PROGRAMS THAT WORK AND PROMISING PROGRAMS FOR PERSONS AT RISK OF ENTERING OR IN THE CRIMINAL JUSTICE SYSTEM

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PROGRAMS THAT WORK AND PROMISING PROGRAMS FOR INDIVIDUALS WITH MENTAL ILLNESS AT RISK OF ENTERING OR IN THE CRIMINAL JUSTICE SYSTEM

Introduction

A recent special report by the Bureau of Justice Statistics estimates that at midyear 1998, 283,800 mentally ill adult offenders were incarcerated in the nation's prisons and jails. These figures result from a survey that indicates that 16% of State prison inmates, 7% of Federal inmates, and 16% of those in local jails reported either a mental condition or an overnight stay in a mental hospital. For probationers this percentage is 16% or 547,800 offenders.[1] The Colorado Department of Corrections mental health staff estimates that 1,200 inmates, approximately 10% of the correction population, meet the diagnostic criteria for major mental illness.[2] Estimates of the prevalence rates of mental illness in the juvenile justice system are as high as 22%.[3]

Given the widespread and growing number of individuals with mental illness in both the juvenile and adult justice systems, policymakers must consider programs that prevent or provide alternatives to incarceration and that may result in favorable outcomes for individuals as well as a cost savings to government. The issue of how to serve individuals with complex, emotional, behavioral and mental health needs before they reach the juvenile or adult justice systems must also be addressed. Policymakers must consider the broader benefit of potential savings to government for families and children participating in interventions that may result in lower government expenditures later in life. The relationship between childhood conduct problems to both delinquency and adult criminal behaviors has been well demonstrated:

> *The best predictor of any individual's future deviant or antisocial behavior is the amount and severity of similar behaviors in the past...age of onset and severity of juvenile records are the two best predictors of adult criminality*.[4]

Preliminary results for a National Institute of Justice research study of more than 1500 abused and neglected children call for a "preventative stance to stop the cycle of violence." This study found that by the time these children reached their late twenties and early thirties, almost half had been arrested for some type of non-traffic offense. Eighteen percent were arrested for a violent crime.[5]

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[1] Ditton, P.M. (1999). Mental health and treatment of inmates and probationers. (Special Report NCJ174463). Washington, DC: Bureau of Justice Statistics.
[2] Colorado Department of Corrections. (1998). Offenders with serious mental illness (A multi-agency task group report to the Colorado Legislature Joint Budget Committee).
[3] Befus, John. (1999) Draft report to the mental Illness and offender task force, Colorado Department of Human Services, Division of Youth Corrections, mental health services summary.
[4] Greenwood, Peter W., Model, Karyn E., Rydell, Peter, C., and Chiesa, James (1998). Diverting children from a life of crime: measuring the costs and benefits. Santa Monica, CA: Rand Publications.
[5] National Institute of Research Preview. The cycle of violence revisited. U. S. Department of Justice, Office of Justice Programs. February 1996.

The case for early-childhood interventions for children at risk is supported by longitudinal studies that consistently demonstrate that risk is associated with single parenthood, poverty and parent youthfulness. Other risk factors associated with later antisocial behavior are parental substance abuse, domestic violence, mental health problems or criminality, birth complications and child abuse and neglect.[6] [7] Karr-Morse and Wiley describe factors associated with violent behavior that may be modified or prevented by early intervention. In addition to the above, they include malnutrition, chronic maternal stress, father as criminal, maternal rejection, lack of consistent caregiver in early life, parental discord and others. In their book, Ghosts from the Nursery: Tracing the Roots of Violence, the authors state:

> *While the causes of violence are highly complex and multifaceted, a growing body of scientific knowledge demonstrates that maltreatment during the nine months of fetal growth and the first twenty-four months after birth often leads to violent older children and adults.*[8]

The financial costs of poor outcomes for children are staggering. A study of 10 high-users of children's services in San Francisco estimates average annual costs at over $200,000 per year per child. A Colorado study of school expulsion on the juvenile justice system estimates an average annual impact of over $10,000,000.[9] Gould and O'Brien estimate the direct and indirect costs attributable to child maltreatment in Colorado, based on appropriations for state fiscal year 1995, were over $400,000,000.[10]

Clearly, the social and economic costs for individuals with mental illness in government systems are enormous. Programs exist, however, that have proved beneficial in terms of outcomes and/or costs. Greenwood, et al.[11] assessed the cost-effectiveness of early intervention strategies targeted at individuals at risk of pursuing a criminal career. Evaluation literature was reviewed, and the costs of four types of program approaches were compared to the crime reduction effectiveness of the "three-strikes" law in California. ***The authors conclude that investments in some interventions for high-risk youth may be several times more cost effective in reducing serious crime than long mandatory sentences for repeat offenders. In fact, graduation incentive programs and***

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[6] Greenwood, Ibid.

[7] Gould, M.S. and O'Brien (1995). Child maltreatment in Colorado: the value of prevention and the cost of failure to prevent, a cost analysis commissioned by the Colorado Children's Trust Fund. Denver: University of Colorado at Denver, Center for Human Investment Policy, Graduate School of Public Affairs.

[8] Karr-Morse, R. and Wiley, M.S., (1997). Ghosts from the nursery: Tracing the roots of violence. New York, New York: Atlantic Monthly Press.

[9] Heller, Lauren E., Coen, A.S. (1996). Supporting the social and emotional development of young children and their families in Colorado: A review of early intervention issues and strategies. Denver, CO: Colorado Department of Human Services, Mental Health Services.

[10] Direct costs include child welfare services associated with investigations, services to children in their own homes, intensive family preservation and out-of-home placement, medical and psychiatric treatment for abused and neglected children and police and judicial involvement in child welfare cases. Indirect costs are those associated with long-term consequences to individuals who were maltreated as children. They include: domestic violence, learning disabilities, school failure, welfare dependency, criminal activity, substance abuse, emotional illness and incarceration.

[11] Greenwood, et al., Ibid.

parent training programs would still be effective even if they averted only a third of the crimes estimated.

The following provides a brief overview of programs that show promise or positive outcomes for children and adults with mental illness who may be at risk, or are involved with the criminal justice systems. When available, outcomes, costs and/or cost benefit analyses are included. There are numerous promising interventions that were not included due to time and resource constraints. For instance, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) has developed a compendium of 425 programs that, in their estimation, merited designation as promising interventions.[12] There may also be effective programs operating at local levels in the state, but information on these programs may not be widely available.

I. EARLY INTERVENTION FOR YOUNG CHILDREN

- The ***Colorado Infant Project in Boulder*** works with mothers and children from the second or third trimester of pregnancy until three years of age. Mothers are referred to the program through other community agencies (e.g., child welfare), and include individuals who have suffered abuse or neglect and may include mental illness or other issues such as substance abuse, and physical health. ***Over a 10-year period, the program had a 96% success rate in prevention of abuse, neglect, and failure to thrive, and the promotion of positive attachments and healthy development.***[13]

- ***The Early Childhood and Family Center of Aurora Community Mental Health Center*** is a partial-day treatment program for preschool children with emotional disturbances. The primary goal of the program is to prevent psychopathology later in life. ***Initial program outcomes on 60 children indicated that 76.5% of the children were functioning better. Foster care placement of children was reduced from 33.3% to 11.7%. Only 5% of the children required out-of-district placement***.[14]

- ***The Clayton Charter School in Denver*** serves children who may be at risk of academic failure. The full-day pre-kindergarten through third grade program uses a learning curriculum that encourages children to engage in a *plan-do-review process.* Children receive a mixture of education and therapeutic interventions. Regular parent meetings and family-based activities are large program components. ***The school boasts 97% student attendance with only 6% turnover. Nineteen former students were assessed in their 4th and 5th grade programs, and 16 scored above average to excellent in their first semester.***[15]

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[12] Montgomery, I.M. Torbert P.M., Malloy, D. A., Adamcik, L.P., et al. (1994). What works: Promising interventions in juvenile justice. Washington, DC: U.S. Department of Justice. Office of Juvenile Justice and Delinquency Prevention.
[13] Heller and Coen, Ibid.
[14] Heller and Coen, Ibid.
[15] Heller and Coen, Ibid.

