person from intercept 1 through intercept 5
- No sustainable funding for jail diversion program
- Liability issues for officers, providers, etc. (1) Is a gap at all intercepts-it influences decision making
- Funding for services

Intercept 3 Courts and Jails

Strengths

- No strengths data reported

Gaps

- Treatment (substance abuse or mental health) within jail setting
- Limited capacities for existing programs
- Some programs don't have sustainable funding
- Transportation to and from work release
- Vouchers not available for all offenses

- Housing a problem for persons on pre-trial release
- Programs for mothers and children to promote bond and/or early childhood development
- WRAP training for individuals sitting in jail
- Funding for services (3)

Intercept 4 Re-Entry

Strengths

- No strengths data reported

Gaps

- No discharge planners at Region 5 jails
- Communication for discharging inmate with Medicaid office
- -What is the communication? There is a lapse between corrections discharge and Medicaid office
- No acceptable substance abuse evaluation done for a person prior to discharge from jail
- Sex offender treatment in community
- Lack of state money invested in resources
- -Metro Community College went away
- Funding for services

Intercept 5 Probation and Parole and the Community

Strengths

- No strengths data reported

Gaps

- Funding for services
- Housing-supported housing for probationers/parolees
- Limited money for community corrections council- focus is primarily on felony offenders
- Supported employment
- Disconnect between treatment recommendations and eligibility for services
- I.E. - IOP for a person who has been sober and incarcerated for six months
- Not enough discharge medication for DOC/local inmates

Region Six - Strength and Gap Analysis

Region Wide Assets/Strengths

- Mobile Crisis Team-Dodge County Pilot/Lutheran Family Services
- -Fremont
- -Soon to be in Sarpy County/ Dec. RFP
- Consumer positive response
- -Re. Diversion Program
- Probation: Specialized caseloads
- CIT Program: Omaha-expanded to other counties (combo of this with Mobile Crisis Team is important)
- -Educate L.E. to divert from custody
- -Dispatchers
- -O.P.D. and NAMI involved
- 4/8/08-Lasting Hope Recovery Center
- -New beds with triage component at Old Richard Young
- Screening for Mental Illness at time of booking then screened for Diversion Program
- Vocational Rehabilitation-in house, co-located, representative in Justice Center
- Day reporting location
- Juvenile-Triage Center RFP-assessment and plan
- -Douglas/Sarpy
- -3/08 up and running
- Emergency B.H. Task Force-problem-solving is consistent with team
- Management Information System, state level-D/S integrated
- Inter-agency collaboration
- Mental Health Court
- Existing diversion programs
- -Lincoln and Omaha
- Consumer/peer support and WRAP (Personalized Wellness Plan) is strong and accessible for consumers

Region Wide GAPS

1.

- Perception of 'lack of beds' and 'holding beds'
- Lack of security in facilities
- -Exclusion, inclusion criteria
- -Education about who is violent, suicidal, homicidal violence
- Abuse of system-how to identify and manage and monitor
- Sufficient housing to help people transition out of high levels of care; creates back log, not a bed capacity issue
- -Up or down, high and low levels of care
- -Pre-discharge planning
- Mental Health vs. Substance Abuse, peer specialists
- -Paid, volunteering, sponsoring
- Medication compliance
- Douglas City: Mental health and physical health
- -Primary health care not integrated
- Data warehouse (lack of): Fragmented information systems-not connected
- Lack of understanding/knowledge
- -Re. HIPPA related issues and access to information and how to share information with other service providers (PHI), CJ vs. Public
- -Volume issue- i.e. arrest records
- -Use of MOU to bridge gaps
- Substance abuse treatment beds (lack of)
- WRAP services for individuals waiting for residential treatment services
- -Beds for families
- Lack of global system professional-getting arms around system, staying up-to-date

2.

- Pre-trial Mental Health diversion outside of Douglas County
- Youth transitioning to adult system-Corrections and behavioral health
- Workforce-B.H.
- CIT Training outside of O.P.D.
- Medication services in and out of corrections
- Mental health services in correctional facilities
- County Attorneys (?) and Public Defenders, judges need education
 - Benefits of diversion
 - How to engage clients for long term mental health quality of life, not just "this charge"
 - Best-interest vs. "crime and punishment"
- Community Program criteria
 - More inclusive admission criteria vs. exclusive specific behaviors, i.e. sex offending behavior
- Information sharing between providers
 - HIPPA
 - "Kids aging out"

- Medicaid coverage suspended when incarcerated and delay with reactivating once released (1)
- When paroled, 2 weeks of medication given at discharge-recidivism
- Maybe need re-entry-pre-discharge so services are set-up
- Silo's/B.H./Corrections (sharing info) = lack of knowledge with other state agencies
 - Adult and child cross cutting
- Just scratched service with Juvenile system
 - Juveniles in adult system-needs work, lack of financial resources, special challenges
 - “Charging youth as adults”-special challenges

Attachment 3

Action Planning Matrices, Regional and State Groups

REGION 1				
QUICK FIX 2				
Standardize Screening instrument for Post Booking				
OBJECTIVE		ACTION STEP	WHO	WHEN
2	Standardized screening instrument for Scottsdale County	a. Present Brief Jail MH Screen to Department of Corrections	Pamela	1-14-08
		b. Review existing screen for MH/SA in use	Pamela	1-14-08
		c. Make decision on jail screening instrument	Pamela	2-1-08
		d. Train staff on the use of the the tool and referral procedures	Pamela	2-15-08
		e. Implement use of screening instrument	All	3-1-08
		f. Monthly tally: 1) total screenings 2) positives 3) referrals	Department of Corrections	Begin 4-1-08
		g. Work with state to investigate reporting system for inmates with MH/SA issues meeting criteria	Sharyn	3-1-08

REGION 1				
PRIORITY AREA 1:				
Access to Peer Support Specialist prior to release				
OBJECTIVE		ACTION STEP	WHO	WHEN
1	Access to peer support prior to release in target areas	a. ID consumers who can be trained to provide peer support services	Judie	3-1-08
		b. ID community areas to initially target	Judie/CS worker	3-31-08
		c. Locate trainers	Judie	3-31-08
		d. Collaborate with WNCC to offer training	Judie/college contact	5-1-08
		e. Provide training to PS designated officers	Judie/WNCC	8-31-08
		f. ID funding for PS (from KC one-time \$, conference grant, ongoing)	Sharyn/Judie	1-31-08
		g. Contact area jail officials for permission /buy-in	Judie/Calvin	2-15-08
		h. Develop regional definition for PS to be provided	Judie/CIC	2-1-08
		i. Implement PS in local target jails	Judie, Sharyn	10-1-08
		j. Evaluate number of referrals generated by PS and number of contacts	Judie	11-1-08

REGION 1				
PRIORITY AREA 2:				
Access to medication				
OBJECTIVE		ACTION STEP	WHO	WHEN
2..	Increase access to medication for individuals released from incarceration for SC County jail	a. Discuss request with Department of Corrections staff to direct inmates in the re-application process for Medicaid and Medication Assistance program for which they are eligible prior to release	Pamela and Sharyn	1-14-08
		b. Work with PMHC nurse to identify necessary Med, Assistance info required and provide forms to Corrections staff/inmates prior to release	Ginger APRN-	2-1-08
		c. Identify required form and provide to inmates to facilitate re-applying for Medicaid prior to release	DOC staff	2-1-08
		d. Provide technical assistance, answer questions and support DOC staff with applications when needed	Assigned ECS worker Peer Support	2-1-08

REGION III				
PRIORITY AREA 1:				
Develop and implement a coordinated re-entry system that will decrease recidivism				
OBJECTIVE		ACTION STEP	WHO	WHEN
1..	Every individual going through the system has a referral to some service that meets indentified needs	Meet with criminal justice partners in Adams County	Beth/Doyle	Jan '08
2..	Develop a pilot project in Adams county that effectively addresses current gaps	a. Gather all existing data and policies	Beth/Doyle	Prior to first meeting
		b. Flow chart current process	Beth/Doyle	At first meeting
		c. ID criteria for population to service in pilot		Feb' 08
		d. ID screening tools and implement screening	Adams Co. team	March '08
		e. Develop interview and follow-up for those screened positively	BH and CJ pilot team members	May '08
		f. Implement re-entry plans through case managers/community support	Team	
		g. Identify funding for case management/community support	Team	
		h. Seek legislative changes (LB40 carve out)	Team	

REGION III PRIORITY AREA 2: Improve medication access to individuals throughout the criminal justice process to decrease costs, improve individual medication adherence				
OBJECTIVE		ACTION STEP	WHO	WHEN
2.	Develop Hall County Pilot Project with Hall County Corrections that effectively addresses medication cost and access to medications	a. Gather existing medication costs/contracts	Beth/Hall Co. Corrections	Jan '08
		b. Meet with partners to flow chart medication process from beginning to end of process		
		c. ID gaps in access and problem areas	Beth/Hall County Corrections Team	March '08
		d. Develop action plan to improve system		
		e. Seek funding and legislative changes (Creative expansion of LB95 program to ensure medication access and increase individual medication adherence)		Throughout process: County funding requests due by May, other state requests due during legislative session

REGION IV				
PRIORITY AREA 1:				
Develop system to ensure mental health and substance abuse treatments are accessible for persons who are incarcerated				
OBJECTIVE		ACTION STEP	WHO	WHEN
1.	Increase collaboration	a. Identify major stakeholders	Melinda	December 20. '07
	Include Representation: <ul style="list-style-type: none"> Housing specialist BH program 	b. Define current process of incarceration (hold meetings)	Melinda and Marcy	January 20, '08
	<ul style="list-style-type: none"> Law enforcement – jail staff, parole, probation 	c. Identify gaps using intercept model		
	<ul style="list-style-type: none"> Hospital 	d. Next steps determined after action step C and report back to stakeholders	Stakeholder and Marcy/Melinda	February 20, 08
	<ul style="list-style-type: none"> Voc Rehab 			
	<ul style="list-style-type: none"> DHHS entitlements 			
	<ul style="list-style-type: none"> SSI/SSDI 			
	<ul style="list-style-type: none"> Community Mental Health 			
	<ul style="list-style-type: none"> Residential and outpatient MH 			
	<ul style="list-style-type: none"> Others as identified (i.e. public defenders, mental health board) 			

REGION V				
PRIORITY AREA 1:				
Sharing Information: Information – Treatment history following a person from Intercept 1 through Intercept 5				
OBJECTIVE		ACTION STEP	WHO	WHEN
1.	Have real time information follow an individual	a. 1.Seek ongoing sustainable funds	RHIO Board Region V	Now – on-going
		b. 2. Bring corrections into the discussion when looking at the RHIO: Parole, Probation, Community Corrections, Council and Crime Commission		
		c. 3. Work with DHHs in developing regional data bases to perform current Megellan “ASO functions		
		d. 4. Develop a web access data base where consumers Actions Plans and safety plans are maintained	Teresa Gomez with Region v	Now
		e. Getting BH, Corrections, etc. to agree on format for safety plans	Teresa Gomez with Region V	Now
		f. 6. Bring County Jail on line with information sharing		
		g. 7. How NIS might be available to person – this is done through probation		
		h. 8. Bring a proposal to the Community Corrections Council for possible finding to assist in the effort	Julie Hipper and C.J. Johnson	End of March 2008

REGION V
PRIORITY AREA 2:
Supported Housing for Probationers/Parolees Coming Back in to Region V

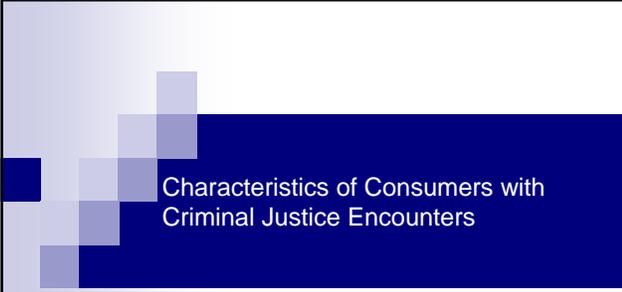
OBJECTIVE		ACTION STEP	WHO	WHEN
2.	Supportive Housing	a. Seek funding: a. Fund Forensic Case Management support since individual has to be connected with community support to qualify for funding. Use some strategy such as LB40 to work with legislature to carve out dollars from real estate stamp tax for this population to be housed	Work with Senator Syrowecki or Pederson	For 2009 legislative session
		b. Rent-wise program-education for person on how to be a good renter	Jim Harvey	FY '07-'08
		c. Discharge planners access website lists of landlords, rental cost, etc. to help tease person better plan for housing	John Turner @ Region V	FY '07-'08
		d. Train MH staff in Corrections on Rent-Wise program	Jim Harvey	FY '07-'08
		e. Explore Community Integration requirement within Initial Sentencing	Community Corrections Council	Now

REGION V PRIORITY AREA 3: Sustainable funding for the Behavioral Health Jail Diversion Program of Lancaster County				
OBJECTIVE		ACTION STEP	WHO	WHEN
3.	Sustainable funding for Jail Diversion	a. Monitor LB669 and LR99 to explore legislative funding possibilities	Travis Parker	2008 legislative session
		b. Explore other grant possibilities, foundations, etc.	Travis Parker	On-going
		c. Work with Lancaster County Board to explore possibility of full funding from Board if needed	Travis Parker	FY '08-'09
		d. Work with Division of BH and/or Region V system to seek partial funding if needed	Travis Parker, Jim Harvey, C.J. Johnson, Scot Adams	FY '08-'09
		e. Potential contracts with Rural County Jails to provide jail diversion services	Travis Parker	FY '08-'09
		f. Look at creating program replicas to create sustainability	Travis Parker	FY '08-'09

STATEWIDE GROUP: DCS, Community Corrections, Probation				
PRIORITY AREA 1:				
Forensic Seamless Service System: information sharing/data management/ service coordination				
OBJECTIVE		ACTION STEP	WHO	WHEN
1.	Develop a system to “flag” individuals with mental health concerns (Forensic Community Support System)	a. Identify a work group with DCS, Parole, Probation, Community Corrections, HHS	New Committee See below	January 2008 (?)
		b. Identify criteria	Medicaid?	
		c. Identify referral process		
		d. Identify role and intervention points		
2.	Integration of discrete data management system from all regions – using data from interceptions 1-5	a. What data needs shared and with whom	New Committee	January 2008
		b. MOUs		
		c. Increase efficiency/access		
		d. Identify levels of access		
		e. Resolve legal issues		
	Participants:	Cameron White, Steve King, Linda Krutz, Deb Minardi, Mark Weilage, Jim Harvey		

Attachment 4

Characteristics of Consumers with Criminal Justice Encounters



Characteristics of Consumers with Criminal Justice Encounters

December 5, 2007
Shinobu Watanabe-Galloway, PhD
University of Nebraska Medical Center



Follow-up Population

- Adults (age 18 and older) who are served within the Regional Center units to be downsized at Hastings and Norfolk, as well as, the Lincoln Regional Center's Short Term Care Unit and Community Transition Program.
- The consumer "enters" the Regional Center Discharge Follow-up System after being discharged from the Regional Centers following a stay in one or more of the Behavioral Health Reform Units

2



DHHS data sources

Data Sources	Description
Magellan	Magellan Behavioral Health Information System data. Covers community mental health and substance abuse programs.
MMIS	Medicaid Management Information Systems data. Provides Medicaid claims information.
N-FOCUS	Nebraska Family On-Line Client User System. Management information system operated by the Nebraska Health and Human Services System that supports over 40 programs.
AIMS/ Avatar	"Advanced Institutional Management Systems" (AIMS) and Avatar contain state psychiatric hospital data.
Axis	Provides information on DSM Axis diagnosis codes and diagnosis dates.

