Up to one in four incarcerations should be prevented

“At least half a million Americans in prison today wouldn't be there if they had instead been ordered to treatment for their substance use or mental health problem,” says Pamela Rodriguez, president of Treatment Alternatives for Safe Communities (TASC), a statewide Illinois organization that advocates for alternatives to incarceration for non-violent offenders (NVOs). That figure doesn't count those detained in the state's county jails, many of whom are awaiting sentencing.

In Illinois, one out of four people incarcerated every year could have been diverted to substance use treatment instead, according to the TASC Center for Health and Justice. Of the 40,000 individuals admitted to the Illinois Department of Corrections, 20,000 are non-violent property or drug crime offenders, and half of these meet the criteria for substance use or dependence. The costs of incarceration are $25,000 a year.

The American Psychiatric Association (APA) estimated in 2000 that 20 percent of people in prisons and jails have a serious mental illness. One of the main reasons is deinstitutionalization—with nothing in the community to take the place of hospitals.

There were half a million people in psychiatric hospitals in this country in 1955, according to Judge Steven Leifman, associative administrative judge in Miami-Dade County and chair of the Task Force on Substance Abuse and Mental Health Issues in the Courts for the Florida Supreme Court. Now, he says that just 40,000 psychiatric hospital beds are now available and instead, there are 550,000 people in prison and jails who have a mental illness.

Leifman is a nationally known proponent of treatment instead of incarceration for people with serious mental illness, and an eloquent spokesman for diversion away from the criminal justice system to treatment. He puts it plainly: “Most of these people aren't criminals.”

Using incarceration as a substitute for treatment is not only ineffective, but also harmful and wasteful, says Leifman, noting that it is best to intervene in the justice process early, even before a suspect goes to booking, to jail, or in many cases, to a local hospital's emergency department.

But, the key to getting people diverted into treatment instead of a local jail or prison is not found with local mental health or substance treatment providers. Instead, it is with local police, who are normally the first responders for individuals who may be experiencing a psychiatric crisis.

Rodriguez of TASC agrees, saying that more and more localities are creating and using Crisis Intervention Teams (CITs), which include specially trained police officers and often, local behavioral health professionals. Traditionally, these teams have focused primarily on people in the community with serious mental illnesses. But because of their success as a front-end element of a larger jail diversion process that better manages non-violent offenders, the use of incarceration, and rates of recidivism, such teams are expanding their scope to include individuals with suspected substance use problems.

“CIT is so successful on so many levels that I don't know where to begin,” says Leifman. During the first six months of 2011, the Miami-Dade County police department handled just over 2,300 mental health calls. After screening, CIT officers were sent out and 750 people were diverted to community-based crisis units. Out of the 2,300 total 911 calls made, just one required an arrest. The CIT training in Miami-Dade County is a 40-hour program. Local 911 dispatchers are also trained in CI so that they can screen incoming calls.
CIT also plays an important role in the lives of veterans returning from Iraq and Afghanistan who have severe PTSD issues, says Leifman, who chairs Partners in Crisis. This group that promotes state and community collaborations that can reduce contact between people with mental health and substance use disorders with the criminal justice system.

“We are alerting officers that if someone is speeding, for example, it may be a vet in a huge crisis,” he says. “We do our best to get them into treatment and recovery.”

Post-arrest

Sometimes, the client is arrested and the CITs can intervene at that point, says Leifman. “We also work post-arrest with people in jail for misdemeanors,” he says. Within 48 hours, the clients are out of jail and in a crisis stabilization unit. “If they go into our program, the state attorney will generally drop the charges,” he says. “We have a written agreement with six of our public providers to take those who were in jail.” After assessment by a social worker, a provider is called and the client proceeds directly to treatment without the need for booking. The recidivism rate for offenders treated through this approach is just 20 percent, says Leifman.

Mental health courts are also invaluable, says Rodriguez. In Illinois, people referred to mental health court are there voluntarily. A clinical social worker in the Cook County jail assesses and identifies referral candidates. The only requirements for such referrals are that the clients be receiving Medicaid or SSI and that their offenses be among those eligible for diversion to the community. According to Rodriguez, some 90 percent of diversion candidates are found to have co-occurring mental illness and substance use disorders.

Building relationships that respond to crisis

Behavioral healthcare professionals work with the police officers on the training, said Rodriguez. This cross-training means the advocacy community, consumers, and service delivery professionals are all involved, and can develop relationships with the police as they work on problems. Typically, there will be a 24-hour crisis center where police can bring people they have assessed to need help-instead of to a jail or emergency department.