- The Colorado Legislature supports ***two early intervention initiatives in Boulder and Denver that are in the early stages of development.*** Evaluations of these programs continue, but early results appear promising. The Child Development Program in Boulder is part of the Children and Family Services Team at the Mental Health Center of Boulder County, Inc. The program uses a relationship-based mental health consultation model in which mental health professionals are based on site to provide consultation and training for childcare facility directors, childcare staff, parents and children who may be at risk. Among the Boulder program's ***results to date are significantly greater improvement in the level of classroom environment at sites receiving services compared to control groups for preschool classrooms and reports of decreased child behavior problems by fathers for children service sites compared to control sites***. [16] A recent report of The Denver Project Parent Empowerment Alternatives with Resources and Learning (PEARL) reports several findings of the project. Among these are that the PEARL Risk Factor Interview was useful in identifying children in most need of services, and PEARL services may be effective in improving children's behavioral adjustment if length and intensity of services are sufficient.[17]

- Greenwood, et al.[18] review ***programs that provide home visits and supported child care.*** Programs varied with some providing home visits before birth and extending for several years beyond, followed by several years of day care. One program provided two years of enriched pre-school and home visits. Home visitors are trained to help families resolve problems in child rearing, family relations and community functioning, and to guide parents on perinatal and infant care. The researchers discuss six programs that are different in target-populations and program components, but, taken together demonstrate the value of home visits, early childhood education, and supported day care in reducing a range of problem behaviors***. Some of the outcomes for these six programs*** are summarized below:

    - ***A ten-year follow up found that 6 percent receiving the program intervention had been referred to probation, compared to 22 percent of matched controls.*** Girls who participated in the program showed greater school achievement and higher ratings by teachers.
    - ***Fewer reports of abuse and neglect*** (4% compared to 19% for a control group receiving child screening services only).
    - The intervention group had ***higher cognitive scores and significantly fewer behavior problems*** than the control group.
    - ***Long term follow up found that the group receiving the intervention had accumulated only half the arrests of a matched comparison group up through age 27.***

[16] Carruth, P., Russel, B.S, Bartholomew, S. and Robinson, J. (1999). Child development program: Program implementation and research findings. Boulder, CO: Mental Health Center of Boulder County, Inc.

[17] Parent Empowerment Alternatives for Resources and Learning. (1999). Eighteen month report: Parent empowerment alternatives for resources and learning (P.E.A.R.L). Denver, CO: Mental Health Corporation of Denver.

[18] Greenwood, et al., Ibid.

COSTS: In another analysis Rand presents ***costs savings for higher-risk families involved in a home visits program. Program costs were $6,093, compared to savings of $24,694, resulting in a net savings to government of $18,611(all 1996 dollars).*** Significant savings differences between the treated and control group resulted from less use of welfare by mothers in the treated program and average savings per child in the program due to behavior which resulted in less crime in the child's lifetime.[19] The Washington State Institute for Public Policy analyzed the costs and benefits of the ***Perry Pre-school Program which provides enriched pre-school and home visits.*** This study estimated a 48% reduction in felony arrests by the time program children reached age 25. Program costs were estimated at $13,938, with taxpayer savings of $13,442. Costs in savings to victims were $16,717, for an ***overall net gain in taxpayer and victims' savings of $16,221, per participant.***[20]

The Boulder Center for the Study and Prevention of Violence (BCSPV)[21] also endorses prenatal and infancy home visitation by nurses as one of ten programs with a proven track record of making a difference for children and youth. The Center notes many ***positive findings of a 15-year follow-up study of a nurse visitation program***. Among them, in contrast to a control group:

- The group receiving services had ***79% fewer verified reports of child abuse or neglect;***
- ***30 months less receipt of Aid to Families with Dependent Children***; and
- ***44% fewer maternal arrests, 56% fewer arrests on the part of the 15-year old children.***

COSTS: ***The BCSPV reports that costs of the program were recovered by the child's fourth birthday, and there were substantial savings to government and society*** calculated over the children's lifetimes. ***Program costs were (in 1997 dollars) $3,200 per family during the first three years of operation, and $2,800 per family per year thereafter.***

- The ***PATHS (Promoting Alternative THinking Strategies)*** is also recommended by the BCSPV[22] in its review of ten programs that make a difference for youth. The program curriculum is designed to promote emotional and social competencies and reduce aggression and behavior problems for elementary school-aged children. Primarily based in the classroom, the curriculum is administered by educators and counselors. Parents are included in activities and provided with information. The

[19] Karoly, L.A., Greenwood, P.W., Everingham, S.S., Hoube, J., Kilburn, M.R., et al. (1998). Investing in our children: What we known and don't know about the costs and benefits of early childhood interventions. Santa Monica, California: Rand Publications.
[20] Washington State Institute for Public Policy. (1998). Watching the bottom line: Cost-effective interventions for reducing crime in Washington. Olympia, WA: The Evergreen State College.
[21] Boulder Center for the Study and Prevention of Violence. (no date) Summaries from Blueprints: 10 Model Programs. Available through www.colorado.edu/cspv/blueprints/model.
[22] Boulder Center for the Study and Prevention of Violence, Ibid.

curriculum is taught three times per week for 20-30 minutes per session, and teaches children emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. The program has been tested and researched with children in regular and special needs classrooms. The program has demonstrated ***significant improvements*** for youth in regular and some special needs classrooms. Compared to control groups, program youth show:

- ***Improved self-control;***
- ***More effective conflict-resolution strategies;***
- ***Improved thinking and planning skills; and***
- ***Decreased conduct problems (special needs students).***

COSTS: ***Program costs over three-year period would range from $15 to $45 per student per year.***

II. PROGRAMS FOR FAMILES OF CHILDREN WITH AGGRESSIVE BEHAVIORS, DELINQUENCY OR AT RISK OF SYSTEM INVOLVEMENT OR OUT-OF-HOME PLACEMENT

- Greenwood, et al.[23] examined ***programs targeted to families of children with aggressive behaviors*** (including Family Functional Therapy discussed in more detail below). Program components varied among three interventions examined. Example program elements include ***training parents*** how to monitor their child's behavior and respond with appropriate rewards and punishments, modifying dysfunctional family communication, training family members to negotiate effectively, setting rules regarding privileges and responsibilities, and assistance in family management for parents and/or social skills training for children. A summary ***of selected outcomes across the three interventions*** examined include:

  - Stealing and other ***antisocial behavior was reduced over*** short time periods.
  - ***Recidivism rates for delinquents were reduced by 30 to 50 percent***, compared to a control group, and this reduction was statistically significant.
  - ***Youths receiving the intervention were doing better in school and reported less involvement in delinquency*** than those in the randomly assigned control group.

- ***Family Functional Therapy (FFT)*** is one of the ten programs recommended by the Boulder Center for the Study and Prevention of Violence (BCSPV)[24]. FFT is targeted towards youth 11 to 18 years of age at risk or presenting delinquency, violence, substance use, Conduct Disorder, Oppositional Defiant Disorder, or Disruptive Behavior Disorder. Service delivery is flexible and is provided in the home, the clinic, juvenile court, and at time of re-entry from institutional placement. The program is composed of steps that build upon each other. These steps include building factors that protect the families from early program dropout, motivation for change in maladaptive emotional reactions and beliefs, assessment, focus on behavior change, and promotion of family case management guided and supported by the FFT therapist/family case manager.

[23] Greenwood, Ibid.
[24] Boulder Center for the Study and Prevention of Violence, Ibid.

FFT outcomes include:

- ***Effectively treating adolescents with the above presenting problems;***
- ***Reducing the need for more restrictive, higher cost services;***
- ***Reducing the need for more social services,***
- ***Preventing younger children in the family from penetrating the system of care,***
- ***Preventing adolescents from penetrating the adult criminal system.***

COSTS: ***FFT costs that range from $1,350 to $3,750*** for an average of 12 home visits per family, according to the BCPSV. The ***Washington State Institute for Public Policy estimated that FFT would reduce felony re-convictions by 27%*** (by the time the child reached age 25). ***Using a program cost of $1,900 per participant, it estimated taxpayer savings at $7,168, and additional victims' cost savings of $8,640 per participant, resulting in a net taxpayer and victims' savings gain of $13,908.***[25]

- ***Multidimensional Treatment Foster Care*** (MTFC), another of the ten effective programs recommended by the BCPSV, is described as a cost effective alternative to group or residential treatment, incarceration and hospitalizations for adolescents with problem behaviors, emotional disturbance and/or delinquency. Children remain in the community, through the efforts of community families who are recruited, trained and closely supervised to provide treatment and intensive supervision at home, in school and in the community. The program is based on clear and consistent limits with consequences; positive reinforcement; a relationship with a mentoring adult; and, separation from delinquent peers. When compared to a control group, MTFC children had many ***positive findings***. Among them were:

  - ***60% fewer days incarcerated at 12-month follow-up;***
  - ***Significantly fewer subsequent arrests;***
  - ***Significantly less hard drug use in the follow-up period.***

COSTS: Program ***cost is $2,691 per month*** for an ***average stay of seven months***. The Washington State Institute for Public Policy examined the costs of ***Treatment Foster Care in Oregon***.[26] The Institute ***estimated a reduction in felony re-convictions of 37% by age 25. Costs for this program were less at $3,941 per participant. Taxpayer savings were estimated at $9,757, and victim cost savings were $11,760, resulting in a total taxpayer and victims' cost savings of $17,576 per participant.***

[25] Washington State Institute for Public Policy, Ibid.

[26] The Oregon program places chronic juvenile offenders in homes with trained foster parents, and also provides other treatment and probation services. These costs are provided for information purposes only and not direct comparison, as it is unknown if the Oregon program has all the components of FFT.