3



NDCS Data

- In August 2007, Nebraska Department of Correctional Services (NDCS) provided datasets pertaining to criminal histories of persons in the NDCS database.
- NDCS datasets were linked to the DHHS data using the social security numbers of those consumers in the follow-up study.

4

- Data period for this presentation:
January 1, 2005 – June 30, 2007
- 1,004 consumers entered the follow-up system
- 38 of these consumers were found in the NDCS database

5

38 consumers with CJ encounters

- 2 had been in prison prior to entering the follow-up system (5.3%)
- 3 were transferred to prison on the day of the regional center discharge (7.9%)
- 33 were imprisoned at some point after discharged from one of the regional centers (86.8%)

6

Number of Arrests

- 36 out of 38 consumers had multiple arrests
- The number of arrests:
 - Range: 1 – 53
 - Mean: 15.3

7

Age Group	Follow-up population	Consumers with CJ encounters	NDCS population
18-20	26 (2.6%)	0 (0.0%)	338 (4.7%)
21-30	275 (27.4%)	9 (23.7%)	2631 (36.2%)
31-40	250 (24.9%)	12 (31.6%)	1925 (26.5%)
41-50	241 (24.0%)	13 (34.2%)	1700 (23.4%)
51-60	146 (14.5%)	4 (10.5%)	533 (7.3%)
61-70	51 (5.1%)	0 (0.0%)	107 (1.5%)
71 and older	15 (1.5%)	0 (0.0%)	20 (0.3%)
Total	1004 (100%)	38 (100%)	7260 (100%)

8

	Follow-up population	Consumers with CJ encounters	NDCS population
Male	598 (59.6%)	33 (86.8%)	6320 (87.0%)
Female	406 (40.4%)	5 (13.2%)	940 (13.0%)
Total	1004 (100%)	38 (100%)	7260 (100%)

9

Psychiatric Diagnosis Combinations among Consumers in F/UP System

Living Status	Number of Readmissions		
	0	1	≥2
SMI, SRD, PD	281 (34.1%)	50 (35.7%)	20 (48.8%)
SMI, SRD	144 (17.5%)	18 (12.9%)	1 (2.4%)
SMI, PD	106 (12.9%)	20 (14.3%)	9 (22.0%)
SMI	97 (11.8%)	12 (8.6%)	0 (0.0%)
SRD, PD	30 (3.6%)	4 (2.9%)	0 (0.0%)
Other combinations	165 (20.0%)	36 (25.7%)	11 (26.8%)
Total	823 (100%)	140 (100%)	41 (100%)

SMI: Serious mental illness SRD: Substance-related disorder PD: Personality disorder 10

Psychiatric Diagnosis Combinations among Consumers Encountered CJ System

	Number	Percentage
SMI, SRD, PD	22	57.9%
SMI, SRD	4	10.5%
SMI, PD	0	0%
SMI	3	7.9%
SRD, PD	5	13.2%
Other combinations	4	10.5%
Total	38	100%

SMI: Serious mental illness SRD: Substance-related disorder
 PD: Personality disorder
 * Number was suppressed due to a small cell size 11

Question?

Shinobu Watanabe-Galloway, PhD
 College of Public Health
 University of Nebraska Medical Center

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 swatanabe@unmc.edu 12

Attachment 5

Standardized Model for Substance Abusing Offenders: A Historical Perspective and Plan for the Future

**Standardized Model for Substance
Abusing Offenders:
A Historical Perspective and Plan for the
Future**

To Illustrate the Problem:

22 Year Old Male

Current charge: Possession of Methamphetamine

Positive Drug test when placed on probation for
Methamphetamine

Extensive Drug use history beginning at age 17

Prior record: Poss of Marijuana, DUI, 2 - alcohol
related assaults and current charge. 5 arrests in 5
years all substance abuse related

Substance Abuse Evaluation Recommends.....

Recommendations

Drug and Alcohol Education

*Clearly no connection between risk of the offender to re-
offend, the current and previous offenses and the substance
abuse evaluation recommendations.*

***Research Supports the
Correlation between Crime
and Substance Abuse***

Purpose:

- *The Standardized Model is about making a connection between Reducing Recidivism, Treatment and Public Safety*

- *The standardized model for substance abuse is the vehicle used to accomplish the goal of recidivism reduction*

Background

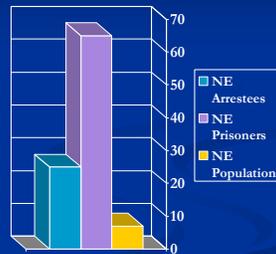
- In 1993, technical review prepared for Nebraska's Department of Public Institution concluded:
 - The relationship between probation and treatment systems was 'ad hoc' and "dependent on the good will and energy of each individual probation officer and each individual treatment provider".
- In 1996, a group of justice practitioners began meeting to address problems related to substance abuse treatment.
- In 1997, group named itself the Criminal Justice Coordinated Response and worked to:
 - Identify gaps in the criminal justice system related to treatment;
 - Eliminate fragmentation in services through the CJ continuum;
 - Identify effective treatment modalities for offenders; and
 - Integrate predictors of recidivism into substance abuse treatment.

Background [cont'd]

- Criminal Justice Coordinated Response work mostly based on the Colorado model
 - Use of legislation to move agenda forward
 - Grassroots initiative
- Resulting in 1999 Legislation
 - LB 865 (Co-Sponsors: Senators Thompson, Hilgert, & Pederson)
 - Created Substance Abuse/Justice Task Force
 - to complete a series of tasks, including the development of a standardized model for assessments
 - offer recommendations to improve justice system's response to substance abuse
 - Governor-appointments

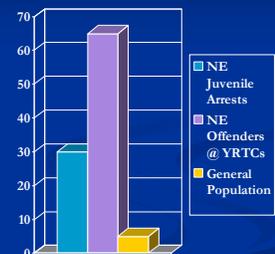
Adult Offender Estimates of Need

- 25-40% of *adult arrestees* in Nebraska need substance abuse treatment.
- 65-85% of *incarcerated adult offenders* need substance abuse treatment.
- **Only 7%** percent of *all adults* in Nebraska need substance abuse treatment.
- Based on these estimates, between **13,900 to 22,241** *adult arrestees* needed some level of substance abuse treatment in 1997.



Juvenile Offender Estimates of Need

- 30-40% of *arrested juveniles* in Nebraska need substance abuse treatment.
- 65-80% of *juvenile offenders at Nebraska YRTCs (Geneva and Kearney)* need substance abuse treatment.
- **Only 5%** of *all juveniles* in Nebraska need substance abuse treatment.
- Based on these estimates, an estimated **6,147 to 8,196** *juvenile arrestees* needed some level of substance abuse treatment in 1997.



Effectiveness of Addiction Treatment

- Treatment of addiction is as successful as:
 - the treatment of other chronic diseases such as diabetes, hypertension, and asthma as long as treatment “best practices” are implemented (NIDA, 1999).
- Treatment of addiction results in cost savings:
 - Estimates show that for every \$1 spent on treatment, there is a \$4-\$7 reduction in drug-related crime and criminal justice costs (CALDATA Study, 1994).
- Coerced addiction treatment works:
 - Sanctions or enticements from the criminal justice system can significantly increase treatment entry, retention rates and the success of drug treatment interventions.

Funding for SA Treatment

- In Fiscal Year 2000, the total amount of substance abuse treatment dollars was \$19,702,701.
- Of these dollars,
 - 4% was allocated to the adult criminal justice system via the Department of Corrections.
 - 1% was allocated to the juvenile justice system via the Office of Juvenile Services.
 - No substance abuse dollars were specifically allocated to the courts or probation.
 - Majority of funds were allocated to the public substance abuse treatment system which served some justice clients.
- Adjusting for inflation, substance abuse treatment dollars decreased 16.5% since 1992. (2000 HHSS Data)

Addiction Treatment “Best Practices”

- Appropriate matching of treatment settings, interventions, and services to individual needs.
- Recognition of relapse as normal in viewing drug addiction as a long-term process.
- Inclusion of multiple types of behavioral modification therapies and service models.
- Addressing multiple needs (e.g., medical, psychological, social, and criminogenic), not just substance use.

Gaps in the Justice/ SA Provider Relationship

- Inconsistent coordination and communication
 - Lack of cross-training
 - Lack of information sharing
- Lack of criteria and accountability
 - Selecting offenders for evaluations (Justice)
 - Producing quality evaluations (SA Providers)
- Need to reexamine and update treatment approaches specific to meet needs of offenders
- Limited system resources to pay for SA treatment
- Limited availability of Licensed Alcohol/Drug Abuse Counselors (LADC) & Certified Provisional Alcohol/Drug Abuse Counselors (PLADC)
 - 1 LADC/3,068 NE Residents
 - 1 LADC/12,500 Western NE Residents

SUMMARY of T/F Work: 1999-2002

- Standardization Subcommittee
 - Developed Standardized Model including selection of SSI, SA Assessment tools (ASI/CASI), & draft reporting format documents
 - Held initial training for 50 justice & 50 providers on Standardized model & for providers on the ASI & CASI, October 2000
- Risk Assessment Subcommittee
 - Reviewed risk tools used in adult and juvenile justice agencies
 - Developed draft risk assessment reporting format
- Training Subcommittee
 - Contracted for development of cross training curricula modules

Governor’s Task Force (2002-2004)

- Inconsistent Recommendations from SA Evaluation
 - Providers Relying on Offender Self-Reporting
 - No Consideration of Risk Factors
 - No Consistency in Reporting to Judiciary, Probation or other Justice Agencies
- Quality of Evaluations Vary Across Providers
- SA Evaluation Shopping
- Inability to Identify Service Gaps in System
- No Outcomes Measurement
 - How do you determine if treatment works
 - How do you determine what works best for offenders

Overview of Standardized Model for Substance Abuse & Justice Systems

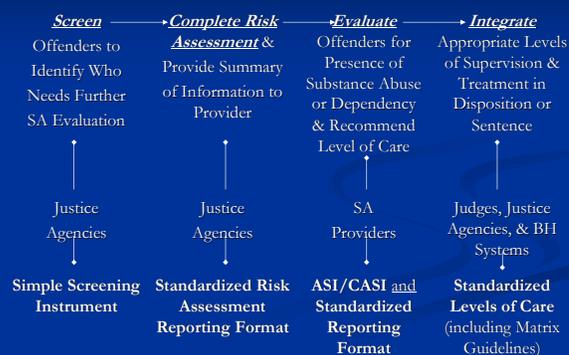
Goals of the Standardized Model:

1. To ensure that all offenders are consistently and accurately screened and evaluated (when necessary) for substance abuse/dependency.
2. To ensure that all SA offenders are consistently and accurately assessed for risk of re-offending.
3. To coordinate & formalize information sharing both ways between the Judiciary, Probation, other justice agencies and providers of screening and risk and SA assessments.
4. To integrate levels of SA treatment care with offender accountability.

Components of the Standardized Model:

- Screening for SA and Risk Assessment completed by Justice
- Evaluation completed by SA Professionals

Model Process & Requirements



Between 500 -600 providers have completed training on the standardized model (2004)

More providers are asking for training everyday

All providers will receive a good faith grace period during the implementation period

Probation's Response to the Standardized Model

- Screening/Assessment (SSI and SRARF)
- Evaluation Referral (Formal Communication)
- Evaluation (Standardized Reporting Format)
- Treatment (Standardized Levels of Care)
- Registered Providers
- Data Collection
- Training

Assessment

- Conducted by a probation officer at the time of a presentence investigation or after having been placed on probation by the Court and includes two parts:
 - Simple Screening Instrument (SSI)
 - *Screens for a potential substance abuse problem and need for further evaluation (4+ refer for evaluation)*
 - Standardized Risk Assessment (SRARF)
 - *Assesses the risk for recidivism of an offender*

REGISTERED PROVIDER CRITERIA

Evaluations for justice clients are completed by:

1. A clinician licensed in Nebraska with their scope of practice to assess and treat substance abuse disorders; AND
2. The clinician completes the Standardized Model Orientation; AND
3. The clinician attends and shows proficiency in the ASI or CASI; AND
4. The clinician passes training on the Standardized Reporting Format; AND
5. The clinician agrees to take 6 hours of criminal justice thinking and behaviors related to substance abuse disorders and participate in 12 hours of ongoing training every 2 years.

Evaluation Referral

- Referral for Substance Abuse Evaluation form (release authorization in body of form)
- Attach: SSI/SRARF/Prior Offense/BAC/Drug test result (if available)
- Referral to Registered Provider
- Signed Release of Information to provider on file during probation term

NEBRASKA STANDARDIZED REPORTING FORMAT

- Purpose:
 - Standardized Organization of Evaluation Information
 - Consistency in Reporting Format When Received by the Judiciary and Justice Agency
 - Provide a Common Unified Language for Consistent Information Exchange Between Treatment Providers, the Judiciary and Probation or other Justice Agency.

Standardized Evaluation Format

- Demographics
- Presenting Problem
- Medical History
- Work/School/Military
- Alcohol and Drug History
- LEGAL HISTORY
- Family/Social/ Peer

Standardized Evaluation Format cont.