“If you don't build relationships, you don't have the language or the skills to solve problems,” Rodriguez says, noting that “There are going to be bumps along the way.”

Rodriguez cautions that not every behavioral healthcare professional will be able to do this kind of work. “I want to be clear about this,” she said. “If you're not comfortable doing it, don't do it. Just because you treat substance use or mental illness doesn't mean you are ready to work with the criminally involved substance user, or someone with a serious mental illness who is cycling through the justice system.” Service providers must, she says, be prepared to deal with “criminal thinking and marginal lifestyles.”

Just because someone is mentally ill or a substance user doesn't mean they don't have to be responsible for their behavior, notes Rodriguez. “Most therapists believe there are logical consequences for behavior, whether it is illegal, or just annoying,” she says. The therapist isn't necessarily the person who administers or levies the consequence. “But protecting the client from the consequences of their behavior isn't necessarily therapeutic.”

Substance use treatment providers may be more familiar with this dilemma than providers who treat mental illness only. The justice system is already the single highest referral source-as many as half of the people in treatment have criminal justice involvement. “People in general need to be coerced into substance use treatment,” notes Rodriguez. “The criminal justice system is a leverage opportunity. It keeps people in treatment long enough for motivation to kick in.”

Culture clash

There is a culture clash between traditional police training and crisis intervention work, and it can take a lot of time and effort to persuade law enforcement that CITs are the way to go. Normal police training encourages officers to be more aggressive when they encounter someone who is aggressive, says Leifman. Of course, this is not the correct approach if someone has a serious mental illness and is paranoid, or is intoxicated or high on
drugs. “Finally, after a long effort to get them to buy in, they understand that's not the right way,” he says.

The CIT officers themselves do see the value in the approach. And instead of being afraid of the police-and acting out whenever they see them-clients are now building trust. “The relationship that these folks have developed with CIT police officers is phenomenal,” says Rodriguez. “Instead of freaking out, when clients see the CIT police officer coming into a program, they will say, ‘That's Officer Jack, he's my friend, let him in.’”

These relationships are particularly important when someone who has been diverted into treatment is missing. The TASC CIT project goes out and looks for people who have disengaged from treatment, because this is a red flag for recidivism. “We go under bridges and to shelters and bring them back into care,” says Rodriguez.

Support from SAMHSA

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) “has supported the diversion of individuals with mental health disorders from the criminal justice system through its jail-based diversion grants programs, its new Adult Treatment Court Collaboratives, and its Systems Transformation grants,” says Kenneth W. Robertson, team leader for criminal justice grants at SAMHSA's division of systems improvement at the Center for Substance Abuse Treatment.

The justice system, he explains, should “respond in a needs-matching manner” based on the severity of risk and needs. Additional training is essential to “increase the ability of law enforcement to recognize and assist the diversion of these individuals before they are jailed,” he says.

Incarceration of individuals with serious mental illness not only exacerbates their condition, but also increases their risk for future criminal involvement, says Robertson, citing the 2010 study by the Treatment Advocacy Center and the National Sheriff's Association: “More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States.” The report shows that incarceration of people with mental illness leads to higher rates of recidivism, lengthier periods of incarceration, more management problems, higher costs, and a higher prevalence of suicide.

How to partner with law enforcement

Below are some ways that behavioral health providers can interface with the criminal justice system.

- Establish information exchanges with the appropriate law enforcement, judicial, bar association, community corrections, and corrections officials to develop a work group to establish a consistent process of communication between the justice system components and the provider community;
- Develop and establish memoranda of understanding between the two systems to outline philosophical and programmatic benefits of collaboration;
- Develop an integrated strategy for dealing with justice-involved individuals with behavioral health needs;
- Cross-train provider staff and justice systems staff on trauma-related information and trauma-informed care;
- Build trauma-informed care into the treatment philosophy and justice approach to these individuals;
- Establish with the justice system a screening and assessment system that measures criminality risk and behavioral health needs and aligns justice and treatment resources to better respond to those risks and needs;
- Incorporate evidence-based practices and models that respond to the community's and the individual's needs;
- Design evaluation studies that will illustrate the economic savings and community betterment when appropriate treatment and recovery are combined with the sanctions of the justice system.
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For further reading

4. Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Jurisdictions (http://consensusproject.org/jc&lowbar;publications/tailoring&lowbar;le&lowbar;responses)
6. To Treat or Not To Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders (http://www.urban.org/UploadedPDF/411645&lowbar;treatment&lowbar;offenders.pdf)