- ***Community Assessment Centers (CAC's)*** complement the Office of Juvenile Justice and Delinquency Prevention's (OJJDP's) Comprehensive Strategy for Serious, Violent, and Chronic Juvenile offenders. CAC addresses these challenges by bringing together the fragmented elements of service delivery in a collaborative, timely, cost-efficient and comprehensive manner. In 1996 OJJDP selected four CAC demonstration sites including Colorado. Key program elements are:

  - Single Point of Entry - by integrating the services of multiple agencies.
  - Immediate and Comprehensive Assessment - by providing cross-system services, CAC's may integrate multidisciplinary perspectives on the client's needs, enhance coordination of effort among service providers, afford the opportunity to assess youth immediately, and reduce duplication of assessment services.
  - Integrated case management - crucial to coordinate and monitor multiple services and provide a link between assessment and service delivery.
  - Comprehensive and Integrated Management Information - to effectively monitor the client's involvement in services across systems, a CAC must have an infrastructure that can support integrated case management.
  - CAC Evaluation - An intensive program evaluation of each of the four sites is being conducted.

  Jefferson Assessment Center (JAC) is a joint program between Jefferson Center for Mental Health, First Judicial District Attorney's Office, Jefferson County Department of Human Services, Family Adolescent Crisis Team (F.A.C.T.) and Jefferson County R-1 Schools. The JAC provides a single point of access for youth and adolescents who face trouble with law enforcement. The JAC also provides a single place for law enforcement to take youth they pick up for minor infractions, such as curfew violations. This process returns officers to the streets quickly and saves hours of patrol time.

  The ***Mesa County Western Region Alternative to Placement (WRAP***) project's goal is ***to reduce and/or prevent out-of-home placements for youth juvenile justices, mental health or social services systems.*** The project is funded with state dollars, federal dollars, foundations, service club, business and individual contributions. The project is highly collaborative including major youth serving organizations, local business representatives, law enforcement, judicial system representatives, parents, and services providers. A Project Team that includes youth serving professionals, business and community representatives, and parents, oversees the program. Guiding values include the principle that families and children are best served in the least restrictive, setting that meets the child's needs.

The project:

- Supports a planning process that is strength-based.
- Involves the parents and the child.
- Develops plans to provide supports and services that are individualized the meet the needs of the child and family.
- Provides parent advocates to assist parents with accessing services.
- Has a pool of flexible, non-categorical dollars that are used to purchase services from existing providers for youth and their families to prevent or reduce stay in out-of-home placement (e.g., in-home counseling, respite care).
- WRAP funds are used only after all other sources of funding are exhausted and parents are unable to purchase needed services.
- Provides assessment services, tracking, residential work programs and case management for delinquent youth. [27]

Project W.R.A.P. estimates a costs savings (comparing cost of placement to cost of WRAP plans) of ***$180, 912 for the 1998-99 Fiscal Year.*** [28]

- New pilot initiatives have begun in Colorado to provide ***substance abuse and mental health assessment and services***[29] for youth at Mount View Detention Center and Grand Mesa Youth Services Center. The Division of Youth Services and community mental health centers in Colorado partner to provide these programs. Target populations are delinquent youth with co-occurring mental health and substance abuse issues. Programs at Mount View and Grand Mesa are provided at the detention level to provide youth with screening. After detention youth are provided with an array of services including individual and group counseling, case management, substance abuse treatment and family interventions.

- According to the BCSPV[30] ***Multisystemic Therapy (MST)*** is an intensive family and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. MST is based on the premise that there are multiple causes of criminal conduct. Sources of criminogenic influence include the youth's values, social skills, etc., as well as the youth's social network, including family relations, school, peer group and neighborhood. In this model of human development these factors are seen to mutually influence one another. Importantly, this model of behavior is empirically supported.[31]

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[27] Western Region Alternative to Placement (W.R.A.P.) Mission Statement. (No Date). Obtained from the W.R.A.P program, 1129 Colorado Avenue, Grand Junction, CO 81501

[28] 1998-99 Year-end Narrative Report on Goals and Objectives. Obtained from the W.R.A.P program, 1129 Colorado Avenue, Grand Junction, CO 81501.

[29] Personal communication with Jeff Jensen, Program Evaluator, Denver University School of Social Work, September 27, 1999 and Befus, J. Ibid.

[30] Boulder Center for the Study and Prevention of Violence, Ibid.

[31] Henggeler, S.W. (1999). Multisystemic therapy: An overview of clinical, procedures, outcomes, and policy implications. Child Psychology & Psychiatry Review. 4. 1-10.

An important feature of MST is its integration of empirically based treatment approaches. Rather than focusing on a limited aspect of the youth's social ecology, MST addresses a range of pertinent factors across the youth's social network. While treatment approaches for MST may vary, the following service delivery characteristics are shared.

- Low caseloads (usually 5 families per clinician) that allow intensive services to be provided to each family (2 to 15 hours per week).
- Delivery of services in community settings (home, school, neighborhood center).
- Time-limited duration of treatment (4 to 6).
- 24 hour a day, and 7 day a week availability of therapists.
- Provision of comprehensive services.[32]

MST philosophy holds that service providers should be held accountable for engaging the family in treatment and removing barriers to successful outcomes, that outcomes should be continuously evaluated, and that treatment integrity must be maintained. To support this philosophy, considerable resources are devoted to therapist training, ongoing clinical consultation, and service system consultation.[33]

Well designed evaluations of MST with randomized clinical trials with chronic and violent juvenile offenders have demonstrated that MST is effective in reducing long-term rates of criminal activity, incarceration, and concomitant costs. Results have also demonstrated reduced rates of institutionalization, drug use, and improvements in family functioning and cohesion. Results are especially encouraging because MST has proven effective in inner-city urban areas, among youth with serious criminal records, youth who are at high risk to re-offend, among economically marginal families, as well as those with long histories of a lack of success in other interventions.[34] MST has also demonstrated success with adolescent sexual offenders, and with youth presenting psychiatric emergencies. Specific outcomes include:

- ***Reductions of 25% to 75% in long-term rates of arrest;***
- ***Reductions of 47% to 64% in out-of-home placements;***
- ***Extensive improvements in family functioning***;
- ***Decreased mental health problems for serious juvenile offenders***;[35]
- ***For adolescent sexual offenders, reduced sexual offending and other criminal offending***;
- ***For youth presenting psychiatric emergencies, a 75% reduction in days hospitalized, and a 50% reduction days in other out-of-home placements***.[36]

[32] Henggeler, Ibid.
[33] Henggeler, S.W., Model family programs for delinquency prevention: Multisystemic Therapy Program (internet source www.strengtheningfamilies.org/html/model_programs/mfp_pg25.html.
[34] Leschied, A.W., Cunningham, A., Dick, T. (1998). Clinical Trials of Multisystemic Therapy (MST) with High Risk Phase I Young Offenders, 1997 to 2001. (Year-end report 1997/98) Ontario, Canada: London Family Court Clinic.
[35] Leschied, A.W., Ibid.
[36] Henggeler, S.W. (1999) Ibid.

Colorado provides MST through four programs across in the state.[37] The Forensic Adolescent and Treatment Program (FAST) includes two service treatment teams. A MST team is targeted to families where youth are leaving the Lookout Mountain Youth Services Center. Another team in this same program is part of a Denver juvenile probation diversion program. Recent evaluation results for both programs [38] indicate that

- ***86% remain in treatment;***
- ***79% remain in the community; and***
- ***79% have not been re-arrested.***

COSTS: MST has demonstrated superior clinical outcomes and reductions in criminal activity, as well as considerable benefits regarding costs. A summary report of MST notes that ***MST was approximately 16% of the cost of institutional placement in South Carolina***.[39] A ***study of serious juvenile offenders in South Carolina found that MST was one-third the cost of usual services that include high rates of incarceration*** ($4,000 compared to $12,000, 1996 dollars). Preliminary findings that evaluate MST as an alternative to psychiatric hospitalization show ***a 75% reduction in hospital days that should translate to considerable cost savings***. A study of substance abusing and dependent juvenile offenders concluded that the ***incremental costs of MST were nearly offset by the savings accruing from out-of-home placements.*** Finally, a recent report from ***the Washington State Institute of Public Policy found that MST was the most cost effective of a wide variety of interventions aimed at reducing criminal activity for adolescents. The average net gain in for MST in comparison with boot camps was $29,000 per youth in decreased program and victim costs.*** [40] The Washington State Institute of Public Policy study found that, for the state of Washington, program costs of about $4,500 per participant could lower the subsequent level of felony offending for participants by 44 percent. Their analysis showed that this level in crime reduction will save taxpayers $12,831 per participant in future criminal justice costs. An additional $13,982 in future victims costs would be avoided, resulting in a net gain of $21,863 in savings per participant.

[37] University of Colorado Health Sciences FAST program; University of Colorado Health Sciences Synergy Program; SAVIO House; and a joint program between Division of Youth Corrections and the Midwest Colorado Mental Health Center (personal communication with Keller Struthers, President, MST Services, Consultant to the Colorado Programs, September 1999).