- Psychiatric/ Behavioral History
- Collateral Information
- Diagnostic/ Screening Tools
- Clinical Impression
- **Recommendations**
 - Primary level of care
 - Available level of care

NEED FOR STANDARDIZED LEVELS OF CARE / SERVICES

- Varying SA service definitions used in different systems and by different private providers
- Perception that one SA treatment can help everyone (e.g., Inpatient)
- No consistency in treatment recommendations with multiple service terms/definitions (one person's outpatient could be another's intensive outpatient)

LEVELS OF CARE / SERVICES

- Levels of Care
 - Assessment/Evaluation Services
 - Screening: brief set of questions to determine the level of the SA problem and refer for full assessment
 - Evaluation: process using psychometric assessment instruments to determine the severity of a Substance Abuse problem and the intensity level of care/service a client would need to change behavior; generally completed in a non-residential setting
 - Treatment Services
 - Intensive Out-Patient, or Out-Patient Counseling

Registered Providers

- Meet provider criteria
- Understand the model process
- Agree to the requirements of the model
- Register their services with the Office of Probation Administration
- Registered Provider list provided by Probation Administration
- Chiefs obtain and maintain up-to-date copies

Data Collection

- Enter SSI and SRARF Data into CJIS and NPMIS
- Upon receipt of SA evaluation the following information is entered into NPMIS under the model tab:
 1. The date completed
 2. Ideal Level of Care
 3. Available Level of Care
 4. Offender Drug of Choice

Training

- All Probation Officers/Case Managers will:
 - Be trained on the model, the process and tools
 - Be trained on the principles of criminogenic risk and need factors
 - Be trained on the nature of substance abuse addiction
 - Understand the operation of Nebraska's substance abuse delivery system
 - Understand the incorporation of the model into PSI/PDI's and supervision
 - Understand utilization of NCJIS and NPMIS in data collection

*The Standardized Model is about
making a connection between
Reducing Recidivism,
Treatment and
Public Safety*

Thank You

Attachment 6

**Behavioral Health Jail Diversion Program
of Lancaster County**



Evaluation Findings

November 15, 2007
 Sheraton Station Square Hotel
 Pittsburgh, Pennsylvania

Today's Presentation

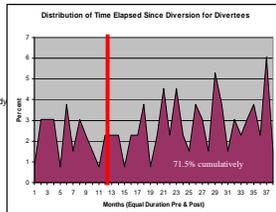
- Methodology – different sources of data and sample sizes.
- Recidivism:
 - Why incarcerating persons with mental illness is an issue.
 - Divertees recidivate less compared to other persons—will compare 3 groups of persons.
 - Divertees recidivate less compared to their own previous behavior.
- Divertees use fewer emergency services.
- Divertees' attitudes have improved.
- Divertees' symptoms have improved.
- Divertees are no longer unemployed and looking for work.
- Questions?

Methodology

Two recidivism research designs:

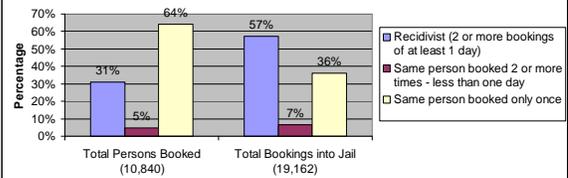
1. Comparison Groups:
 - No association with mental illness
 - Potentially mentally ill persons who remain in corrections
 - Divertees
2. Classical pre- and post-test design:
 - Individual level pre- and post-diversion booking comparison
 - One year prior and one year post
 - Equal durations: ranging from 38 months to less than 1 month
 - 71.5% of the equal duration sample have a study period greater than 12 months
 - T-test
 - What is a paired samples t-test?
 - 90% confidence interval

- Longitudinal design
- Symptoms
 - Improvement
 - Employment



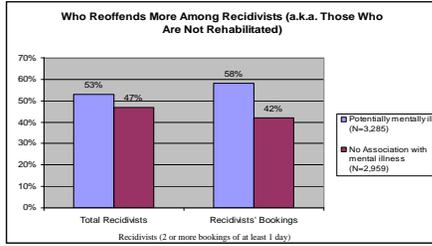
Those Who Re-Offend Commit Most of the Crimes

Who consumes the most jail capacity in Lancaster County Corrections?



- 31% of those booked are responsible for 57% of the bookings (a.k.a. arrests)-This is a 2 year "snap shot" at the L.C.J.
- How "recidivist" is operationalized.

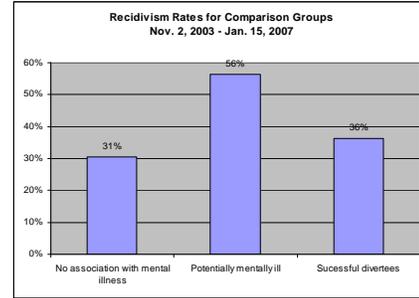
Recidivists Differentiated by Mental Illness



Persons who are potentially mentally ill:

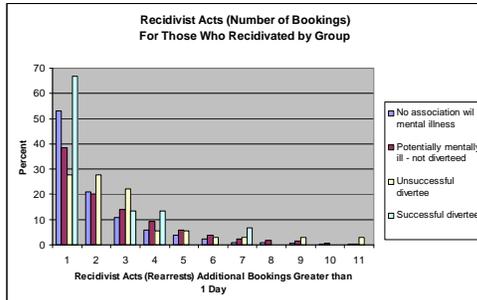
- Are the majority of those booked back in and;
- They account for disproportionately more than their share of the recidivists' bookings.
- 53% of recidivist population comprises 58% of recidivist bookings.

Divertees Recidivate Less Than Others with MI in Corrections



Dimensions of Recidivism

Successful divertees are booked back into jail less often.

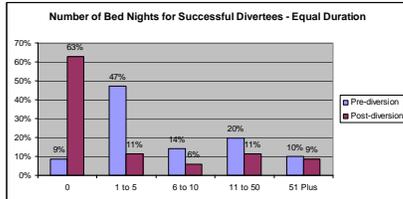


Successful Divertees

	Mean Number of Bookings		Mean Number of Bed Nights			
	Prior	Post	Significant	Prior	Post	Significant
Equal Duration	1.5429	0.6857	Yes	22.7429	16.1571	No
One Year	1.3857	0.3714	Yes	20.6286	5.0143	Yes

- The difference between successful divertees being **booked into jail** pre- and post-diversion is statistically significant regardless of the test parameters.
- There is a decrease in average **bed nights per divertee**.
 - For One Year pre- and post-diversion the difference is statistically significant.
 - Equal Duration average bed nights per divertee has a few anomalies--will talk about these in the next slide.

Successful Divertees Reduction in Jail Bed Nights



- A few anomalies skew data.
 - 3 successful divertees were booked in for over 200 days creating a variance problem for the statistical analysis.
- Regardless, divertees do recidivate less.
 - 63% of those who successfully have met or are meeting the terms of the program have never gone back to jail.

Unsuccessful Divertees

	Mean Number of Bookings			Mean Number of Bed Nights		
	Prior	Post	Significant	Prior	Post	Significant
Equal Duration	2.1356	2.1695	No	26.5593	38.5593	No
One Year	1.7119	1.0508	Yes	19.5085	21.8983	No

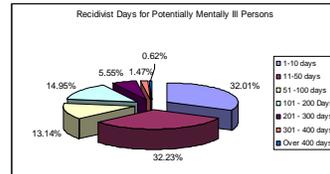
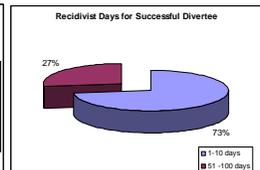
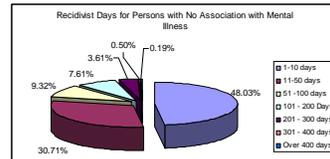
- Revolving door spirals upward
 - In Equal Duration the mean number of bookings and bed nights increased.
- Positive effect of being in the program, even for unsuccessful divertees
 - The comparison between One Year prior and One Year post diversion shows an improvement – even terminated divertees, on average, spend a substantial amount of time in the program with their Intensive Case Manager.

Length of Stay Facts

- Those divertees who recidivate are not staying as long as their counterparts.
- When those who are potentially mentally ill recidivate, they stay longer than any successful divertee.

	Longest term - days	Percent staying past 62 days
No association	562	17.90%
Potentially mentally ill	644	32.40%
Successful divertee	62	0%
All divertees (incl. terminated)	119	21.20%

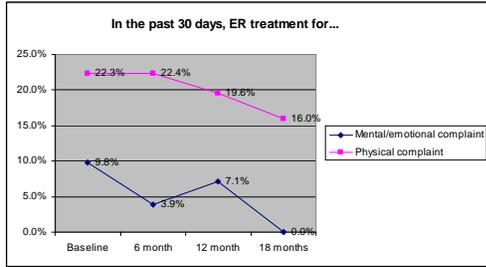
Length of Stay Comparison



Successful Divertees who recidivate do so for shorter durations than both:

- Recidivists in corrections with no association with mental illness.
- Recidivists in corrections who are potentially mentally ill.

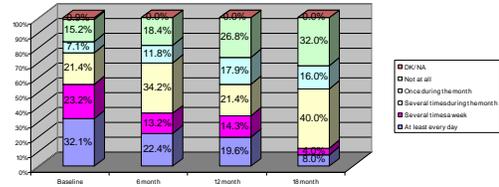
Reduction in the Most Costly Care



- Fewer divertees use the Emergency Room over time.
- Frequency of those divertees who continue to use is less.
- Overall usage declines.

Divertees' Symptoms Improve

In the past month, how often did you have trouble thinking straight or concentrating on something you needed to do (like worrying so much or thinking about problems so much that you can't remember or focus on other things)?

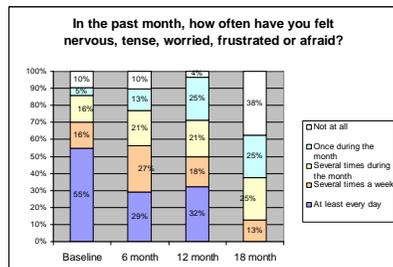


Colorado Symptom Index – 15 questions

- Improvement in all symptoms
 - Two most frequent occurrence categories diminish over time for divertees
 - Two least frequent occurrence categories increase over time for divertees
- Statistically significant improvement in most

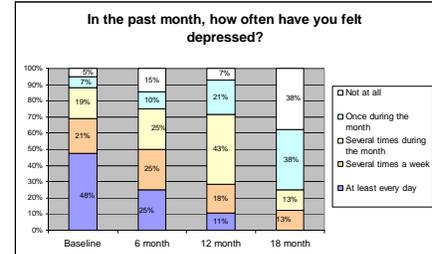
Divertees' Symptoms Improve

Colorado Symptom Index—15 Questions.

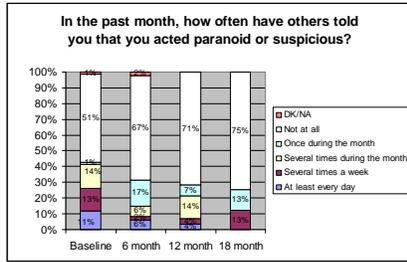


Divertees' Symptoms Improve

- ### Colorado Symptom Index – 15 questions
- Two most frequent occurrence categories diminish over time for divertees



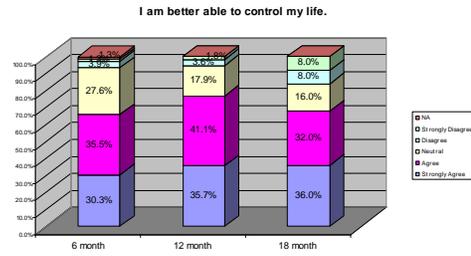
Divertees' Symptoms Improve



Colorado Symptom Index – 15 questions

- Only question that offers others' perspective, even though it is self-reported

Improvement Statistics

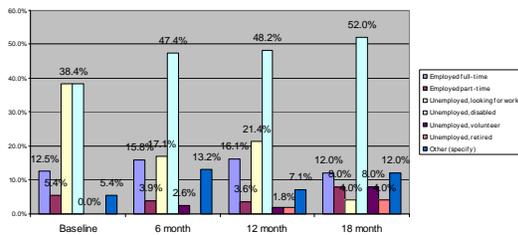


Series of questions

- Indication of the lasting effects of the program after direct contact.
- Similar results for the "work/school" question.

Employment

Are you currently employed?



- Not everyone will become a full-time employee – a more realistic goal may be to stabilize and contribute to society.
- Considerable reduction in "unemployed looking for work" 4% at 18-months vs. almost 40% at baseline.

Implications of the Data

- Program effectiveness:
 - Reductions in recidivism.
 - Better delivery of therapeutic services:
 - Divertees' symptoms have improved.
 - Divertees' attitudes are better.
 - Divertees are using fewer ER services and more regular ongoing services.
 - Finding a niche role in society.
- Questions?

CONTACT INFORMATION

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Lancaster County
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Lincoln, Nebraska 68502
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Attachment 7

**Douglas County, Nebraska:
Mental Health Diversion Program**

Douglas County Mental Health Diversion Program

- Established in April 2006 via joint efforts of the Douglas County Community Mental Health Center, Douglas County Attorney and Douglas County Department of Corrections. Funding (\$216,030 per year) provided by Alegent Community Benefit Trust for first 2 years
- Program diverts some mentally ill persons 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 (post booking program)
- 52 total participants from April 2006-October 2007 (41 successfully completed) (2232 total individuals screened)
- Entry process
 - o Everyone arrested asked 3 questions during booking related to mental health (MH) care
 - Are you or have you ever been under the care of an MH professional?
 - Are you or have you ever taken psychiatric medications?
 - Have you ever been hospitalized for MH reasons?
 - o Positive response to any 1 question yields referral to Screener
 - o Screener interviews client at jail
 - o Client must volunteer; County Attorney/City Prosecutor, public defender, MH provider, and judge must concur with diversion
 - o Formal treatment plan is created and signed by the client with a copy to above parties. Progress notes provided regularly
 - o Client followed by case manager until program completion (approximately 6-9 months)
- Program expenses
 - o Screener (supervisor) and 2 case managers salary and benefits
 - o Cell phone, travel, consulting physician, evaluation

- Program assistance fund to help with client transition expenses (deposits, rent, food, clothing, medications, transportation for very short term client needs)
- Office expenses provided by County as matching funds
- Evaluation by UNMC Department of Epidemiology
 - Includes baseline data for each participant with follow-up surveys completed at 6, 12, and 24 month post program points
 - Includes “control group” of eligible participants who do not receive case management services (currently 30 in the group)
- Mental Health Diversion Advisory Committee began in March 2006
 - Consists of representatives from law enforcement, BH providers, consumers, County officials, Region 6 to provide advice on how the program can be more effective
 - Committee meets bi-monthly
- Objectives achieved (actual numbers in parenthesis)
 - Screen 100% of persons booked by law enforcement for MH issues
 - Evaluate 100% of identified clients for appropriateness for program
 - Enroll at least 50 individuals by end of second year (52)
 - Decrease days participants spend in the hospital by 50% (95%)
 - Decrease homelessness among participants by 60% (80%)
 - Decrease substance abuse among participants by 20% (76%)
 - Increase participants engaged in employment or job training by 50% (540%)
 - Reduce participant contacts with law enforcement that result in arrest by 50% (92%)
 - Reduce contacts with law enforcement that do not result in arrest by 50% (90%)
 - Reduce number of days spent in jail by participants by 50% (87%)

Attachment 8

Hidden Cost of Homelessness: Lincoln, NE

Hidden Cost of Homelessness – Lincoln, NE

1

The cost to the community of individuals not accessing mainstream services and housing.

