



FAIR AND JUST PROSECUTION

Promoting justice through leadership and innovation

ISSUES AT A GLANCE

Effective Collaborative Responses to Individuals with Mental Illness: A Compendium of Models from Across the Nation

Fair and Just Prosecution (FJP) brings together recently elected district attorneys¹ as part of a network of like-minded leaders committed to change and innovation. FJP hopes to enable a new generation of prosecutive leaders to learn from best practices, respected experts, and innovative approaches aimed at promoting a justice system grounded in fairness, equity, compassion, and fiscal responsibility. In furtherance of those efforts, FJP's "Issues at a Glance" briefs provide district attorneys with information and insights about a variety of critical and timely topics. These papers give an overview of the issue, key background information, ideas on where and how this issue arises, and specific recommendations to consider. They are intended to be succinct and to provide district attorneys with enough information to evaluate whether they want to pursue further action within their office. For each topic, Fair and Just Prosecution has additional supporting materials, including model policies and guidelines, key academic papers, and other research. If your office wants to learn more about this topic, we encourage you to contact us.

SUMMARY

This FJP "Issues at a Glance" brief offers a compendium of examples and strategies for responding to individuals with mental illness who come into contact with the justice system. This brief discusses suggested avenues of engagement — and replicable models from around the nation — for DAs interested in promoting reform, including examples of promising practices that can avoid criminalization and reduce incarceration of people with mental illness at every stage of the criminal justice system. For additional background information, as well as over-arching principles and recommendations for DAs to implement in this area, please see FJP's brief on "Improving Justice System Responses to Individuals with Mental Illness."

Individuals with mental illness are overrepresented at every stage of the criminal justice system,² yet research indicates that the vast majority of these individuals do not pose a threat to the community.³ Rather, the over-incarceration of persons with mental illness reflects the fact that communities are ill-equipped to respond to people experiencing a mental health crisis.⁴ In communities without mental health crisis response systems and services, police may be called unnecessarily to respond to individuals experiencing a mental health crisis.⁵ Often these law

"Prosecutors must consider the people before them as individuals with unique needs, histories, and motivations who require a variety of methods to change their behavior."

— MILWAUKEE COUNTY (WI) DISTRICT ATTORNEY JOHN CHISHOLM

enforcement responders lack appropriate training and police officers are left with few tools but arrest. When arrest and jail placement is the only response available, crisis situations may rapidly escalate and in too many instances deterioration and even deadly violence results.⁶ Likewise, without appropriate diversion resources, prosecutors may also resort to overly-incarcerative and punitive responses even as over-incarceration continues to be a key driver of gaps in public health outcomes along racial and socioeconomic lines.⁷

Many jurisdictions around the nation have begun to explore proactive public health approaches to individuals with mental illness who otherwise find themselves trapped in the justice system. These new approaches emphasize fair and compassionate treatment and result in improved outcomes for the individual and the community, as well as significant cost savings. This brief supplements FJP's brief on "Improving Justice System Responses to Individuals with Mental Illness"⁸ by discussing the strategic planning process for cross-system reform and offering examples of best practices, promising approaches, and innovations at every stage of the criminal justice system.

BACKGROUND

Prosecutors seeking to improve their responses to individuals with mental illness must collaborate with traditional partners such as law enforcement, the bench and defense bar, and also with behavioral health providers, correctional administrators, and community leaders. Prosecutors can use their convening power to bring essential stakeholders to the table. Effective collaboration requires a shared understanding of needs, assets, and the interaction of systems, in addition to a shared commitment to reform.

Strategic planning tools, processes, and structures can help ensure that collaborations are fruitful. **Criminal justice coordinating councils (CJCCs)** are one such structure for collaboration.⁹ A criminal justice coordinating council generally refers to a body of justice system and behavioral health system decision-makers and community representatives who meet regularly to coordinate systemic responses to justice issues, often staffed by a dedicated independent director and/or data analyst.¹⁰ The regular meetings of the council may be open to the public, or the minutes may be published, to encourage accountability and productivity. The CJCC can serve as a forum for strategic planning, a means for communication, and a central entity to perform data analysis and seek and manage grants for cross-system improvement.

The Sequential Intercept Model (SIM) is a useful strategic planning tool for CJCCs or other planning bodies to help partners develop a shared understanding of needs, assets, and goals. The SIM is a means of examining how people with mental illness interact with every stage of the criminal justice system.¹¹ At each "intercept," or stage, leaders can ask what interventions are most needed and will be most effective in their community. Leaders should also consider what resources are available already in the community and how to improve linkages between various service providers and between service providers and the justice system.¹² The answers to those questions can form the basis of an overarching strategy to be implemented by the prosecutor and community partners. In the paragraphs that follow, each intercept is described and promising practices and innovations are detailed at the applicable intercept.