[38] Personal communication with Erica Viggiano, Director of the Forensic Adolescent Consultation and Treatment Service MST Program, September 14, 1999.

[39] Office of Prevention, Texas Youth Commission. (1995) A summary of multisystemic therapy using home-based services: A clinically effective and cost effective strategy for treating serious antisocial behavior in youth. (A summary of a text by Scott W. Henggeler, Ph.D., Family Services Research Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, SC 29425-0742 (803) 792-8003).

[40] Henggeler, S.W. (1999) Ibid.

- The ***Office of Juvenile Justice and Delinquency Intensive Aftercare Program (IAP)***[41] model for youth is based on research conducted over the last several decades pertaining to supervision and intervention. Demonstration programs exist in at least four states including Colorado and are targeted to youth in correctional facilities. Each participating correctional site produced an empirically based risk assessment instrument to identify likely re-offenders within its care. Using this assessment, youth were randomly chosen to participate in the IAP or be part of a control group within the general population of the facility. Program participants include many with multiple appearances before a judge, most have dropped out of school, between a third and half have been abused or neglected as children, between a third and two-thirds have major substance abuse problems. Over 50 percent of the participants have family members with histories of incarceration. About half had family members who seriously abused drugs in the last five years.

  Program elements include:

  - Interagency teams to determine how program development, implementation, administration and evaluation decisions should be made.
  - Participants in IAP live in specified cottages in the correctional facility. Staff assigned to these cottages work closely with the youth's case management team, which includes parole officials and aftercare providers.
  - A transition plan is developed that focuses on risk factors that revolved around family, peers, community, and school and identified types of services to be provided to address these areas.
  - Program objectives include ensuring that specialized treatment begins when the child is in the facility and continues when he returns to the community.
  - Each jurisdiction was asked to develop a graduated system of response to parole violations. Rewards and incentives may be incorporated into the assessment of progress of youth in their families.
  - An important service delivery component is ongoing contact with the parole officer or aftercare provider. Services received include mental health, victim sensitivity training, drug and alcohol counseling, health services, and life skills training.

  The ***initial evaluation found that IAP participants under community supervision averaged between two to four times as many contacts with parole officers as the control group.***

  Researchers will track new arrests, appearances before a judge, and convictions as well as social adjustments and other outcomes.

[41] Atschuler, D. M. (1998). Reintegrating juvenile offenders into the community: OJJDP's intensive community-based aftercare demonstration program. (NIJ Report FS 000234). Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

III. PREVENTION PROGRAMS TARGETED TO REDUCE CRIMINAL BEHAVIOR AND SUPPORT POSITIVE OUTCOMES FOR CHILDREN

- Problems in school or early dropout are primary risk factors for juvenile delinquency and have led to a wide range of interventions. Greenwood, et al.[42] reviewed evaluative studies showing that ***graduation incentives were found to significantly increase high-school graduation and college-enrollment rates. The program was also successful in reducing crime. Arrests for participating students were three-tenths of arrest rates of control students***. The BCSPV[43] also endorses the value of financial incentives for completing high school. The ***Quantum Opportunities Program*** (QOP) is designed to service disadvantaged adolescents from families receiving public assistance. The program is a community-based case management approach which provides 250 hours of education and tutoring to advance academic skills; 250 hours of activities for personal, cultural and life skills development, and 250 hours of participation in community service and volunteer activities. Compared to a control group, the QOP group was:

  - ***More likely to graduate high school (63% compared to 42% controls);***
  - ***More likely to go to post secondary schools (42% compared to 16% controls);***
  - ***Less likely to become a teen parent (24% compared to 38% controls).***

COSTS: ***Program cost was $2,650 per year***. The Washington State Institute for Public policy examined the costs and benefits of Quantum Opportunities and did not find that costs exceeded benefits in dollars terms. The Institute used program costs for four years totaling $12,528. It estimated taxpayer and victim benefits at $8,643 for a net dollar loss of ($3,885). Despite the unfavorable cost comparison, the ***Quantum Opportunities program was estimated to have one of the highest rates of felony arrest reduction--71 percent***. Details of the cost study are not currently available, but it appears that other economic benefits, such as an increase in taxes paid by adults who finish school, and are more likely to be employed, are not included.

[42] Greenwood, et al., Ibid.
[43] Boulder Center for the Study and Prevention of Violence, Ibid.

- The BCSPV[44] endorses ***two programs specifically aimed at reduction of tobacco, drug and alcohol use***. The ***Midwestern Prevention Project (MPP)*** and ***the Life Skills Training (LST)*** program have both proven effective in their goals. The MPP provides information through a system of well-coordinated, community-based strategies including mass media programming, a parent education and organization program, community organization and training, and local policy changes. The effort is primarily school-based.

COSTS: Costs for the MPP program were a minimum of $175,000 over a three-year period, and include costs of training 20 teachers, 20 parents, and 1,000 middle school students. The LST program, which targets middle/junior high school students, can be implemented at a cost of $7 per student per year, plus the cost of training at $2,000 per day for one or two days.

- The BCSPV also recommends ***Big Brothers Big Sisters of America (BBBSA)*** as another program with proven effectiveness. Volunteers provide services by developing a one-to-one relationship with youth. Case managers screen applicants, make and supervise matches between volunteers and youth, and close the case. Compared to controls, BBBSA youth were:

  - ***46% less likely to initiate drug use;***
  - ***27% less likely to initiate alcohol use; and***
  - ***Almost one-third less likely to hit someone.***

COSTS: The national ***average cost of the program is $1,000 per year for each volunteer and youth match***. Working with this figure, the Washington State Institute for Public Policy estimates that the program results in a 20% reduction of felony convictions by age 25. It reports taxpayer savings of $1,978 and victims' savings of $2,505. ***Total savings by taxpayers and victims are estimated at $3,483 per participant.***

IV. STRATEGIES FOR SERVING ADULTS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

Providing Services as Persons Enter the Criminal Justice System

- ***Screening***. A National Institute of Justice (NIJ) survey identified innovative practices used in jails for serving individuals with mental illness.[45] A number of facilities with limited available resources were able to implement innovative programs and policies in six core areas: screening evaluation, and classification procedure; crisis intervention and short-term treatment practices; discharge planning

[44] Boulder Center for the Study and Prevention of Violence, Ibid.
[45] Steadman, H. J and Veysey, B.M. (1997). Providing services for jail inmates with mental disorders. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. 7.

mechanisms; court liaison mechanisms; diversion practices; and contracting procedures. The practices indicate that locating the jail as one agency in a continuum of county-based services may break down barriers to securing other services. Jails interested in developing mental health services should convene a work group to include criminal justice, social services, mental health, substance abuse service and political and religious leaders. Several programs were highlighted for their innovative approaches. A program developed in Summit County Ohio provides a ***three-tier inmate screening approach*** that incorporates recommendations on screening evaluation of the American Psychiatric Association Task Force on Psychiatric Services in Jails and Prisons. The association recommends

- Preliminary screening to detect suicide potential, mental health history and current medications.
- Followed by an intake mental health screening administered by a mental health worker within 24 hours of booking.
- Finally, a complete mental health evaluation should be completed, ideally within 24 hours of referral, by an appropriate mental health professional.

Another innovative program for screening has been implemented in Fairfax County Virginia. This ***inmate classification program*** includes:

- Special training for jail deputies in the classification department on mental health issues, including making appropriate referrals to the forensics and substance abuse staffs.
- A formal written policy that involves mental health providers in classification decisions.
- Responsibility for inmate classification is delegated to an institutional classification committee. The committee consists of representatives from the jail's diagnostic, treatment and classification programs and confinement, medical, and forensics departments. The committee assigns and effects any changes in inmate custody during confinement.

- ***Crisis intervention*** in the jail setting is critical. The American Psychiatric Association recommends the following:

  - Training to recognize crisis situations.
  - Twenty-four hour availability of mental health professionals to provide evaluations.
  - A special housing area for those requiring medical supervision.
  - Round-the-clock availability of a psychiatrist to perform clinical evaluations and prescribe emergency medications.

  The NIJ survey[46] found several innovative ways to deliver crisis intervention services that met or exceeded APA guidelines. Two of the sites they examined employ crisis intervention specialists, and one has a crisis intervention team. The primary goals of

[46] Steadman and Veysey, Ibid.

these individuals are to assess, stabilize, (e.g., in a mental health or special housing unit), and provide direct mental health services to inmates with mental illness.

- ***Training in crisis intervention*** is key in managing offenders with mental illness in the jail environment. The following are training examples from the above programs:

  - One specialist receives 40 hours of training per year from the facility's mental health coordinator.
  - Another is a technician specially trained in crisis intervention to evaluate and refer clients to the infirmary psychiatrist, administer prescribed medications, and maintain contact with involved agencies and community resources, and to assist the psychiatrist during patient assessment and treatment.
  - The crisis intervention team includes a master's level clinical psychologist, a certified psychiatric mental health nurse.
  - One jail has developed an Inmate Suicide Watch Program that uses two-man teams of inmates to accompany correctional officers on their nightly rounds. Inmate observers receive training to recognize signs of depression and risky behavior.