Contact Information: Jean L. Chicoine
NE Homeless Assistance Program Specialist
301 Centennial Mall South – 4th Floor, Lincoln, NE 68509
(402) 471-9644
jean.chicoine@dhhs.ne.gov

Introduction:

Research conducted in 2002 by Culhane, Metraux, Hadley indicated a marked reduction (59.8 percent) in emergency shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated when individuals were housed in supportive housing versus living on the streets. Over the past five years, communities nationwide have implemented successful supportive housing projects. The success of Nebraska's housing rental assistance for individuals with serious and persistence mental illness is one example of the viability of this housing approach. Supportive housing for individuals and families who are homeless represents a cost-effective alternative to emergency shelter and services.

Lincoln Continuum of Care Research:

Over the past year, members of Lincoln's Continuum of Care: Long-Term & Discharge Planning Committee researched the cost of the top utilizers of emergency services in Lincoln, NE. The purpose was to determine the top utilizers, who were homeless, of emergency services in Lincoln. Committee representatives from Bryan Hospital, the jail, the ambulance service and Cornhusker Detox provided unduplicated data. Personal identification was coded so names were not revealed. The top 27 utilizers had continuous or repeated episodes of street homelessness in Lincoln. Data was collected for the one-year period from September of 2005 - 2006.

Individual data is shown for the top 13 users of emergency services in Lincoln. Additionally, a dollar amount was determined for the next 14 individuals. The data is shown in the table below.

Cost of Services – Sept. 2005-2006	
Client #	Cost of Services Used
1	\$77,105.00
2	\$67,958.00
3	\$57,616.00
4	\$45,404.00
5	\$45,032.00
6	\$43,299.00
7	\$42,045.00
8	\$40,128.00
9	\$38,024.00
10	\$34,472.00
11	\$32,863.00
12	\$27,768.00
13	\$22,238.00
Sub-Total	\$573,952.00
Next 14 individuals	\$126,521.00
Grand Total (27 individuals)	\$700,473.00

November 14, 2007

Hidden Cost of Homelessness – Lincoln, NE

The cost to the community of individuals not accessing mainstream services and housing.

Sources:

1. Detox costs were provided by Cornhusker Place and are actual costs incurred by top utilizers for the time period September 2005 - 2006.
2. Assistant Fire Chief Furseak estimated ambulance costs at \$200.00 per ride. This was an average; some rides may be less and others may be more.
3. Jail costs are based on \$200.00 per booking and daily care of \$70.00 per day. The costs provided are actual costs of the top utilizers for the September 2005 – 2006 time period.
4. Hospital costs were provided by Bryan/LGH and are actual costs incurred by top utilizers for the September 2005 – 2006 time period.

Note: Costs do not include other medical costs, such as drug and/or alcohol abuse treatment, mental health services, or any prescriptions; services from agencies and organizations that serve persons who are homeless; any contact with the Crisis Center.

Housing & Food Costs for Household of One:

Housing & Food Costs – Lincoln, NE Household of One			
Housing	Description	Monthly Expense	Annual Cost
HUD 2008 Fair Market Rent (includes utilities, but not telephone)	Efficiency Apartment	\$450.00*	\$5,400.00
Food Stamp Allowance – (Household of one)	(\$40.50 per week)	\$162.00	\$1,944.00
TOTALS		\$612.00	\$7,344.00

Note: For an individual to afford a Fair Market Rent (FMR) of \$450.00 and maintain housing costs at 30 percent of income, s/he should earn \$8.65 per hour at 40 hours per week. This would be a gross annual income of \$18,000.00. For the purpose of this example, other household costs, such as clothing, are not estimated.

FMR is established annually by the Department of Housing and Urban Development. FMR varies in each of Nebraska's 93 counties. The FMR used in this example is HUD's 2008 rate.

Cost Comparison of Living on the Streets to Living in an Apartment:

	Living on the Street	Living in an Efficiency Apartment	Potential Savings as a Result of Housing	% Saved
Monthly Cost	\$2,162.00	\$612.00	\$1,550.00	71.3
Annual Cost	\$25,943.00*	\$7,344.00	\$18,599.00	71.7

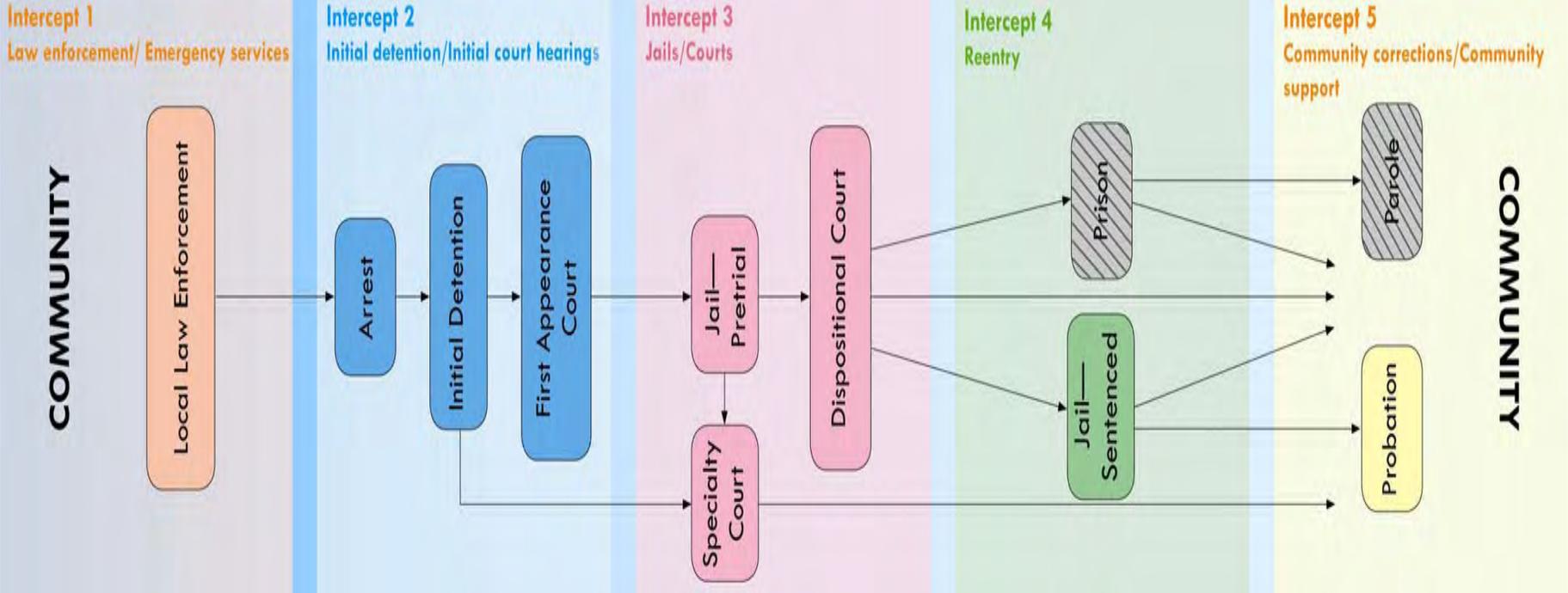
*Total cost of 27 individuals (\$700,473.00) divided by 27 = \$25,943.00

Comparison of Costs: Street Living versus Efficiency Apartment				
Location	Number of Individuals	Annual Cost per Person	Annual Cost for 27 Individuals	% Saved
Living on the Streets	27	\$25,943.00	\$700,461.00	71.7
Living in an Efficiency	27	\$7,344.00	\$198,288.00	
Annual Cost Savings			\$502,173.00	

Attachment 9

Sequential Intercepts for Change: Criminal Justice—Mental Health Partnerships

Sequential Intercepts for Change: Criminal Justice – Mental Health Partnerships



Sequential Intercepts for Change: Criminal Justice – Mental Health Partnerships

Examples of Action Steps for Service Level Change by Intercept

Intercept 1 - Law enforcement/ Emergency services – Examples

- Request for Police Service: Train dispatchers to identify calls involving persons with mental illness and refer to designated, trained respondents
- On-Scene Assessment: Train officers with de-escalation techniques to effectively assess and respond to calls where mental illness may be a factor
- Incident Documentation: Document police contacts with calls involving a person with mental illness to promote use of available services and ensure accountability
- Police Response Evaluation: Collaborate with mental health partners to identify available services and reduce frequency of subsequent contacts by individuals with histories of mental illness and with prior arrests

Intercept 2 - Initial detention/Initial court hearings – Examples

- Appointment of Counsel: Provide defense attorneys with earliest possible access to client mental health history and service needs, available community mental health resources, and legislation and case law impacting the use of mental health information in case resolution.
- Prosecutorial Review of Charges: Maximize the use of alternatives to prosecution through pretrial diversion in appropriate cases involving people with mental illness
- Pretrial Release & Modification of Pretrial Diversion Conditions: Maximize the use of appropriate pretrial release options and assist defendants with mental illness in complying with conditions of pretrial diversion

Intercept 3 - Jails/Courts – Examples

- Intake Procedure: Establish a comprehensive, standardized, objective, and validated intake procedure to assess individuals' strengths, risks, and needs upon admission
- Individualized Programming Plan: Using information obtained from assessments, identify programs necessary during incarceration to ensure safe and successful transition to the community
- Physical Health Care & Mental Health Care: Facilitate community-based providers' access to prisons and jails and promote service delivery consistent with community and public health standards
- Substance Abuse Treatment, Children & Families, Behaviors & Attitudes, Education & Vocation Training: Provide effective substance abuse treatment, services for families and children of inmates, educational and vocational programs, peer support, mentoring, and basic living skills

Intercept 4 – Reentry – Examples

- Subsequent Referral for Mental Health Evaluation: Identify individuals not identified in screening and assessment process who show symptoms of mental illness after their intake into the facility and ensure appropriate action is taken
- Development of Transition Plan: Effect the safe and seamless transition of people with mental illness from prison or jail to the community
- Transition Planning: Facilitate collaboration among corrections, community corrections, and community providers and utilize a transition Checklist to identify service needs and provide effective linkage to services
- Identification & Benefits: Ensure releasees exit prison or jail with ID and prior determination of eligibility and linkage to public benefits to ensure immediate access upon release from prison or jail

Intercept 5 - Community corrections/Community support – Examples

- Implementation of Supervision Strategy: Concentrate community supervision resources on the period immediately following the person's release from prison or jail, and adjust supervision strategies as the needs of releasee, victim, community, and family change
- Maintaining a Community of Care: Connect inmates to employment, including supportive employment services, prior to release. Facilitate releasees' sustained engagement in treatment, mental health and supportive health services, and stable housing
- Graduated Responses & Modification of Conditions of Supervised Release: Ensure a range of options for community corrections officers to employ to reinforce positive behavior and effectively address violations or noncompliance with conditions of release

Attachment 10

**GAINS Re-Entry Checklist for Inmates Identified
with Mental Health Service Needs**

GAINS Re-Entry Checklist For Inmates Identified with Mental Health Service Needs

Detainee's Name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth mm dd yy	Today's Date mm dd yy	Jail ID # _____
<small>Last First MI</small>				SSN# _____

Name of Facility	Name of Person Completing Form and Phone Number	Current Status <input type="checkbox"/> Pre-Trial Detainee <input type="checkbox"/> Sentenced Inmate	Date of Admission mm / dd / yy	Projected Release Date mm / dd / yy
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Potential Needs in Community After Release	Steps Taken by Jail Staff and Dates	Detainee's Final Plan & Contact Information for Referrals
Mental Health Services <input type="checkbox"/>	_____	_____
Psychotropic Medications <input type="checkbox"/>	_____	_____
Housing <input type="checkbox"/>	_____	_____
Substance Abuse Services <input type="checkbox"/>	_____	_____
Health Care <input type="checkbox"/>	_____	_____
Health Care Benefits <input type="checkbox"/>	_____	_____
Income Support/Benefits <input type="checkbox"/>	_____	_____
Food/Clothing <input type="checkbox"/>	_____	_____
Transportation <input type="checkbox"/>	_____	_____
Other <input type="checkbox"/>	_____	_____

Full plan completed and discussed with detainee? Yes No Attachments? Yes No

If no, why?
 Detainee refused Court released before plan completed
 Incomplete for other reasons Specify: _____

Detainee's Copy



General Information

It is recommended that the form be completed in quadruplicate for all detainees identified with mental health service needs within 48 hours of arriving at the facility. The quadruplicate forms should be distributed as follows: top copy in detainee's file to give upon discharge, second copy to medical personnel, third copy to mental health personnel, and the fourth copy for use according to facility's procedures.

- Detainee's Name: Enter detainee's last name, first name, and middle initial
- Gender: Check Male (M) or Female (F)
- Date of Birth: Enter month, day, and year
- Today's Date: Enter month, day, and year
- Jail ID#: Enter Jail ID# associated with detainee
- SSN#: Enter detainee's Social Security Number
- Name of Facility: Enter name of jail
- Name of Person Completing Form and Phone Number: Print name of person completing form and unit phone number. If multiple people use this form, each person must print his/her identifying information on this form.
- Current Status: Check Sentenced Inmate or Pre-Trial Detainee
- Projected Release Date: Enter projected date of release (if known)

Instructions:

Potential Needs in Community after Release

Discuss each service *with detainee* to determine if there is a need to plan for this service prior to discharge. Check the appropriate boxes that correspond to the services identified as a need by the detainee. If the person completing the form identifies a need for which the detainee does not agree to receive planning, indicate this in the Steps Taken and Date(s) section (Ex: Detainee is homeless but does not agree to receive assistance with housing upon discharge).