While reform at every intercept is ideal in the long-term, many jurisdictions begin by prioritizing a single intercept. For example, some jurisdictions implemented court and jail-based diversion programs.¹³ Other jurisdictions, such as Bexar County, Texas, found it most effective to prioritize improved crisis response measures at the pre-arrest stage.¹⁴ The decision of where to begin the reform process is individual to each community. The practices and innovations summarized below are neither exhaustive, nor do they represent a checklist of reforms that all jurisdictions dedicated to mental health reform must immediately implement; rather, they represent an array of possible responses to consider.

INNOVATIONS AND PROMISING EXAMPLES AT EVERY INTERCEPT

Key Characteristics for Interventions

The interventions described below all represent promising practices for reducing the incarceration rates of individuals with mental illness. Although these interventions vary widely, effective programs share many essential characteristics:¹⁵

- **b**Interventions should be designed by clinicians to incorporate up-to-date research and best practices, particularly around defining and classifying risk to the community.¹⁶
- **b**Prevention and early-stage intervention should be prioritized, and care should be evidence-based, trauma-informed, and recovery-oriented.¹⁷
- **b**Individuals with lived experience should be involved at all stages of planning and implementation to incorporate their expertise and build public trust.¹⁸
- **b**Data must be both shared by collaborating agencies and regularly collected and analyzed, to assess the efficacy of programs¹⁹ and monitor for any unintended outcomes.²⁰

Intercept Zero — Community Services and Crisis Response

Background

Intercept Zero refers to community-based mental health services, including crisis response, that avoid in the first instance contact with the justice system.

When an individual is experiencing a mental health crisis, in many communities the only point of access to immediate treatment is a hospital emergency room or the police, via a 911 call. Removing criminal justice players and emergency rooms from the frontline of crisis response as much as possible is preferable as a way to limit conflict and unintended consequences of law enforcement involvement and can also provide a significant source of cost savings, which can be reinvested to improve and increase service options.

Prosecutors are important voices in public debates around crisis services — and should be vigorous advocates for **effective mental health crisis services** given the public safety implications. Alternative crisis response interventions include mental health crisis hotlines, community mental health clinics, mobile crisis teams,²¹ and crisis stabilization²² or respite centers,²³ where individuals can receive immediate support and connections to services in a welcoming, trauma-sensitive environment.

Beyond crisis response, community **harm reduction services**,²⁴ such as syringe exchanges, are critical to addressing co-occurring substance use disorders and mental illness.²⁵ Given the reticence that some law enforcement agencies may have toward harm reduction approaches or clinics, prosecutors have a particularly significant role to play in advocating for public health approaches, defending the legitimacy of harm reduction clinics, and discouraging policing practices that target the users of such clinics.²⁶

Examples

In **Eugene and Springfield, Oregon, Crisis Assistance Helping Out on the Streets (CAHOOTS)** provides an alternative to 911 for people experiencing or concerned about someone experiencing a mental health crisis. Community members can call a local non-emergency number and a team consisting of either a nurse or EMT and a trained mental health crisis worker will respond to provide immediate stabilization, assessment, referral, and advocacy.²⁷ This service is available 24 hours per day. CAHOOTS has been in operation since 1989 and, in 2015, responded to approximately 15,000 calls, resulting in approximately \$4.5 million in annual savings to the Eugene Police Department and \$1 million in annual savings in emergency medical costs.²⁸

In **San Antonio, the Crisis Care and Restoration Centers** offer sobering, detoxification, and intensive substance abuse services and serve as walk-in or drop-off points for individuals experiencing a mental health crisis. The Crisis Care Center and the Restoration Center treat roughly 2,200 people per month or 26,000 people per year who would previously have been arrested or transported to the emergency room.²⁹ Previously, law enforcement officers spent an average of 12 to 14 hours per drop-off in emergency rooms waiting on psychiatric evaluations. On average, officers can now drop off an individual at a crisis care or restoration center in 15 minutes.³⁰