  Jails involved in these crisis intervention programs report that they are better able to manage and supervise offenders with mental illness as a result of having a specific position responsible for handling crisis intervention and short term treatment.

- The ***Memphis Police Crisis Intervention Team (CIT***)[47] is a partnership with the Memphis Chapter of the Alliance for the Mentally Ill, mental health providers, and two local universities in organizing, training and implementing a specialized unit to develop a safe approach to mental crisis events.

  - Officers selected for CIT participate in a 40-hour multidiscipline training to provide understanding of mental illness as a disease and not a crime.
  - The Memphis Police Department has 180 CIT officers who provide coverage 7 days a week, 24 hours a day.
  - CIT officers respond immediately to crisis calls.
  - Mental health professionals provide ongoing training at no expense to the City.

[47] City of Memphis. (No Date). Memphis Police Crisis Intervention Team information packet. Memphis, Tennessee: Memphis Police Department, Lt. Sam Cochran (901)-545-5735.

Program achievements include:

- ***A*** significant (***almost six-fold) decrease in CIT program officer injury rates*** during mental illness events.
- ***Increased access to mental health care***. Forty-five percent of individuals brought in by CIT officers had not previously received care in the mental health system.
- Those brought in to emergency rooms are calmer and require less use of restraints and seclusion***. Officer's time at the emergency room has decreased from 4 to 6 hours to an average of 15 minutes***.
- In a study of three programs developed to respond to individuals with mental illness in crisis, ***CIT officers assigned the highest ratings to effectiveness in meeting objectives***.[48] These included meeting the needs of people with mental illness in crisis, keeping people with mental illness out of jail, minimizing time spent on calls and maintaining community safety.

COSTS: Program information notes that mental health professionals provide training at no cost.

- The NIJ study reports that ***discharge planning*** was the weakest element of all programs for jail detainees with mental illness. However, two programs were an exception to this finding. In Hillsborough County Jail in Tampa, Florida, most discharge planning is handled by two social workers who set mental health appointments and provide follow up to assure that appointments are met. They also assist with housing and transportation. The Fairfax County, Virginia Jail Offender Aid and Restoration Program links detainees on release with mental health and related services and maintains ties with the inmate's family during incarceration to provide the offender with additional support after release. The program is located directly across the street from the jail. Discharge planning is provided for every individual. Especially important for those with mental illness, is that detainees work with the same professional staff from intake to discharge. The following are these programs' essential elements:

  - An excellent working relationship between the agency and the jail's mental health unit.
  - Weekly meetings with the agency, the jail mental health unit and the jail psychiatrist.
  - Good communication among the judge, the booking staff, the jail's forensic unit, and the agency.
  - Transportation and housing assistance upon release.
  - Emergency services for those without plans at release.

[48] Borun, R., Deane, M. W., Steadman, M.J., Morrissey, J. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness. Behavioral Sciences and the Law, 16, 393-405.

- Volunteers trained to teach, mentor and tutor educational classes, and to service as post-release "guide".
- Professional and volunteer teachers to instruct in life skills.
- Group therapy for inmates and their families.
- Support groups for families and close friends of inmates.
- Emergency funds for family food, clothing and necessities during the former provider's jail stay

- ***Court Liaison Programs.*** The Forensic Clinic in the Hampshire County Jail in Massachusetts is administered and funded by the Department of Mental Health's Division of Forensic Mental Health and contracts for staff with a private nonprofit agency. Contracted services include those of a psychiatrist, psychologists, and social workers. Services include counseling, evaluations for competency and a medication clinic. A licensed social worker is the liaison between the court and the Hampshire County Jail and House of Corrections. Major strengths of the program are its location within the jail resulting in immediate treatment responses ultimately decreasing the number of hospitalizations that otherwise would be required.

  In Pinellas County, Florida the Court Liaison goes to the jail to identify likely candidates for civil commitment as an alternative to the criminal justice tract, and follows the case through the courts to final disposition. This program appears to be effective in diverting offenders with mental illness out of the criminal justice system into the mental health system to address the individual's needs.

  In Shelby County, Tennessee, the court liaison program is supported by a multi-agency memorandum of understanding that provides that each of the signing agencies, including pretrial services and the public defender's office, appoint contact persons to act as liaisons with all other social service agencies and service providers. This system allows for expedited court dates for those with mental illness. The court liaison also meets periodically with judges to inform them of available services.

  The court liaison program in Fairfax county, Virginia is built into the screening process and provided by jail magistrates. The magistrates work with pretrial services staff around the clock to decide whether the defendant should be routed to jail or not. Although the program is new, it appears to be successful in diverting offenders with mental illness from jail to more appropriate treatment settings.

  Elements of successful court liaison programs are:

  - Open communication, cooperation, and trust among all involved parties to ensure that those in the system are not working at cross-purposes. Effective and open communication also allows the support and input of those involved in the case.
  - Educating the courts and prosecutors to make critically important pretrial decisions.
  - Screening detainees to facilitate the triage process so mental heath staff may respond with immediate treatment if needed.

- Availability of appropriate services.

- ***Diversion practices***. A ***crisis center*** has been established as an alternative to jail in Hillsborough County, Florida.

  - Police can bring criminal offenders suspected of having serious mental illness to the center for assessment, crisis intervention, and treatment.
  - The center can accept persons charged with offenses up to nonviolent felonies.

  Fairfax County, Virginia has designed a ***mobile crisis unit (MCU)*** as a pre-booking diversion program to divert inmates with mental illness from jail. The mobile crisis unit works with the family, police and courts and is staffed and funded by the county.

  - The MCU provides home visits for those unable to go to a mental health center.
  - It is staffed seven days a week from 3 p.m. to midnight.
  - Upon arrival to work, staff members check with area mental health centers for referrals.
  - Services include assessment, prevention, intervention, psychiatric crisis evaluation, hospitalization, medication, stress relief for service providers, and assistance for people coping with trauma or tragic events.
  - MCU members also serve as consultants to police SWAT teams.
  - They provide training for magistrates and officers on mental health issues, educate families and the community about the criminal justice system.
  - Provide backup for the jail's crisis intervention team.
  - Act in lieu of police officers as petitioners at hearings for offenders with mental illness.

Programs Provided in Containment and Community Settings

- A National Institute of Justice report[49] concludes that ***case management*** techniques are used across the country to provide services for ***arrestees, probationers, and parolees who need services such as batterer intervention, drug treatment, mental health treatment or to provide help for mentally retarded offenders.*** The report highlights fundamental activities of case management that include:

  - Engaging the client in treatment.
  - Assessing client's needs.
  - Developing a treatment plan.
  - Linking the client with appropriate services.
  - Monitoring client progress.
  - Intervening with sanctions.
  - Advocating for the client.

[49] Healey, K. M. (1999) Case management in the criminal justice system. Washington, D.C: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

There are several examples of case management programs across the country. ***In Hampshire County, Massachusetts, case management was adopted 20 years ago by the jail to coordinate services on an inmate-specific basis.*** In this program, case managers are assigned to pre-trail inmates without or without mental illness. The program provides assessment at intake and appropriate referrals to resources inside and outside the facility.

Since 1983, the city jail ***in Alexandria, Virginia*** and the Alexandria Departments of Mental Health, Retardation, and Substance Abuse have cooperated to bring case management services to inmates. [50] Trained jail staff are responsible for initial treatment, and only the most serious cases are referred to the mental health department counselors. Case management for mentally ill offenders involves regular case review by a behavior management team, which includes security personnel, classification personnel, and clinicians who develop a treatment plan. Approximately 20 percent of the jail's inmates receive some sort of mental health services from the unit. The inmates are linked to community services while they are in jail and are expected to continue a relationship with their case manager upon release.

Case management ***programs in Lancaster County, Pennsylvania target probationers with mental illness who have committed nonviolent crimes and have been diagnosed with major mental illness***. Case management is directed to client needs and can include monitoring (supervision), medication monitoring, day programming, employment counseling, vocational testing, job placement and family and personal counseling. Program goals are to limit incarceration and hospitalization of offenders and to assist in the successful completion of probation.[51]

- Pima County Arizona offered ***an innovative program to target offenders at high risk of probation revocation due to substance abuse***. Racial and ethnic minorities, as well as younger offenders were included. Key elements of a therapeutic community were incorporated into a day and evening program. Despite promising results, the program was terminated due to lack of funding. The program provided:

  - Escalating sanctions (urine screens and varying supervision levels).
  - Case management assessment and support services.
  - Educational or vocational training.
  - Family support and counseling.
  - Health services coordination.
  - Intensive aftercare.
  - Community-based site housing both probation officers and treatment staff.

After two years,

[50] Healy, Ibid.
[51] Healy, Ibid.