Steps Taken by Jail Staff and Date(s)

Indicate the steps taken to set-up the identified services and the dates this was done. Notes in this section should reflect a continuous effort to plan for re-entry services throughout the detainee's stay in the facility. If multiple people complete this form, each person must identify the steps that she/he completes in this section with initials, as well as entering his/her name at the top of the form.

Example:

Detainee identifies Mental Health Services as a need:

- 9/1/03 L.T. Contacted Community Mental Health Services (MHS) to set-up appointment with intake coordinator upon release. Will contact closer to projected date of release.*
- 9/25/03 S.P. Release date is firm for 10/3/03. Contacted MHS and made appointment for 10/3/03 at 1:00 p.m. MHS agreed to provide 1 bus token and jail will provide 1 token to assist with transportation.*
- 10/2/03 L.T. Appointment confirmed at MHS for 10/3/03 at 1:00 p.m.*

Detainee's Final Plan & Contact Information for Referrals

Identify final plan in terms of appointment times, next steps, and person to contact for each identified need.

Example:

1:00 p.m. appointment on 10/3/03 at MHS with intake coordinator: Julie Young. Phone: 333-1212; Address: 1234 Street, City, USA 11120.

Final Section

- Full plan completed and discussed with detainee? Check Yes or No
- If no, why? In this section, specify why the full plan was not completed or discussed with detainee by checking: Detainee refused; Court released before plan completed; Incomplete for other reasons—specify (e.g., provider was unable to be contacted)
- Attachments? Check Yes if attaching corresponding materials; Check No if not.

GAINS Re-Entry Checklist For Inmates Identified with Mental Health Service Needs

Detainee's Name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth mm dd yy	Today's Date mm dd yy	Jail ID # _____
<small>Last First MI</small>		<small>mm dd yy</small>	<small>mm dd yy</small>	SSN# _____

Name of Facility	Name of Person Completing Form and Phone Number	Current Status <input type="checkbox"/> Pre-Trial Detainee <input type="checkbox"/> Sentenced Inmate	Date of Admission mm / dd / yy	Projected Release Date mm / dd / yy
-------------------------	--	---	--	---

Potential Needs in Community After Release	Steps Taken by Jail Staff and Dates	Detainee's Final Plan & Contact Information for Referrals
Mental Health Services <input type="checkbox"/>	_____	_____
Psychotropic Medications <input type="checkbox"/>	_____	_____
Housing <input type="checkbox"/>	_____	_____
Substance Abuse Services <input type="checkbox"/>	_____	_____
Health Care <input type="checkbox"/>	_____	_____
Health Care Benefits <input type="checkbox"/>	_____	_____
Income Support/Benefits <input type="checkbox"/>	_____	_____
Food/Clothing <input type="checkbox"/>	_____	_____
Transportation <input type="checkbox"/>	_____	_____
Other <input type="checkbox"/>	_____	_____

Full plan completed and discussed with detainee? Yes No Attachments? Yes No

If no, why?
 Detainee refused Court released before plan completed
 Incomplete for other reasons Specify: _____

GAINS Re-Entry Checklist For Inmates Identified with Mental Health Service Needs

Detainee's Name _____		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth mm dd yy	Today's Date mm dd yy	Jail ID # _____
Last First MI					SSN# _____
Name of Facility	Name of Person Completing Form and Phone Number	Current Status <input type="checkbox"/> Pre-Trial Detainee <input type="checkbox"/> Sentenced Inmate		Date of Admission mm / dd / yy	Projected Release Date mm / dd / yy
Potential Needs in Community After Release		Needs Taken by Jail Staff and Dates		Detainee's Final Plan & Contact Information for Referrals	
Mental Health Services <input type="checkbox"/>					
Psychotropic Medications <input type="checkbox"/>					
Housing <input type="checkbox"/>					
Substance Abuse Services <input type="checkbox"/>					
Health Care <input type="checkbox"/>					
Health Care Benefits <input type="checkbox"/>					
Income Support/Benefits <input type="checkbox"/>					
Food/Clothing <input type="checkbox"/>					
Transportation <input type="checkbox"/>					
Other <input type="checkbox"/>					
Full plan completed and discussed with detainee? <input type="checkbox"/> Yes <input type="checkbox"/> No			Attachments? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, why?					
Detainee refused <input type="checkbox"/>		Court released before plan completed <input type="checkbox"/>			
Incomplete for other reasons <input type="checkbox"/>		Specify: _____			

GAINS Re-Entry Checklist For Inmates Identified with Mental Health Service Needs

Detainee's Name _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth mm dd yy	Today's Date mm dd yy	Jail ID # _____
Last First MI				SSN# _____

Name of Facility	Name of Person Completing Form and Phone Number	Current Status <input type="checkbox"/> Pre-Trial Detainee <input type="checkbox"/> Sentenced Inmate	Date of Admission mm / dd / yy	Projected Release Date mm / dd / yy
-------------------------	--	---	--	---

Potential Needs in Community After Release	Steps Taken by Jail Staff and Dates	Detainee's Final Plan & Contact Information for Referrals
Mental Health Services <input type="checkbox"/>	_____	_____
Psychotropic Medications <input type="checkbox"/>	_____	_____
Housing <input type="checkbox"/>	_____	_____
Substance Abuse Services <input type="checkbox"/>	_____	_____
Health Care <input type="checkbox"/>	_____	_____
Health Care Benefits <input type="checkbox"/>	_____	_____
Income Support/Benefits <input type="checkbox"/>	_____	_____
Food/Clothing <input type="checkbox"/>	_____	_____
Transportation <input type="checkbox"/>	_____	_____
Other <input type="checkbox"/>	_____	_____

Full plan completed and discussed with detainee? Yes No Attachments? Yes No

If no, why?
 Detainee refused Court released before plan completed
 Incomplete for other reasons Specify: _____

Attachment 11

Emergency System Process

EMERGENCY SYSTEM PROCESS

ACTION	PROCESS		ISSUES
	EMERGENCY SYSTEM	COMMUNITY SERVICES	
1. LE responds to request for assistance			2a. Frequency of involvement of team
2. LCRT Team Contacted			2b. Training of LCRT
3. LE determines if "dangerous" and needs EPC or CPC			2c. Liability of Law LE if involving LCRT
4. If EPC, LE contacts or travels to Crisis Ctr or Hospital			4. Travel time to Crisis Services
5. If hospital has a bed person is admitted - if not			5. Beds not available at hospitals
6. _____ contacts other hospitals regarding beds and travels to hospital with available bed			6a. Search for beds
7. After admission person is assessed within 36 hours/have 24 hours to complete report			6b. Travel to alternate hospitals
8. County Attorney reviews report and if needs hearing files petition within 1 week.			8. Access to services in community
9. Clerk of District Court schedules hearing. Hearing held within 7 days			9. Training of MHBs
10. Board decides if person is to be committed. Board determines type of care to be provided			10a. Access to services in community

EMERGENCY SYSTEM PROCESS

ACTION	PROCESS		ISSUES
	EMERGENCY SYSTEM	COMMUNITY	
	<p>PROCESS CONTINUED</p> <pre> graph TD Start[PROCESS CONTINUED] --> D10{10 COMMITMENT?} D10 -- NO --> CS[COMMUNITY SERVICES] D10 -- YES --> Inpatient[Inpatient] D10 -- YES --> Outpatient[Outpatient] Inpatient --> R11[11 HOSPITAL TREATMENT] Outpatient --> CS R11 --> D12{12 DISCHARGE READY?} D12 -- NO --> R13[13 REGIONAL CENTER TREATMENT] D12 -- YES --> CS R13 --> D14{14 DISCHARGE READY?} D14 -- YES --> CS </pre>	<div style="background-color: #c8e6c9; padding: 10px; border: 1px solid black; width: 100%;"> <p style="text-align: center; margin: 0;">COMMUNITY SERVICES</p> </div>	
10. Board decides if person is to be committed. Board determines type of care to be provided			10a. Access to services in community
11. Hospital provides inpatient treatment for an ave. of 25 days			10b. MHB knowledge of community services
12. Treatment team decides if person is ready for discharge. Persons needing longer term care are discharged to LRC			11. Hospitals do not want ALOS in excess of 8-10 days
13. LRC provides inpatient care			12. Access to services in community
14. When ready for discharge to community services patient is discharged			14. Access to services in community

Attachment 12

The EPC Crisis

THE EPC CRISIS

October 1, 2007

PROBLEM STATEMENT:

Local, County, and State law enforcement officers are having difficulty accessing crisis beds in the hospitals contracted with BH regions for Emergency Protective Custody (EPC) care. Law Enforcement officials on occasion must contact more than one facility to find an available bed and transport persons who have been EPC'd long distances.

BACKGROUND:

Although the information provided by law enforcement officials is largely anecdotal there is a history of complaints from law enforcement regarding the availability of emergency beds in the state's emergency behavioral health system. For example, Legislative floor debate in 1981 referenced the fact that persons who had been EPC'd were being driven around in law enforcement vehicles as police officers searched for a facility willing to admit the consumer.

The following information relates to the current situation:

1. More than 200 regional center beds have been closed since FY 2003.
2. A fundamental element of the emergency system is the participation of private hospitals. The decision was made early in the Behavioral Health reform planning process to replace the inpatient services at regional centers by contracting with hospitals for an average of 25 days of inpatient care prior to the consumer returning to the community or being moved to the regional center. The number of reported EPCs has decreased from FY02 to FY07. The first significant decrease in EPCs occurred between FY02 and FY04 when the total was reduced by 329 (-11 %.) In FY 2007, the number of EPCs decreased by 12.5%.
3. Available hospital information indicates although the number of EPCs has been reduced over time these individuals are remaining in the Emergency Department longer. In one hospital persons who have been committed now have an average length of stay 3 days longer than the length of stay for committed individuals in 2005. The length of stay for individuals who were "voluntary" (not EPC'd) or about 75% of the admissions, has remained steady.
4. Access to hospital beds for persons needing to be EPC'd has been reduced over the last few months. Mary Lanning Hospital in Hastings has reduced capacity by 5 beds because of remodeling. Faith Regional Hospital capacity in Norfolk has been reduced by 3 beds for the renovation required to add 10 new beds. Douglas County Hospital has reduced capacity by 10 beds for remodeling. Assuming the average length of stay for each consumer is 10 days, approximately 650 more people could have been served in these beds. If the seven beds at Faith Regional Hospital would have been operational as

planned more than 300 additional persons could have been served in the emergency system.

5. Hospitals have proposed opening NRC beds temporarily to handle “overflow” when the system was at its peak demand for inpatient beds. Funding and psychiatric coverage is not available for the expansion of NRC services.
6. The lack of access to emergency and acute care in private hospitals has become a national issue. Hospitals are inundated with individuals seeking psychiatric and health care as a result of inadequate community resources, reduction in insurance coverage, and other structural issues resulting from a wide variety of causes.

POSSIBLE CAUSES FOR THE EPC PROBLEM

A number of possible causes for the limited access to emergency beds have been identified:

- Capacity in community-based services is not adequate to meet demand and provide for timely discharge of individuals from hospitals
- Extended lengths-of-stay at community-based services that serve as the step-down from hospitals and regional centers limit access to services
- The diversionary services necessary to prevent the need for individuals to be EPC'd are inadequate
- There is not a centralized management of “Emergency System”
- Increased demand for hospital beds for persons not being EPCd
- There is limited access to community-based services that support living in the community
- Consumers cannot access services because of lack of funding (lack of insurance coverage)

RECENT RESPONSES TO THE PROBLEM

Meetings with hospital administrators and regional representatives to develop solutions to the problem began in September, 2006. The plan developed focused on three major strategies. The first was to increase the number of acute hospital beds in order to provide easier access to services, the second was to reduce the length of stay at LRC thereby reducing length of stay at private hospitals, and the third is to adjust the service array and capacity within the regions to facilitate the movement of consumers out of the hospitals. The table that follows outlines the plan agreed to by the parties.

Strategy	Begin Date	Operational Date	Status
<i>1. Add seven subacute beds at Faith Regional Hosp. in Norfolk</i>	<i>July 1, 2004</i>	<i>October 2007</i>	<i>This added capacity was part of the original implementation plan. The project is expected to complete in October 2007, 2 years behind the original time line. It is included here because of its potential impact on the availability of beds in Region 4</i>
2. Create 16 acute beds at Richard Young	May 2006	July 2006	Operational
3. Create 10 acute beds at Richard Young	July 2006	?	Richard Young has been unable to find personnel to staff new beds
4. Add 7 acute beds at LRC	February 2006	July 2006	Operational
5. Add 10 acute beds at LRC	July 2006	April 2007	Beds have been on hold for renovation and meeting Fire Marshall standards
6. Bed Allocation Plan	September 2006	April 2, 2006	Operational
7. Effective use of Telecare subacute beds	December 2006	Bellevue Telecare operational July 2007	In the fall of 2006 the Telecare facilities were operating at less than 50% capacity. Problems remain with the Omaha facility
8. Develop Crisis Respite Beds, Intensive Case Mgmt, LCRTs and other support services	December 2006	In process	
9. Develop service definitions for ICM and Care Monitoring	December 2006	In process	
<i>10. Add 32 beds in Region 6 at Lasting Hope Recovery Center</i>	<i>July 1, 2004</i>	<i>April 2008</i>	<i>Again, although not a strategy developed as part of this effort these services will impact the availability of beds at hospitals for EPCs and Voluntaries.</i>

Other strategies have also been discussed including:

- Add emergency psychiatric beds at the Columbus hospital
- Improve the effectiveness of Local Crisis Response Teams
- Establish Crisis Respite beds in Columbus
- Investigate the feasibility of using of smaller community hospitals, enhanced with security personnel, to accept persons who have been EPC'd
- Investigate the legality of using transportation other than law enforcement to transport individuals who have been placed in EPC
- Establish a limited number of beds at NRC to utilize for 23:59 services until January 2008.
- Investigate the development of Crisis Centers in Norfolk and the Tri-City area to replace the use of hospital emergency rooms for the admission of persons who have been EPC'd
- Local Crisis Response Team development and training
- Utilization of Peer Specialists at hospitals
- Develop relationships between law enforcement, regional/provider staff, and hospital staff
- Include CIT and LCRT training in the curriculum for the Law Enforcement Training Center.
- Create Short Term Residential and Dual Diagnosis services
- Centralized Emergency Management System – Hospitals provide regions with admissions, discharges, and number of beds available
- Expand Crisis Respite capacity
- Add limited 23:59 services at NRC
- Fund the creation of services with funds to be moved from regional centers.
- Establish information system to collect EPC information related to the transporting of consumers placed in EPC
- Establish the standard of persons placed in EPC will be admitted to a crisis bed within 90 minutes of being EPC'd

Attachment 13

Brief Jail Mental Health Screening



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Mental Health Screens for Corrections

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MAY 07

Mental Health Screens for Corrections

This Research for Practice is based on two final reports to the National Institute of Justice: "Evidence-Based Enhancement of the Detection, Prevention, and Treatment of Mental Illness in the Correction Systems," by Ford and Trestman, August 2005, NCJ 210829, available online at www.ncjrs.org/pdffiles1/nij/grants/210829.pdf; and "Validating a Brief Jail Mental Health Screen," by Osher, Scott, Steadman, and Robbins, November 2004, NCJ 213805, available online at www.ncjrs.org/pdffiles1/nij/grants/213805.pdf.

Findings and conclusions of the research reported here are those of the authors and do not necessarily reflect the official position or policies of the U.S. Department of Justice. This research was supported by NIJ under grant numbers 2000-IJ-CX-0044 and 2001-IJ-CX-0030.

NCJ 216152

ABOUT THIS REPORT

Identifying entering inmates' mental health needs when they first enter an institution is critical to providing necessary services and enhancing safety in corrections settings. The purpose of the two projects discussed in this report was to create and validate mental health screening instruments corrections staff can use during intake.

What did the researchers find?

The researchers created short questionnaires that

accurately identify inmates who require mental health interventions. One mental health screen was found to be effective for men and is being adapted for women; the other has effective versions for both men and women.

Who should read this report?

Corrections administrators and mental health professionals.

Julian Ford and Robert L. Trestman/Fred Osher, Jack E. Scott, Henry J. Steadman, and Pamela Clark Robbins

Mental Health Screens for Corrections



As corrections staff across the United States struggle to keep up with the rapid influx of new inmates while maintaining a secure environment, their efforts are increasingly hampered by the presence of individuals with serious mental illnesses who are entering corrections facilities in growing numbers. Numerous studies show that jail detainees have a significantly higher rate of serious mental illness (e.g., bipolar disorder, major depression, schizophrenia, and other psychoses) than the general population.¹ One pair of studies reported that approximately 6 percent of men and 15 percent of women who were admitted to Chicago's Cook County jail displayed severe symptoms of mental illness and required treatment.²

Many serious mental illnesses are chronic and are subject to exacerbation and relapse. The stress of incarceration can worsen symptoms in persons with preexisting mental disorders, leading to acute psychiatric disturbances, including harm to self or others; inmates with

histories of *severe* mental illness may present an even greater risk. Moreover, several studies have shown that inmates with psychiatric impairment may exhibit more serious and more numerous adjustment and disciplinary problems (such as refusal to leave one's cell or destruction of property) during incarceration than unimpaired inmates.³

Prisons and jails have a substantial legal obligation to provide health and mental health care for inmates.⁴ Case law and statutes have not provided a clear definition of what constitutes adequate mental health care. The American Psychiatric Association has, however, recommended that all corrections facilities provide at minimum mental health screening, referral, and evaluation; crisis intervention and short-term treatment (most often medication); and discharge and prerelease planning.⁵ A national survey of 1,706 U.S. jails reported that 83 percent of them provide some form of initial screening for mental health treatment needs.⁶ Still, screening procedures are

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highly variable; they may consist of anything from one or two questions about previous treatment to a detailed, structured mental status examination. One result of this variability is apparent in data that showed fully 63 percent of inmates who were found to have acute mental symptoms through independently administered testing were missed by routine screening performed by jail staff and remained untreated.⁷

Clearly, there is a pressing need to develop valid and reliable procedures to screen incoming detainees for signs and symptoms of acute psychiatric disturbance and disorder.

Researchers funded by the National Institute of Justice have created and tested two brief mental health screening tools and found that they are likely to work well in correctional settings. These tools are the Correctional Mental Health Screen (CMHS)⁸ and the Brief Jail Mental Health Screen (BJMHS).⁹ The tools are in the appendixes.

CMHS. The CMHS uses separate questionnaires for men and women. The version for women (CMHS–W) consists of 8 yes/no questions, and the

version for men (CMHS–M) contains 12 yes/no questions about current and lifetime indications of serious mental disorder. Six questions regarding symptoms and history of mental illness are the same on both questionnaires; the remaining questions are unique to each gender screen. Each screen takes about 3–5 minutes to administer. It is recommended that male inmates who answer six or more questions “yes” and female inmates who answer five or more questions “yes” be referred for further evaluation.

BJMHS. The BJMHS has 8 yes/no questions, takes about 2–3 minutes, and requires minimal training to administer. It asks six questions about current mental disorders plus two questions about history of hospitalization and medication for mental or emotional problems. Inmates who answer “yes” to two or more questions about current symptoms or answer “yes” to either of the other two questions are referred for further evaluation. Instructions for administering the screen appear on the back of the form. Corrections classification officers, intake staff, or nursing staff can administer the screen

without specialized mental health training, but may receive brief informal training before administration.

Criteria for Detecting Mental Illness in Jails

When inmates enter a corrections facility, the staff's first task is to separate out those who may be at significant risk for suicide, acute psychotic breakdown, or complications from recent substance abuse from those who are merely experiencing varying degrees of distress usually associated with arrest, conviction, and detention.

Effective mental health triage in the corrections setting can be viewed as a three-stage process: (1) routine, systematic, and universal mental health *screening* performed by corrections staff during the intake or classification stage, to identify those inmates who may need closer monitoring and mental health assessment for a severe mental disorder; (2) a more in-depth *assessment* by trained mental health personnel conducted within 24 hours of a positive screen; and (3) a full-scale psychiatric *evaluation* when an inmate's degree of acute disturbances warrants it.

Screening is the crucial part of the process, because it is the primary means by which staff can determine which inmates require more specialized mental health assessment or evaluation, as well as treatment. Unless inmates are identified as potentially needing mental health treatment, they will not receive it.

Screening, however, is the weak link and, as already noted, varies considerably. Until now, there were no valid, standardized tools available that could be recommended for adoption nationwide.

A valid standard screen needs to be *brief*, because corrections classification staff have only a limited amount of time to spend with any one inmate. It also needs to provide *explicit decision criteria*, because the mental health training and experience of corrections staff is likely to be relatively low. Corrections staff traditionally are confident in their ability to discern overtly psychotic symptoms, but are considerably more uncertain about identifying less obvious—though equally serious—signs and symptoms of anxiety and depression. Thus, they need a tool that can provide them with the basis for a clear decision (“refer” or “don’t refer”).

A useful jail mental health screen also needs to exhibit a *low false-negative rate*—that is, it would not miss many inmates who have a serious mental disorder because the potential consequences of not treating an inmate with a serious mental illness could be grave. On the other hand, it must have a *low false-positive rate* too, because mental health resources in corrections settings are scarce and burdening trained mental health staff with the need to assess many people who do not have a serious mental illness is an inefficient use of their time. Thus, an effective mental health screening tool would have a *high degree of predictive validity*, in that most of the people who are flagged by it as being “positive” should, on further assessment, be found to have a treatable serious mental illness.

Different Instruments for Different Needs

There are few available screening tools that meet all of these criteria. Symptom checklists, like the Symptom Checklist-90 and the Brief Symptom Inventory (BSI),¹⁰ focus on the recent, self-rated

experience of specific symptoms within the past week. These checklists have 90 and 53 items, respectively, and require more time to administer than is desirable. Another major drawback for the use of the BSI is its cost, which is currently more than \$1 per administration. Rating instruments like the Brief Psychiatric Rating Scale¹¹ and the Schedule of Affective Disorders and Schizophrenia—Change Version¹² require independent symptom ratings by a clinically-trained interviewer. Although they can be useful as part of a followup assessment, these instruments are not practical for use as a screen by corrections staff.

One instrument that has shown promise for meeting the key criteria is the Referral Decision Scale (RDS),¹³ which was designed to serve as a rapidly administered and easily scored screening tool for use in corrections settings. As a screening tool, it was not developed to diagnose disorders, nor was it intended to serve as a measure of the severity of dysfunction. Rather, the RDS was meant to flag signs and symptoms of gross impairment associated with serious mental health disorders. The final published

version of the RDS consists of three scales—one each for schizophrenia, bipolar disorders, and major depression—incorporating 14 items predictive of these disorders that were derived from the National Institute of Mental Health’s Diagnostic Interview Schedule (DIS).¹⁴ Each of the scales contains a cutoff score that, if met or exceeded, should result in a referral for mental health assessment.

Research has provided preliminary evidence of the validity of the RDS by comparing results of the RDS with those of the parent instrument, the DIS.¹⁵ On lifetime diagnoses of schizophrenia, bipolar disorders, and major depression, the average *sensitivity* of the three RDS scales (how well they detect illness among inmates who are truly ill, as defined here by the DIS) was reported as 88 percent, and the mean *specificity* (how well they detect no illness among inmates who do not have a disorder) was 99 percent. Several researchers have raised questions, however, about the RDS’s content and validity. Notably, one group of researchers¹⁶ questioned whether several items in the RDS scales were appropriate for use with incarcerated individuals, and

whether the use of lifetime occurrence of symptoms rather than current symptoms may overestimate the current need for further mental health services.

In response to these concerns, two teams of researchers set about to create and validate even better screens. One team’s screen, the CMHS, began as an amalgam of the RDS and three other diagnostic tools. The other screen, the BJMHS, is a major revision of the RDS.

CMHS: A Gender-Specific Screen

Development. The CMHS–W and CMHS–M were developed by first presenting to study participants a lengthy, 25-minute composite of all the questions from four separate screens, including the RDS and part of the Structured Clinical Interview for DSM–IV (SCID).¹⁷ The composite contained 53 items. The study participants were 2,196 adults detained in 5 State of Connecticut jails. About one-fifth of the participants were randomly selected to be brought back 1–5 days later for an even lengthier clinical assessment (45–180 minutes) consisting of the

complete SCID plus additional screening questions.

Statistical analysis was performed, separately by gender, to determine the questions with the most statistical sensitivity, specificity, and predictive power to measure nine clusters of mental health disorders, including current depressive disorders, current anxiety disorders, antisocial personality disorder, and posttraumatic stress disorder (PTSD). On the basis of this initial analysis, some questions were eliminated and others that were judged redundant were combined. The result was two composite pools, one with 38 items for women and one with 40 items for men. Additional, complex analysis was then performed¹⁸ leading to the 8-item CMHS–W and 12-item CMHS–M, each of which takes 3–5 minutes to administer. (See the forms in appendix A.) These final versions were validated on an additional group of 206 participants, using the same protocol as the first phase of the study.

Validation. Statistical analysis of the validation test results against the clinical assessments showed that the new screens proved highly valid in

identifying depression, anxiety, PTSD, some personality disorders, and the presence of any undetected mental illness. The CMHS–W was 75.0 percent accurate in correctly classifying female inmates and the CMHS–M was 75.5 percent accurate in correctly classifying male inmates as having a previously undetected mental illness.¹⁹

Interestingly, the clinical assessments that were performed found the incidence of serious mental illness among the participants to be far higher than in the general population and comparable to that in psychiatric settings. This finding is especially significant given that inmates who had already been referred for mental health hospitalization were excluded from the study.

Assessment. The CMHS accurately identifies individuals in corrections settings with mental illness. Validation testing confirmed that versions for both women and men showed evidence of reliability, validity, and predictive utility in relation to the accurate identification of undetected psychiatric disorders. Both correctly classified at least 75 percent

of inmates, thus providing reasonable certainty of identifying inmates in need of mental health services without burdening mental health providers with the responsibility of evaluating inmates who have less serious mental health problems.

The CMHS–W has additional relevance because it is the first mental health screen developed and validated specifically for women. In contrast to prior studies that either have not included jailed women, have included female inmate samples too small to develop gender-specific screening instruments, or used a single screening measure for both genders, the CMHS–W shows promise as a mental health screen for newly incarcerated women in jails.

Brief Jail Mental Health Screen

Development. The BJMHS is directly derived from the RDS. Because the existing RDS scales have not performed well in discriminating among schizophrenia, bipolar disorders, and major depression, the scoring approach for the BJMHS was to develop a single composite scale. Thus, a positive score now indicates

that an individual has recent or acute symptoms associated with any one or more of the three disorders. The number of items was reduced from the original 14 to a smaller set of 8 items by eliminating items that had questionable validity and did not contribute statistically to the composite scale. Several items were rephrased to provide clearer wording. Finally, the timeframe employed by the RDS was changed from lifetime occurrence to “currently.” (See the form in appendix B.)

The BJMHS takes, on average, about 2.5 minutes to administer. Step-by-step instructions for recording an inmate’s responses are printed on the back of the interview form. The first six questions ask about specific current symptoms. Two additional questions ask whether the inmate has ever been in a hospital for emotional or mental health problems and if he or she is currently taking any medication prescribed by a physician for any emotional or mental health problem. Anyone who scores positively on *two or more* current items, or *either* the hospitalization or medication item should be referred to mental health services for immediate attention.

Validation. Although the BJMHS was intended to be a step forward in the evolution of the RDS, important questions remained about its operation in a jail setting. Among the most important—what was the validity of the BJMHS when compared to a “gold standard” such as the SCID? The SCID must be administered by a carefully trained clinician and typically takes between 1 and 2 hours to complete. A study was devised to test the concurrent validity (that is, validity when compared against an independent, validated instrument) of the BJMHS in relation to the SCID.

Corrections classification officers in four county jails—two in Maryland and two in New York—participated in information sessions that provided training on administration of the BJMHS. This unstructured training, which took place in the jails, included a brief description of the research project and instructions on completing the BJMHS during the intake process.

Participants in the validation study were 11,438 male and female detainees admitted to one of the four jails between May 2002 and January 2003.