- ***Drug use relapses decreased,***
- ***Probationer employment increased, and***
- ***Positive urine tests decreased by more than 50%.***

- ***Maryland's Community Criminal Justice Treatment Program (MCCJTP)***[52] targets individuals 18 or older who have a serious mental illness with or without a co-occurring substance use disorder. MCCJTP brings together treatment and criminal justice professionals to screen individuals with mental illness while confined to local jails, prepare treatment and aftercare plans, and provide community follow-up upon release. Program goals are to improve identification and treatment of mentally ill offenders early in the justice system, improve, reduce or eliminate incarceration with pre-booking and post booking diversion (in some jurisdictions), improve the quality of care for mentally ill offenders, and decrease *"system cycling"* of offenders with mental illness. Key program features include:

  - Local partnerships guided by an advisory board that represents detention centers, mental health, drug and alcohol treatment programs, defense attorneys, assistant State's attorneys, judges, probation and parole officers, law enforcement, social services, local hospitals, housing specialists, mental health advocates, and consumers.
  - Support from state government agencies.
  - Case management services for offenders who are incarcerated or living in the community.
  - Enhanced services for mentally ill offenders who are homeless and/or have co-occurring substance abuses disorders.
  - Diversion from jail is utilized in some locations. One county offers post booking diversion; this is not offered to violent or arson offenders. A pre-booking diversion program in one county is staffed with a mobile crisis unit.
  - Training for criminal justice, mental health professionals, and substance abuse treatment staff.

  Program accomplishments include:

  - ***Reduced disruptive behavior*** in jails,
  - ***Increased ability to identify inmates with mental illness*** and refer them for assessments,
  - Increased confidence that defendants will follow treatment plans and receive better care while confined; and,
  - Case managers report that program participants have made substantial improvements.

[52] Conly, C. (1999). Coordinating community services for mentally ill offenders: Maryland's community criminal justice treatment program. Washington, DC: U. S. Department of Justice, National Institute of Justice.

COSTS: In 1996 1,682 jailed individuals with mental illness received MCCJTP services. Program costs are approximately $4 million annually ($2,378 per individual served).

- ***Advocacy***. The Court Appointed Special Advocate (CASA) program is a non-profit organization that trains volunteers to advocate for children, who are abused, neglected or abandoned by their families. This type of program may have application for offenders with serious mental illness, who sometimes face similar issues, i.e., falling through the cracks or being overwhelmed in a complex and overburdened system with inadequate services. The CASA is a trained community volunteer appointed by the judge to serve the bests interests of the client. The CASA responsibilities include serving as a fact-finder for the judge by thoroughly researching the background of each assigned case; speaking for the child in the courtroom to represent the child's best interests, and continuing to oversee the child during the life of the case. ***An advocacy program for offenders with mental illness might be structured with similar volunteer responsibilities, adding representation of the interests of the community and public safety as well as that of the client.***

  - CASA volunteers handle only one or two cases as a time to ensure that the history of each case can be explored thoroughly.
  - The volunteer has close, consistent contact with children who may be overwhelmed by the complexities of the system and who also may be removed from the home.
  - Volunteers receive thorough training (on average 30 hours) regarding courtroom procedure, effective advocacy techniques for children, as well as training about specific topics such as child sexual abuse.
  - Volunteers devote on average more than 70 hours to the program annually.[53]

COSTS: ***Median cost of service per child is $562 and the median cost per volunteer is $1,947*** (1997). The average number of children per volunteer is 3.8. However, volunteers are usually assigned to no more than two cases at once. [54]

It is important to note that ***case management programs for offenders with mental illness often include an advocacy component.*** Several types of advocacy are required of case managers in a criminal justice setting, including providing testimony and recommendations on the client's behalf, negotiating pro bono services for client, or securing priority program placements. The case manager may also mediate situations such as arranging visitation with children. The case manager is also

[53] CASA Volunteer Fact Sheet. Colorado CASA, 1234 Bannock Street, Denver, CO 80204. (303)623-5380.
[54] The 1998 National CASA Association Survey. National CASA Association, 100 West Harrison Street, North Tower, Suite 500, Seattle, WA 98119. (206) 720-0072.

responsible for assisting the client in negotiating the bureaucratic maze of service systems.[55]

- ***Mental Health Courts (MHC)*** are ***designed to better serve the misdemeanant population with mental illness and to improve public safety for the community***. Currently, there are four programs across the Country. King County, Washington[56] provides a description of program elements.

  - The Mental Health Court provides misdemeanants (may include violent misdemeanants with victim's permission) with mental illness a single point of contact with the court system.
  - The MHC is staffed as a team by a dedicated judge, prosecutor, defender, treatment court liaison, and probation officers.
  - Defendants may be referred to the MHC by jail psychiatric staff, police, attorneys, family members, probation officers, or another District Court.
  - Participation is voluntary, as defendants waive their rights to a trial on the merits of the case.
  - A court liaison to the treatment community is present at all hearings and is responsible for developing an initial treatment plan and linking the defendant to appropriate services.
  - Defendants receive court ordered treatment in place of standard sentencing. Successful participation may result in dismissed charges or reduced sentencing.
  - If the defendant is placed on probation, the case is assigned to a mental health specialist probation officer. These officers are assigned to the program and carry substantially reduced caseloads.

  Lessons learned from existing programs indicate that successful programs must be linked with aftercare and that release planning must occur well before release. Systems must be in place to ensure that relevant information follows the individual. [57]

  Mental Health Courts are new, but initial outcomes are available:

  - Broward County, Florida reports ***some success in linking individuals to community mental health treatment.***
  - King County reports ***improvement in defendant's satisfaction, use of jail resources and public safety.***[58]

[55] Healey, Ibid.
[56] Mental Health Court: A King County District Court Pilot Program. Obtained at http://www.metrokc.gov/kcdc/mhfact.htm
[57] English, K. (1999). Mental health courts: Overview presentation to the task force for the study of the seriously mentally ill in the criminal justice system. Denver, CO: Colorado Division of Criminal Justice, Office of Research and Statistics.
[58] English, Ibid.

Community-Based Programs for Offenders

- ***Assertive Community Treatment (ACT)***[59] is a nationally recognized treatment approach demonstrated to be effective in the treatment and oversight of individuals with serious and persistent mental illness. The program targets difficult to engage clients, those at high risk for psychiatric deterioration, and those with co-occurring substance abuse and criminal behavior. Key components of the model as implemented by the Mental Health Corporation of Denver include:

  - Community-based treatment approach.
  - Multidisciplinary staff (psychiatrist, nurses, master and bachelor level case managers, vocational and substance abuse counselors, and a supervisor).
  - Client to staff ratio of 10:1.
  - Frequent contacts with staff.
  - Psychopharmacologic treatment (including new anti-psychotic and antidepressant medications).
  - Case management.
  - Individual supportive therapy.
  - Mobile crisis intervention.
  - Hospitalization.
  - Substance abuse treatment.
  - Behaviorally oriented skills teaching (e.g., structuring time, activities of daily living).
  - Supportive employment that includes paid and volunteer work.
  - Support for resuming education.
  - Collaboration with families and assistance with children.

  ACT has demonstrated the following ***outcomes***:

  - ***Reduced hospitalizations*** (A National Alliance for the Mentally Ill study indicates that only ***18% of ACT clients were hospitalized in the first year of treatment compared to 88% of non-ACT clients),***
  - ***Reduced homelessness***,
  - More clients have jobs,
  - More clients are reunited with families,
  - More clients are getting medical treatment, and
  - ***Fewer arrests*** for a client with a history of involvement with the legal system.

  The MCHD undertook a study to examine and document changes in consumers' involvement in the criminal justice system before and after the ACT program (called High Intensity Treatment Teams--HITT--in Denver). The study examined the records of clients three years prior to HITT involvement and three years after HITT

[59] All information on the ACT program is summarized from a presentation by Carl D. Clark, M.D., September 1999 to the Task Force on Offenders and Mental Illness. Assertive Community Treatment. Mental Health Corporation of Denver.

involvement, and found that, after removing four outliers representing numerous prostitution arrests, there was a

- ***30% decrease in total arrests***, and a
- 44% decrease in fresh arrests (that is, removing those arrests that were from earlier unresolved contacts with the legal system, many of which were found when the client attempted to secure housing),
- Drug and alcohol offenses decreased 20%,
- Fresh violent offenses decreased by 49%.

COSTS: Dr. Carl Clark of MHCD indicates that the cost of the program is ***about $12,500 per participant, per year,*** and does not include housing. Program cost decreases as outcomes for individuals improve. For ***comparison***, a costing study[60] undertaken between April 17, 1988 and January 31, 1990 (pre-managed care) reviewed the ***costs of serving individuals with mental illness*** in six areas: mental health, physical health, drug and alcohol, law enforcement and courts, casework services, and government benefits, and ***calculated of approximately $24,000*** per person for a one year period ($33,720 in 1999 dollars).