All participants were given the BJMHS upon admission to the jails.

The BJMHS data were used to identify a subsample of detainees (approximately 90 from each jail) who were given a detailed clinical assessment conducted by a trained research interviewer using the SCID. This subsample was designed to comprise a large enough number of females to enable separate analysis by gender.

The results showed that the BJMHS referrals and nonreferrals matched the SCID findings of serious mental illness or no serious mental illness for 73.5 percent of males and 61.6 percent of females. There were 20 false negatives among males (14.6 percent of male nonreferrals) and 33 false negatives among females (34.7 percent of female nonreferrals). The large percentage of female false negatives was cause for concern.

An examination of the false negatives among both men and women showed that 2 of the 20 men and 6 of the 33 women were missed because the screen focused solely on current symptoms as opposed to symptoms in the past 6 months.

Another problem was the inconsistent reporting of symptoms. All the questions asked on the BJMHS were repeated during the SCID interview. They were either part of the SCID or added for the research study. In all but seven of the false negative cases, the inmates reported different information to the SCID interviewer than they had to the corrections officer. Had they reported the same information on the BJMHS, they would have been referred for further mental health assessment and only one male case and six female cases would have been missed.

Assessment. In light of these data, the BJMHS is shown currently to be a powerful tool for screening men booked into U.S. jails. It is simple to use for intake officers, requires only modest training, and is almost 74 percent accurate. Based on correction officer feedback, the creators of the BJMHS recommend the following to maximize accuracy:

- Detailed training of corrections staff on proper administration of the screen, including clarifying the purpose of the screen and providing help with interviewing techniques.

- Administration of the screen by nurses (where available) in cases of uncooperative inmates or those who state discomfort answering corrections officers' questions about mental illness.
- Use of a computer-assisted version of the tool, which may reduce the problem of symptom underreporting.

The BJMHS was not as effective for women. That it correctly identified 54.9 percent (28 of 51 women) of the true positives among the women participants is an improvement over current practices. Still, the screen missed 34.7 percent of women with current symptoms.

The lower accuracy of the BJMHS among women may be due to the fact that the BJMHS does not measure symptoms of anxiety that are associated with the high incidence of PTSD experienced by women detainees.²⁰ Subsequent modifications of the BJMHS for women will need to add questions that capture anxiety symptoms. It may also be that women are less likely to disclose symptoms to corrections officers, who are most often male, on

intake. Whatever the explanation, research is needed to create an appropriate jail intake screen for women. The developers of the BJMHS have received additional NIJ funding to test and refine the screen further for female inmates.

Both Screens Meet Needs at Intake

Both the BJMHS and the two gender-specific versions of CMHS offer improvement over existing tools in standardizing and increasing the accuracy of initial mental health screening in corrections facilities. Their brevity, use of yes/no questions, simple scoring techniques, and *availability at no cost* make them well suited for quick mental health screening of large numbers of inmates during intake. Their effectiveness in identifying inmates in need of mental health treatment compares favorably with the longer, more cumbersome, and training-intensive tools currently used in clinical assessments. Based on their successful validation results, it is anticipated that these tools will be disseminated nationwide for use in all corrections facilities.

Notes

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In the United States, it is the main reference used by mental health professionals to diagnose mental disorders.

18. For a detailed discussion of the additional analysis, see the final report, available online at www.ncjrs.org/pdffiles1/nij/grants/210829.pdf.

19. Five or more “yes” answers out of 8 questions on the CMHS–W and

6 or more “yes” answers out of 12 on the CMHS–M were considered “positive” results for referral to additional mental health assessment.

20. Veysey, Bonita M., “Specific Needs of Women Diagnosed With Mental Illnesses in U.S. Jails,” in *Women’s Mental Health Services: A Public Health Perspective*, ed. B.L. Levin, A.K. Blanch, and A. Jennings, Thousand Oaks, CA: Sage, 1998.

Appendix A*

Correctional Mental Health Screen for Women (CMHS-W)

Name _____ Last, First, MI	Detainee # _____	Date ___/___/____ mm/dd/year	Time ___:___
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Questions	No	Yes	Comments
1. Do you get annoyed when friends and family complain about their problems? Or do people complain you are not sympathetic to their problems?			
2. Have you ever tried to avoid reminders of, or to not think about, something terrible that you experienced or witnessed?			
3. Some people find their mood changes frequently-as if they spend everyday on an emotional rollercoaster. For example, switching from feeling angry to depressed to anxious many times a day. Does this sound like you?			
4. Have there ever been a few weeks when you felt you were useless, sinful, or guilty?			
5. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
6. Do you find that most people will take advantage of you if you let them know too much about you?			
7. Have you been troubled by repeated thoughts, feelings, or nightmares about something terrible that you experienced or witnessed?			
8. Have you ever been in the hospital for non-medical reasons, such as a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			

TOTAL # YES: _____	General Comments:
Refer for further Mental Health Evaluation if the Detainee answered Yes to 5 or more items OR If you are concerned for any other reason	
<input type="radio"/> URGENT Referral on ___/___/____ to _____	
<input type="radio"/> ROUTINE Referral on ___/___/____ to _____	
<input type="radio"/> Not Referred	
Person Completing Screen: _____	

* The forms in appendixes A and B are shown exactly as they are provided to correctional institutions.

INSTRUCTIONS FOR COMPLETING THE CMHS-W

General Information:

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Women (CMHS-W), with a grant funded by the National Institute of Justice.

Instructions for administration of the CMHS-W:

Correctional Officers may administer this mental health screen during intake.

Name: Detainee's name- Last, first and middle initial
 Detainee#: Detainee's facility identification number
 Date: Today's month, date, year
 Time: Current time (24hr or AM/PM)

Questions #1-8 may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in her answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says she does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

Total # YES: total number of YES responses

General Comments: Staff may include information here to describe overall concerns about the responses (for example: intoxicated, impaired, or uncooperative)

Referral Instructions:

Urgent Referral: A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

Routine Referral: A detainee answering "**YES**" to **5 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

** If at any point during administration of the CMHS-W the detainee experiences *more than mild and temporary emotional distress* (such as severe anxiety, grief, anger or disorientation) she should be referred for immediate mental health evaluation.

Referral: Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

Person completing screen: Enter the staff member's name

Correctional Mental Health Screen for Men (CMHS-M)

Name _____ Last, First, MI	Detainee # _____	Date ___/___/____ mm/dd/year	Time ___:___
--------------------------------------	-------------------------	--	---------------------

QUESTIONS	NO	YES	COMMENTS
1. Have you ever had worries that you just can't get rid of?			
2. Some people find their mood changes frequently – as if they spend everyday on an emotional roller coaster. Does this sound like you?			
3. Do you get annoyed when friends or family complain about their problems? Or do people complain that you're not sympathetic to their problems?			
4. Have you ever felt like you didn't have any feelings, or felt distant or cut off from other people or from your surroundings?			
5. Has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments?			
6. Do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through?			
7. Do you tend to hold grudges or give people the silent treatment for days at a time?			
8. Have you ever tried to avoid reminders, or to not think about, something terrible that you experienced or witnessed?			
9. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
10. Have you ever been troubled by repeated thoughts, feelings, or nightmares about something you experienced or witnessed?			
11. Have you ever been in a hospital for non-medical reasons such as in a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			
12. Have you ever felt constantly on guard or watchful even when you didn't need to, or felt jumpy and easily startled?			

TOTAL # YES: _____	General Comments:
<p>Refer for further Mental Health Evaluation if the Detainee answered Yes to 6 or more items OR If you are concerned for any other reason</p> <ul style="list-style-type: none"> <input type="radio"/> URGENT Referral on ___/___/____ to _____ <input type="radio"/> ROUTINE Referral on ___/___/____ to _____ <input type="radio"/> Not Referred 	
Person Completing Screen: _____	

INSTRUCTIONS FOR COMPLETING THE CMHS-M

General Information:

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Men (CMHS-M) with a grant funded by the National Institute of Justice.

Instructions for administration of the CMHS-M:

Correctional Officers may administer this mental health screen during intake.

Name: Detainee's name- Last, first and middle initial
 Detainee#: Detainee's facility identification number
 Date: Today's month, date, year
 Time: Current time (24hr or AM/PM)

Questions #1-12 may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in his answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says he does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

Total # YES: total number of YES responses

General Comments: Staff may include information here to describe overall concerns about the responses (for example: intoxicated, impaired, or uncooperative)

Referral Instructions:

Urgent Referral: A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

Routine Referral: A detainee answering "**YES**" to **6 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

** If at any point during administration of the CMHS-M the detainee experiences *more than mild and temporary emotional distress* (such as severe anxiety, grief, anger or disorientation) he should be referred for immediate mental health evaluation.

Referral: Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

Person completing screen: Enter the staff member's name

Appendix B

BRIEF JAIL MENTAL HEALTH SCREEN

Section 1

Name: _____ <small>First MI Last</small>	Detainee #: _____	Date: ____/____/____	Time: _____ AM PM
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Section 2

Questions	No	Yes	General Comments
1. Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you currently feel that other people know your thoughts and can read your mind?			
3. Have you currently lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are currently much more active than you usually are?			
5. Do you currently feel like you have to talk or move more slowly than you usually do?			
6. Have there currently been a few weeks when you felt like you were useless or stupid?			
7. Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you ever been in a hospital for emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check all that apply):

- Language barrier Under the influence of drugs/alcohol Non-cooperative
 Difficulty understanding questions Other, specify: _____

Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- YES to item 7; OR
- YES to item 8; OR
- YES to at least 2 of items 1 through 6; OR
- If you feel it is necessary for any other reason

Not Referred

Referred on ____/____/____ to _____

Person completing screen: _____

INSTRUCTIONS ON REVERSE

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INSTRUCTIONS FOR COMPLETING THE BRIEF JAIL MENTAL HEALTH SCREEN**GENERAL INFORMATION:**

This Brief Jail Mental Health Screen (BJMHS) was developed by Policy Research Associates, Inc., with a grant from the National Institute of Justice. The BJMHS is an efficient mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the intake process.

This screen should be administered by Correctional Officers during the jail's intake/booking process.

INSTRUCTIONS FOR SECTION 1:

NAME:	Enter detainees name — first, middle initial, and last
DETAINEE#:	Enter detainee number.
DATE:	Enter today's month, day, and year.
TIME:	Enter the current time and circle AM or PM.

INSTRUCTIONS FOR SECTION 2:ITEMS 1-6:

Place a check mark in the appropriate column (for "NO" or "YES" response).

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

ITEMS 7-8:

ITEM 7: This refers to any *prescribed* medication for any emotional or mental health problems.

ITEM 8: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

General Comments Column:

As indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

All "YES" responses require a note in the General Comments section to document:

- (1) Information about the detainee that the officer feels relevant and important
- (2) Information specifically requested in question

If at any point during administration of the BJMHS the detainee experiences distress, he/she should follow the jails procedure for referral services.

INSTRUCTIONS FOR SECTION 3:

OFFICER'S COMMENTS: Check any one or more of the four problems listed if applicable to this screening. If any other problem(s) occurred, please check OTHER, and note what it was.

REFERRAL INSTRUCTIONS:

Any detainee answering YES to Item 7 or YES to Item 8 or YES to at least two of Items 1-6 should be referred for further mental health evaluation. If there is any other information or reason why the officer feels it is necessary for the detainee to have a mental health evaluation, the detainee should be referred. Please indicate whether or not the detainee was referred.

The National Institute of Justice is the research, development, and evaluation agency of the U.S. Department of Justice. NIJ's mission is to advance scientific research, development, and evaluation to enhance the administration of justice and public safety.

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Attachment 14

**Nebraska DHHS Strategic Planning Workshop
Contact Information**

Nebraska DHHS
Strategic Planning Workshop on Transforming Services for Persons with Mental Illness in Contact with the Criminal Justice System
 December 5 and 6, 2007

	Last Name	First Name	Title	Representation	Email	Mailing Address	Phone
1	Abreu	Dan	Speaker	Policy Research Associates	DAbreu@prainc.com		
2	Adams	Scot	Director	DHHS - Behavioral Health	scot.adams@dhhs.ne.gov	P.O. Box 98925 301 Centennial Mall South Lincoln, NE 68509-8925	402-471-8553
3	Adams	Sue	Regional Program Coordinator	DHHS - Behavioral Health	susan.adams@dhhs.ne.gov		402-471-7820
4	Barner	Peg		Juvenile Services Program Administrator	peg.barner@dhhs.ne.gov	P.O. Box 95026 Lincoln, NE 68509-5026	402-471-8402
5	Barton	Jean	staff	Region V	jbarton@region5systems.net		
6	Baxter	Beth	Regional Administrator	Region III	bbaxter@region3.net	PO Box 2555 Kearney, NE 68848-2555	308-237-5113, ext 222
7	Boganowski	Cindi		Douglas County Community Mental Health Center	cboganowski@co.douglas.ne.us	4102 Woolworth Avenue Omaha, NE 68105	402-599-2338
8	Brockway	Corey	Regional Consumer Specialist	Region II		PO Box 818 McCook, NE 69001	308-345-2770
9	Brown	Marcy		Region IV	mbrown@frhs.org	1500 Koenigstein Ave Norfolk, NE 68701	402-644-7461
10	Bulling	Denise		University of Nebraska Public Policy Center	dbulling@nebraska.edu		402-472-1509
11	Chicoine	Jean		DHHS	jean.chicoine@dhhs.ne.gov		402-471-9644
12	Crippen	Melinda	Emergency System Coord. Regional Administrator	Region IV	mcrippen@region4bhs.org	206 Monroe Norfolk NE 68701	402-370-3100 ext.122
13	Daiss	Doyle	Therapist	Region III	ddaiss@scbsne.com	616 W. 5th Street Hastings, NE 68901	402-463-5684
14	Davis	Jeff	Sarpy County Sheriff	Community Corrections Council	jldavis@sarpy.com	1208 Golden Gate Drive Papillion, NE 68046	402-593-2290