- ***Community Treatment Alternative Programs*** (CTAP) may be developed to provide community-based mental health services as an alternative to incarceration for adjudicated offenders with chronic mental illness. In Jefferson County, Kentucky, criteria for admission are chronic offender status (usually misdemeanants) along with severe mental illness. The target population excludes those with primary substance abuse and personality disorders. Monthly meetings among jail mental health staff, CTAP caseworkers, and the court liaison provide an opportunity to determine who in the jail should be targeted for services. The program works as follow:

  - Correction, community mental health services and the courts develop a coordinated plan for securing the detainee's release from jail and to assist in meeting the detainee's mental health needs.
  - Detainees are released from jail into the community. CTAP caseworkers help set up appropriate housing before an inmate's release.
  - Detainees are supervised closely. For the first month, this is done mainly by the CTAP caseworker.
  - After the first month, detainees come into the office for appointments or staff provide home visits to check on life management skills.
  - Medications are monitored closely (some detainees must come into the center every day for medications while others are given injections).
  - CTAP participants must sign a contract that commits them to the program for a two-year period or a jail term in case of revocation.

[60] Shern, D.L., Coen A.S., Nelson, L. Wilson, N.Z., Vasby, K. O. (1990). Final Report: Innovative service delivery models and the cost of chronic mental illness. Denver, CO: State of Colorado, Mental Health Services.

- Wisconsin has developed a ***Community Support Program*** in Milwaukee[61] to keep offenders who are mentally ill and require medication, monitoring and other services, out of jails and hospitals but under close supervision. The program is well suited to clients who come to the attention of criminal justice agencies as well as those who are at risk to do so.

  Defining elements include:

  - Medical and therapeutic services -- including administering and monitoring of medications. Psychotherapy and group sessions are available. Case management services help link clients with primary health care.
  - Money management -- arranges for social security and other disability benefits. The client's fixed expenses, such as rent, are paid directly by the program.
  - Housing and other support services -- intensive casework assists with meeting the client's basic needs. The program arranges housing in the community, and daily living is monitored by home visits.
  - Day reporting and close monitoring -- most clients must report to the clinic Monday through Friday, where they can take their medications or stay for brief or long periods. This allows the opportunity for daily observation and interaction with the clients.
  - Participation -- clients must agree to enter the treatment program or face less desirable alternatives such as jail.

  Although the program has not be formally evaluated, the authors note the following successes:

  - The program appears to be achieving its goals ***of keeping those with chronic mental illnesses out of the local jails and hospitals and to help them live independently.***
  - The program's administrators report that in recent years ***the proportion of jail inmates diagnosed as mentally ill has been about three percent, a much smaller percentage than before the program's inception.***
  - ***County officials support the program*** to the extent that scarce State and Federal dollars have been allocated to fund three similar programs.

  COSTS: about $3,000 per year per participant. Low costs are achieved by primarily employing paraprofessionals.

[61] McDonald, D.C., Teitelbaum, M. (1994). Managing mentally ill offenders in the community: Milwaukee's community support program. (NCJ145330). Washington, D.C: U. S. Department of Justice, Office of Justice Programs, National Institute of Justice.

Services for Inmates

- ***The San Carlos Correction Facility (SCCF) in Colorado is a 250-bed facility and serves inmates with mental illness or developmental disabilities. A dual-diagnosis program is a 32-bed unit within the facility***. Inmates served by the program are those with the highest needs as determined by diagnosis, symptom severity, and disruptive behavior.

  - The program is a modified therapeutic community that provides psychoeducation, life skills training, and cognitive-behavioral interventions.
  - Inmates typically spend eight hours a day in treatment, educational programs, and work activities within the therapeutic community.
  - Average stay six to nine months.
  - Step down into less restrictive containment and transitional housing and community follow-up is incorporated into the program.

    - Research findings from national studies show ***reductions in overall recidivism ranging from 10% to 25%.***[62]

- A ***Crisis Care Unit*** in the Sussex Correctional Institution in Delaware[63] is a 40-bed unit located in maximum security. The program was originally designed for inmates with mental illness and mental retardation. Specialized services for inmates with co-occurring disorders were developed as greater numbers of substance abusers were placed in this program. Recently, the program has become more focused on stabilization of inmates with severe psychiatric conditions rather than on long-term treatment.

  The program provides:

  - A mental health counselor, activity therapist, correctional counselor, and a consulting psychiatrist provide treatment services seven days a week.
  - Comprehensive psychosocial assessment.
  - Individual and group therapy, medication monitoring.
  - Psychoeducational groups.
  - Relapse prevention.
  - Recreational therapy.
  - Individual case management.
  - Behavioral reinforcement is provided through use of a level system, in which inmates progress to higher levels of responsibility and privileges based on compliance with treatment goals and community rules and regulations.

[62] Strommel, J. DOC therapeutic community programs for mentally ill chemical abusers (MICA). Presentation to the Legislative Committee HB-1042 Taskforce Subcommittee Report October 1, 1999. Colorado Department of Corrections, Alcohol and Drug Services. Contact Joe Strommel (719)269-4151.
[63] Edens, J.F., Peters, R. H. and Holls, H. A. (1997). Treating prison inmates with co-occurring disorders: an integrative review of existing programs. Behaviorial Sciences and the Law, 15, pp.439-457.

V. STRATEGIES FOR SERVICE SPECIAL POPULATIONS

Special Populations - Inmates with co-occurring Disorders

- Intervention strategies for offenders with co-occurring disorders are aimed at the growing population of substance abusers who are under criminal justice supervision and have a range of psychosocial problems that contribute to their involvement in the criminal justice system. An estimated 7 percent of jail inmates and 3-11 percent of prisoners have co-occurring mental health and substance use disorders***. Co-occurring disorders are used to describe individuals with a DSM-IV Axis I major mental disorder and a substance abuse disorder.*** Indicators for identifying co-occurring disorders among offenders include use of psychotropic medication; history of mental health symptoms and/or treatment; youthful offenders; males; and individuals who have a history of poor family relationships, homelessness, criminal justice involvement, suicide, emergency room and other acute care visits. Many of these indicators are also associated with aggressive and violent behavior, criminal recidivism, and poor treatment outcomes. [64]

  The following key elements were identified in a survey of several correctional treatment programs that treat co-occurring disorders:[65]

  - Inmate referral usually occurs in three ways: (1) after completion of screening at a prison intake facility, (2) after referral to a substance abuse or mental health treatment program, or (3) after identification of symptoms while placed in the general population.
  - Screening procedures vary across programs. Most combine a diagnostic interview with self-report instruments that address both substance abuse and mental health symptoms. Most screening for co-occurring disorder programs is done or supervised by doctoral-level staff, and may be reviewed by an evaluation team.
  - Admission criteria vary across programs. Most program participants have major mental health and substance abuse disorders, but there is a wide range of functional impairment among participants. Admission criteria are broad for some programs; at others referral decisions are based on whether or not the inmate will benefit from treatment.
  - All programs include an intensive initial period of assessment. Prior diagnoses are re-evaluated, structured assessment interviews and instruments are used, medication is evaluated, case managers are assigned, and treatment plans are developed. Correctional treatment programs differ in the types of standardized assessment and objective diagnostic instrument used. This may reflect the

[64] Peters, R. H. and Hills, H. A. (1997). Intervention strategies for offenders with co-occurring disorders: what works? Tampa, FL: Department of Mental Health Law and Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida (prepared with support from the GAINS Center. Available from the GAINS Center, 262 Delaware Avenue, Delmar, New York 12054 (800)311-GAIN)

[65] Edens, J.F., Peters, R. H. and Holls, H. A. (1997). Treating Prison Inmates with co-occurring disorders: an integrative review of existing programs. Behaviorial Sciences and the Law, 15, pp.439-457.

diagnostic heterogeneity of inmates served and the quality and accuracy of initial screenings.

- Treatment interventions differ to some extent in philosophy and type, but all endorse the importance of a strong community atmosphere and include psychoeducational, 12-step, cognitive-behavioral, and relapse-prevention strategies.
- Differences between treatment for co-occurring disorders and traditional treatment approaches may include:

    - Smaller caseloads to provide more individualized counseling or case management services. Caseload ratios for programs surveyed range from 5-1 to 30-1. Staff is often certified/licensed chemical dependency counselors with varying degrees of training in mental health and co-occurring disorder treatment issues.
    - Shortened and simplified meetings and increased repetition occur to foster better comprehension by attenuated cognitive abilities of some inmates.
    - Criminal thinking with specific interventions is addressed.
    - Medication education is provided.
    - Minimization of confrontation is emphasized, as inmates with co-occurring disorders are often less able to tolerate the interpersonal stress or emotional arousal evoked by these encounters.

All reviewed programs for co-occurring disorders have procedures for transitioning inmates from treatment into aftercare services. Aftercare services include those provided in another prison facility for the duration of the sentence; enrollment in a transitional living center, work release program, or halfway house; or direct release into the community. For the most part inmates who are discharged prior to completion of their sentence are not transferred directly into the community. They are often placed in therapeutic communities or in aftercare dorms for inmates who have completed substance abuse treatment. Pre-release programs usually include opportunities or require transfer to halfway houses or placement in transitional settings. Some programs employ transitional coordinators with the primary responsibility of identifying and linking inmates with other institutional or community resources. Pre-release plans may include development of a service plan and coordination and pre-release meetings with case managers from community agencies or halfway houses or other transitional settings. All programs that release inmates to community supervision programs provide parole/supervision officers with an aftercare plan to be used during the period of 'conditional' release.

Gaps often exist between specialized institutional services and those provided in the community. Difficulties in providing services include: a lack of community resources for inmates returning to rural settings, resistance to provide services to those with criminal histories, an absence of mental health services or medication monitoring among many community-based substance abuse programs, a lack of awareness of mental health issues among community supervision officers, and resistance among ex-offenders to continue involvement in treatment upon release.

Preliminary research findings provide some evidence for the efficacy of these treatment approaches.

- One program reports that ***participants are less likely to be re-incarcerated following release*** compared to the general inmate population.
- Results from another program indicate a ***high rate of treatment retention***. Program participants also had ***lower rates of criminal activity and drug use*** compared to a comparison group.
- Also see San Carlos Correctional Facility (SCCF) above.

COSTS: A study conducted by French et al. (1999) and reported by Stommel notes that a study of homeless individuals with co-occurring disorders found a savings of ***$13 in direct costs for services to this population for every $1 spent on modified therapeutic community treatment***.[66]

V. PROVIDING SERVICES TO SPECIAL POPULATIONS

Special Populations - Female Inmates with Co-occurring Disorders

In the past 15 years the number of women in the criminal justice system has increased 273 percent. Often women entering the system have multiple problems such as mental health and substance abuse issues, parenting difficulties, health issues, and histories of physical and sexual abuse. Although women represent about 10 percent of the criminal justice population, they have much higher rates of mental illness. Often co-occurring diagnoses include Post Traumatic Stress Disorder resulting from histories of violence and abuse. Studies on women in correctional settings have found that generally they are under-served. [67]

- The Turning Point Alcohol and Drug Program in the Columbia River Correctional Institution in Oregon[68] is a 50-bed ***therapeutic community for women with co-occurring substance abuse and mental illness disorders***, housed in a 500-bed minimum security state prison for female and male inmates. The program, entirely supported by the Oregon Department of Corrections, is housed separately from the main prison population and serves as a pre-release institution for female inmates. The program provides a five-phased treatment program of six to 15 months in duration. The program was conceptualized as a substance abuse treatment program but now includes mental health services due to the high rate of dropout attributed to untreated Axis I mental health disorders. About 60% of the program inmates are dually

[66] Stommel, Ibid. (Taken from French, M.T., Sacks, S., DeLeon, G., & McKendrocl L. (1999). Modified therapeutic community for mentally ill chemical abusers: Outcomes and costs. Evaluation and the Health Professional, 22(1),60-85.)
[67] GAINS Center (1999). Addressing the needs of women in mental illness/substance use disorder jail diversion programs. Delmar, NY: Policy Research Associates, Inc.
[68] Edens, et al., Ibid.

diagnosed. Seventy percent are dually diagnosed with Post Traumatic Stress Disorder attributed to a history of physical and/or sexual abuse reported by a majority of female inmates. The program provides:

- A minimum of 30 hours a week treatment and educational services.
- Treatment services are oriented towards group sessions and incorporate substance abuse education, life skills, and relapse prevention within a therapeutic community environment.
- Special groups for physical and sexual abuse survivors are provided.

The Substance Abuse Felony Punishment Facility is a 288-bed program operated by Phoenix House of Texas that provides ***treatment for women with substance use disorders who are also either pregnant, have developmental disabilities, chronic medical problems, or Axis I mental health disorders*** (approximately 55% with the later). The program is a ***modified therapeutic community*** that incorporates psychoeducational programs, women's issues, Alcoholics Anonymous, process groups and relapse prevention strategies.

Special Populations - Co-occurring substance use for females: A diversion to incarceration

- The Phoenix Project in Wicomico County, Maryland is under the umbrella of the Wicomico County Health Department's Forensic Services Program that provides mental health and substance abuse services for adults and children. The Phoenix Project is closely linked with the Maryland Community Criminal Justice Treatment Program (MCCJTP) (discussed earlier in this paper) and the Mobile Crisis Unit which provides 24-hour emergency response to police calls for persons with signs of mental illness or substance use disorders.

  The Phoenix Project is a pre-booking and post booking diversion program for females that provides intensive case management and integrated mental health and substance abuse in-house and on-site. This program aspect is different from other programs that link individuals to community services. Referrals are received from the Mobile Crisis Unit; law enforcement; jail staff; judges, prosecutors, defense attorneys; and district court commissioners. Most participants are probationers who have been diverted from incarceration after a violation of probation. Eligibility criteria include females over 18 who are dually diagnosed with substance abuse and mental illness disorders, and are charged or at risk of being charged with a misdemeanor or non-violent felony. The program is strength-based and works predominately with high-end service users. All staff members are female, and program goals include helping women become responsible for themselves and to assist them in navigating the system and services.

Project components include:

- Intensive case management is the key program component to provide a supportive relationship between the client and the case manager. Case managers work with women to develop short-term and long-term goals. They also act as brokers to assist participants with a range of services to meet their needs (e.g., transportation, childcare, housing arrangements, etc.).
- Integrated mental health and substance abuse treatment is provided on site by in-house staff. Treatment includes medication monitoring.
- The Phoenix Project addresses a main concern of women in the program -- their children. The project provides parenting classes, childcare, and works with the participant on re-unification issues. The program also provides mental health services for children, as many of the women in the Phoenix Project come from situations of abuse and violence to which their children are often exposed.
- The project helps connect women to vocational training and education programs. This service is a critical element for women who may have no employment experience or have never lived independently.
- Women involved in the project are able to access critical emergency shelter for themselves and their children. Project staff report that safe housing is a critical component of program success. Assistance with HUD-Shelter Plus Care rental assistance is also provided.
- The program is currently implementing a trauma component to address the critical issues of violence and abuse that exist for many of the women in the project.

Special Populations - Adolescent Females with Co-occurring Disorders

Adolescent females are coming in contact with the criminal justice system with increasing frequency. In 1993, adolescent females accounted for nearly one-fourth of all those arrested under age 18. Many researchers indicate that the most significant underlying cause of risk factors leading to delinquency for adolescent girls is the high prevalence of physical, sexual and emotional abuse and victimization in their histories. Other research shows that compared to boys, adolescent girls have higher rates of depression, more suicide attempts and self-mutilation, lower self-esteem, and lower rates of educational retention. Further, adolescent females in the juvenile justice system with complicated clinical profiles that include mental health, substance abuse, and primary health care needs do not fare well in a system designed for boys. There are profound differences between male and female adolescents in gender socialization, environmental stressors, and development.[69] The GAINS Center has recommended the following policy and practice suggestions for working with adolescent girls in the juvenile justice system:[70]

- Develop gender-specific programs and practices that use strength-based approaches that focus on skills adolescent girls have developed in order to survive.

[69] GAINS 1999. Ibid.
[70] GAINS 1999. Ibid.

- Design strength-based assessments that are gender specific and culturally and developmentally sensitive.
- Shame and distrust may prevent young women from disclosing personal information; thus interviews and assessments should be performed by women in private.
- Small single-sex dialogue groups have been successfully used to facilitate discussions on sensitive topics and to facilitate the development of peer support systems for girls in community and juvenile detention settings.
- Adapt trauma-based treatment models known to be successful with women with co-occurring disorders in correctional settings.
- Support mobile assessment, intervention and treatment in community settings. Many adolescent girls who come in contact with juvenile justice are poor and have little access to services. Neighborhood environments also provide a way to avoid stigmatizing those in need of services.
- Increase alternative, single-sex, residential placements in the community as well as foster care placements, alternatives for those running away from abusive homes, a network of "safe homes" for temporary placement, and alternative drop-in sites.
- Develop interventions with family members and other community supports.
- Develop crisis intervention in restricted environments that mitigate retraumatization, e.g., providing female staff all situations and using alternatives to restraints that mirror sexual abuse.
- Develop cross-system collaboration on gender-specific issues. Linkages with teachers, guidance personnel, and others in the educational system can promote school retention, which is closely associated with long-term, positive outcomes.
- Provide information on gender specific services, treatment needs, etiologies of behavior.

Summary

Effective and promising interventions and strategies for individuals with mental illness at all phases of the criminal justice system do exist. There is evidence of the proven-cost effectiveness of providing intervention early in an individual's life. It should be clear that there is no single-step *cure all* for the numerous issues that face individuals with mental illness and the systems that serve them. Effective intervention strategies address the individual's needs at multiple levels. Aftercare and linkages to community services are essential to program success. These persons cannot be served with a *pill* or *a quick fix*; however, it should also be evident that investments in individuals both before and during their involvement with criminal justice results in long term savings to taxpayers as well as benefits to those receiving services.