	Last Name	First Name	Title	Representation	Email	Mailing Address	Phone
15	Dawson	Sheri	Regional Program Specialist	DHHS	sheri.dawson@dhhs.ne.gov		402-471-7856
16	DeKraai	Mark		University of Nebraska Public Policy Center	mdekraai@nebraska.edu		402-472-1496
17	Eriksen	Jim	Hall County Supervisor RGB Executive Committee	Hall County Supervisor	NA	4233 Nordic Road Grand Island, NE 68803	308-381-0952
18	Gibson	William	Facility Administrator	Lincoln Regional Center	william.gibson@dhhs.ne.gov	P.O. Box 94728 Lincoln, NE 68509-4728	402-479-5404
19	Glenn	Tom	Consumer	Region V		% Houses of Hope 2009 South 16th Street Lincoln, NE 68502	430-5676 441-9221 Renee-CM
20	Harrifeld	Chris	Jail Examiner	Nebraska Crime Commission	Chris.Harrifeld@ncc.ne.gov	301 Centennial Mall South Lincoln, NE 68509	402-471-3133
21	Harvey	Jim	Quality Improvement, Housing Program Coordinator	DHHS- Behavioral Health	jim.harvey@dhhs.ne.gov	301 Centennial Mall South Lincoln, NE 68509	402-471-7824
22	Heuertz	Mickey	Consumer	Region III	grandma_2@windstream.net	411 S. Elm Ave. #267 Hastings, NE 68901	402-462-8288
23	Hippen	Julie	Southeast Regional Director-Lutheran Family Services	Community Corrections Council	jhippen@lfsneb.org	2900 "O" Street Lincoln, NE 68510	402-435-2910
24	Houston	Robert	Director, NDCS	Nebraska Department of Correctional Services	bhouston@dcs.state.ne.us	P.O. Box 94661 Lincoln, NE 68509-4661	402-479-5710
25	Hultine	Connie	Drug Court Coordinator	Region III	chultine@adamscounty.org	131 S. Locust Grand Island, NE 68801	402-984-7805
26	Johnson	C.J.	Regional Administrator	Region V	cj@region5systems.net	1645 "N" Street, Ste. A Lincoln, NE 68508	402-441-4343
27	King	Steven	Planning/Research/ Accreditation Administrator	Nebraska Department of Correctional Services	sking@dcs.state.ne.us	P.O. Box 94661 Lincoln, NE 68509-4661	402-479-5767
28	Korver	Ardi	staff	Region V	akorver@region5systems.net		
29	Krutz	Linda	Executive Director	Community Corrections Council	Linda.Krutz@ncc.ne.gov	301 Centennial Mall South Lincoln, NE 68509	402-471-4327
30	Maca	Vicki	Administrator	DHHS	vicki.maca@dhhs.ne.gov	P.O. Box 98925 301 Centennial Mall South Lincoln, NE 68509-8925	402-471-7727

	Last Name	First Name	Title	Representation	Email	Mailing Address	Phone
31	McCleary	Joel	Administrator Office of Consumer Affairs	DHHS	joel.mccleary@dhhs.ne.gov	P.O. Box 98925 301 Centennial Mall South Lincoln, NE 68509-8925	402-471-7853
32	McKellips	Mary Ellen	Emergency Support Care Coordinator	Region II	maryellen@r2hs.com	PO Box 1209 North Platte, NE 69103	308-324-7200
33	Medinger	Betty	DHHS Administrator	DHHS	betty.medinger@dhhs.ne.gov	301 Centennial Mall South 4th Floor Lincoln, NE 68509	402-471-9434
34	Milligan	Connie	Speaker	Policy Research Associates	cpmilligan@bluegrass.org		
35	Minardi	Deb	Deputy Administrator	Office of Probation Administration	deb.minardi@nsc.ne.gov	521 South 14th Street, Room 101 Lincoln, NE 68509	402-471-3525
36	Minor	Joni	Director of Correctional Services	Vocational Rehabilitation	joni.minor@vr.ne.gov	1313 Farnam Street Omaha, NE 68102	402-595-1307
37	Moorehouse	Judie	Consumer Initiatives Coordinator	Region I	jmoorehouse@pmhc.net	4110 Avenue D Scottsbluff, NE 69361	308-635-3171
38	Parker	Travis		Community Mental Health Center of Lancaster County	tparker@ci.lincoln.ne.us	2201 South 17th Street Lincoln, NE 68502	402-441-6610
39	Petersen	Taren	Director of Network Services	Region VI	tpetersen@regionsix.com	Region 6 Behavioral Healthcare 3801 Harney St. Omaha, NE 68131	(402) 996-8391
40	Reckling	Todd	Policy Unit Administrator	DHHS	todd.reckling@dhhs.ne.gov	P.O. Box 95026 Lincoln, NE 68509-5026	402-471-8404
41	Reiber	Gary	Dawson County Sheriff	Dawson County Sheriff	send to Robyn at above	709 N Grant St. Lexington, NE 68850	308-324-3011
42	Remington	Arnold	Director, TASC	Region V	aremington@tasc.ws	2000 "P" Street Lincoln, NE 68503	402-474-0419 x10
43	Richardson	Dr. Pamela	Clinical Director	Region I	prichardson@pmhc.net	4110 Avenue D Scottsbluff, NE 69361	308-635-3171
44	Salvatore	Christine		Region V	csalvatore@nsc.state.ne.us		
45	Schultheiss	Robyn	Director, Emergency Support Program	Region II	robyn@r2hs.com	PO Box 519 Lexington, NE 68850	308-324-7200
46	Shaffer	Blaine	Chief Clinical Officer	DHHS- Behavioral Health	blaine.shaffer@dhhs.ne.gov	P.O. Box 98925 301 Centennial Mall South Lincoln, NE 68509-8925	402-471-7795

	Last Name	First Name	Title	Representation	Email	Mailing Address	Phone
47	Sheehan	John	Douglas County Community Mental Health Center	Douglas County Community Mental Health Center	jsheehan@co.douglas.ne.us	4102 Woolworth Avenue Omaha, NE 68105	402-444-7608
48	Silverman	Steve	Chief Deputy Probation Officer, District 10	Chief Deputy Probation Office	steve.silverman@nsc.ne.gov	1825 10th Street Gering, NE 69341	308 436-6655
49	Sorensen	Ron	Administrator	DHHS- Behavioral Health	ron.sorensen@dhhs.ne.gov	P.O. Box 98925 301 Centennial Mall South Lincoln, NE 68509-8925	402-471-7791
50	Stewart	Cynthia	Omaha District Supervisor	Nebraska Department of Correctional Services	cstewart@dcs.state.ne.us	1313 Farnam Street Omaha, NE 68102	402-595-3810 402-699-9700 (cell)
51	Stutzman	Shane	Probation District 3	Probation	shane.stutzman@nsc.ne.gov	510 Lincoln Ave York NE 68467	
52	Sullivan	Lisa	Consumer Specialist	Region IV	lsullivan@region4bhs.org	206 Monroe Norfolk NE 68701	402-370-3100
53	Synowiecki	John	District 7 Senator	State Senator	jsynowiecki@leg.ne.gov	Room 2004, State Capitol Lincoln, NE 68509	402-471-2721
54	Vega-Hernandez	Michaelle	Director	Region VI		1702 Nicholas St. Omaha, NE 68102	402-346-6901
55	Watanabe-Galloway	Dr. Shinobu	Assistant Professor Epidemiology Department College of Public Health	University of Nebraska Medical Center	swatanabe@unmc.edu	984395 UNMC Omaha, NE 68198-4395	402-559-5387
56	Weilage	Mark	Behavioral Health Assistant Administrator for Mental Illness	Nebraska State Penitentiary	mweilage@dcs.state.ne.us	P.O. Box 2500 Lincoln, NE 68542-2500	402-326-3781
57	Weiss-Eby	Deanna	Emergency Support Care Coordinator	Region II	deanna@r2hs.com	PO Box 519 Lexington, NE 68850	308-324-7200
58	White	Cameron	Behavioral Health Administrator	Nebraska Department of Correctional Services	cwhite@dcs.state.ne.us	P.O. Box 94661 Lincoln, NE 68509-4661	402-479-5971
59	Wohlers	Sharyn	Regional Administrator	Region I	swohlers@pmhc.net	4110 Avenue D Scottsbluff, NE 69361	308-635-3171
60	Yakel	Paul	Douglas County Adult Drug Court Coordinator	Region VI	pyakel@dc4dc.com	Center 1709 Jackson St., 4th Floor Douglas County Adult Drug Court	402-599-2655 402-651-3995
61	There was someone here with Dr. Watanbe-Galloway but I can't read his signature and he didn't complete the remainder of the information on this sheet.						

Attachment 15

**“The New Veterans Court Helps
Vets in Trouble Get Back on Track”
by: Lou Michel**

THE BUFFALO NEWS

FOCUS: WAR VETERANS

The new Veterans Court helps vets in trouble get back on track

By Lou Michel - News Staff Reporter

Updated: 1/12/08

A small army of veterans advocates is putting the finishing touches on what is believed to be the country's first Veterans Court, where military veterans having problems adjusting to civilian life will get special attention.

The goal is to intercept troubled veterans before they plunge further into an already overwhelmed criminal justice system, which lacks the resources to help them get their lives back on track.

"Rather than be reactionary, we thought if we could be proactive, we could design a system that would better serve our community, the veterans and their families," said Buffalo City Court Judge Robert T. Russell Jr., who will preside over Veterans Court when it starts Tuesday.

In some ways, this court is similar to the Drug Court and Mental Health Court that Russell already supervises, offering defendants a chance to wipe the slate clean and avoid time behind bars so long as mandated treatment programs are followed.

The Veterans Court, operating in Buffalo City Court, will be open to all Erie County veterans who commit nonviolent offenses, even if the crimes occur outside city limits.

That's because judges in other jurisdictions have the option of referring veterans to this special court.

And there's no question of the need. A recent study determined more than 300 area veterans, many of them who served in Iraq and Afghanistan, entered the criminal justice system in 2007.

The move to create the new court for veterans was praised by West Huddleston, president of the National Association of Drug Courts in Alexandria, Va.

"It's certainly the first designated veterans court in the United States, and it is a step in the right direction for veterans with post-traumatic stress, emotional and mental health issues," Huddleston said, adding that the local judicial system is recognizing that these individuals, who sometimes turn to drugs and alcohol, require "help not punishment."

Court officials here said that historically the criminal justice system has not done well with returning war veterans.

“Vietnam vets did not have this kind of service. The system was ill-prepared, and we’re hoping to learn from our mistakes,” said Henry G. Pirowski, a former Marine, social worker and project director for City Court.

Working with Pirowski on establishing the court, which will be in session every Tuesday, are Jack O’Connor and David Mann, co-founders of the Western New York Veterans Project.

Veterans need the special judicial attention, said Mann, who also works as a Buffalo police lieutenant.

“Nationally, we’re seeing an increase of domestic violence, child abuse and neglect among veterans. We also know that there are higher rates of drug and alcohol abuse, which sometimes leads to arrests,” Mann said.

In this mix of behavior, Pirowski said, are war-related psychological wounds.

“There’s a lot of self-medication with drugs and alcohol, and when you throw in post-traumatic stress and traumatic brain injuries, it’s a formula for failure and unacceptable behavior,” he said.

Compounding the problem, Pirowski said, is that the veterans who need the help the most are the least likely to find it on their own.

“They have a warrior mentality. Treatment is for the weak, and so they don’t seek it,” he said.

But part of the message in Veterans Court is that there is no shame in accepting help. And the help will be comprehensive, going beyond drug and alcohol treatment and counseling from mental health experts:

- Homeless veterans will be placed in lodging.
- Unemployed veterans will receive job training and education at Erie Community College.
- Volunteer mentors will be assigned to work with the offending veterans.

“What we hear a lot in court is that ‘no one understands me,’ ‘they don’t know how I feel,’ and ‘I no longer fit in,’ ” Pirowski said.

That won’t be the case in Veterans Court.

“We have close to 20 veterans who are volunteering as mentors to help them readjust to civilian life,” Russell said. “It’s amazing to see how one veteran talking to another veteran can help in encouraging treatment.”

The judge witnessed this first hand through a pilot program of Veterans Court over the last year, in which more than 160 veterans, many from Iraq and Afghanistan, were assisted. But not all were from the latest wars.

Melvin Sharp is a Vietnam War vet, who wound up being committed to psychiatric treatment 54 times in the years following his return home from war in 1969.

The 60-year-old Cheektowaga man was able to avoid jail through the pilot program and received help.

“I started with illegal drugs in Vietnam, and when I came home, it led to a lot of criminal activity,” Sharp said. “Mentally, I cracked up in the 1980s, but through divine intervention for 17 years after that, I was able to kick the heroin and cocaine.”

That lasted until two years ago, when his life unraveled.

“I fell in with bad company and started using crack cocaine,” he said.

One of his relatives spoke with Russell’s office, and Sharp became one of the first to enter the pilot program. Since then, he has been attending a veterans support group in North Buffalo three times a week and has remained drug free.

That has allowed him to address other mental health issues that he tried to bury through drug use.

“Your eyes are opened to a much larger perspective and basically you see that the drugs were sheltering and hindering you,” Sharp said of his newfound sobriety.

No one knows the plight of troubled war veterans better than Peter Knauber, an Army Reservist from the first Gulf War. He will serve as the Veterans Court care coordinator, a job he already performs in the Drug and Mental Health courts.

Upon returning home from the 1991 war, Knauber, now 44, drank heavily and eventually turned to drugs.

He repeatedly sought help, but nothing worked until he was sent to Drug Court.

“It wasn’t that I just wanted to get out of trouble. I wanted to stop using,” Knauber said.

With court oversight, he succeeded in remaining focused and accountable. The result has been seven years drug free, a four-year college degree, and employment as care coordinator assigned to Russell’s staff.

Knauber along with counselors from the Department of Veterans Affairs in Buffalo and other agencies say they plan to link veterans with the services that will help rebuild their lives.

And for those who embrace the second chance offered by Veterans Court, the prospects of staying out of trouble with the law are better than those of the typical criminal.

“The overall national average for recidivism is 60 to 80 percent. With vets we’ve worked with informally over the last three years, the rate has been 4 percent,” Pirowski said. And there’s another big plus.

Dr. Terri Julian, manager of the VA’s post-traumatic stress residential program in Batavia, says this type of early intervention will save lives that might otherwise be destroyed.

“If we can introduce opportunities for a healthier alternative, like treatment to deal with emotional problems and alcohol problems, then we are doing the veteran a service and society as well,” Julian said. There’s no disagreement on that point.

Pirowski says that while the criminal justice system lacks the resources to treat veterans, it will make a difference with the Veterans Court. “In the old days it was search and destroy,” said Pirowski, referring to his military service and that of other vets. “Now it’s identify and help.”

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