Likewise, in **Tucson, at the Crisis Response Center (CRC)**, officers can drop off people experiencing a mental health crisis and return to active service in under 10 minutes. In 2011 alone, its first year, the CRC served 12,840 individuals, and received approximately 10,000 crisis calls per month that would otherwise have been handled by far costlier 911 dispatchers or hospital switchboards.³¹ Of the 7,665 adults transported to the CRC by law enforcement in 2014 and 2015, approximately 2,529 were diverted from jail, saving Pima County an estimated \$2,934,162 in jail costs.³²

In **New York City, the Parachute Pilot Program** was an innovative “soft-landing” crisis response program spanning the five boroughs of New York City.³³ The program had three primary components: respite centers, conventional and enhanced mobile crisis teams, and a crisis support line.³⁴ Under Parachute’s model, the respite centers provided a safe space to weather an acute psychiatric crisis for individuals voluntarily seeking care — without medical staff, locked doors, compulsory programming, or the other hallmarks of a far-costlier hospitalization.³⁵ Individuals could check into the bed and breakfast-like facilities at no cost for up to 10 days and receive support from trained peers, who were present 24 hours per day, and also connect to necessary services.³⁶ Parachute’s enhanced mobile crisis teams moved beyond the traditional mobile crisis model — enhanced mobile teams had the ability to work with individuals for up to one year.³⁷ Finally, Parachute’s peer-staffed “warmlines” provided both a listening service and another means of connecting to services. The success³⁸ of the Parachute Pilot Program led to its incorporation in the broader **NYC Thrive Initiative**,³⁹ which includes three crisis respite centers,⁴⁰ a peer-staffed warmline operated by Community Access,⁴¹ the 24/7 NYC Well helpline which serves as an entryway to services,⁴² and Mobile Crisis Teams.⁴³

In **Miami**, a new **Diversion Facility** aims to go beyond these models to act as a “one-stop shop” for all mental health services. The Miami-Dade Criminal Mental Health Project is currently renovating a former state forensic hospital which will serve as a facility for jail diversion, as well as crisis stabilization, short-term residential treatment, day treatment and day activities programs, intensive case management, outpatient behavioral health and primary care treatment services, and employment services. The Diversion Facility will ultimately provide a seamless access point for ongoing care and reintegration into the community.⁴⁴

In sum, while many “zero intercept” interventions are not prosecutor-led, DAs should use their elected position, authority, and ability to speak credibly on public health and safety measures to advocate for needed funding and support to develop community services, given the proven impact of such programs on incarceration and community well-being.

Intercept One — Law Enforcement Response

Background

Intercept One refers to law enforcement responses to individuals experiencing mental health crises prior to booking. In mental health crisis situations where a law enforcement response is deemed necessary for public safety, training of responders and early diversion opportunities are both key to avoiding escalation of the situation and reducing arrests. Interventions at this intercept include the Crisis Intervention Team model, Law Enforcement Assisted Diversion (LEAD),⁴⁵ corresponding multidisciplinary teams, and other opportunities for law enforcement officers to efficiently connect individuals to treatment in lieu of arrest, often at an access point like a crisis stabilization center. Law enforcement, however, must first be empowered to divert, rather than arrest, individuals. Prosecutors can play a key role in promoting such a shift in the approach of their law enforcement partners.

The **Crisis Intervention Team** model is based on a program developed in Memphis in 1988, and is designed to train police officers to respond appropriately to individuals experiencing a mental health crisis, so that the situation does not escalate to the point of force or arrest.⁴⁶ CIT training is a 40-hour course consisting of lectures, site visits to mental health facilities, interaction with individuals with mental illness, and scenario-based de-escalation training.⁴⁷ The program requires partnerships with both the local mental health advocacy community and behavioral health providers and is a means not only of improving police responses, but also improving community perceptions of legitimacy. An often-accompanying strategy is the use of multidisciplinary teams where law enforcement co-responds with mental health professionals.

Examples

In **San Antonio**, all police officers undergo 40 hours of CIT training. The San Antonio Police Department’s specialized **Mental Health Unit**, consisting of ten officers and one detective, coordinates CIT training and engages in proactive outreach to individuals in the community with a history of mental illness. Since the advent of the San Antonio Police Department’s mental health detail and its CIT program, more than 100,000 people with mental illness have been diverted away from jail or emergency rooms.⁴⁸

Through the Mental Health Unit's **co-responder program**, the San Antonio police department also partners with a local healthcare provider to respond to the highest utilizers of criminal justice and behavioral health resources, who are identified via 911 calls and other data. An officer from the Mental Health Unit and a trained clinician visit the individual in the community, assess the circumstances, and explore how they can connect the individual to services and avoid further police contact.⁴⁹

Similarly, in 2014, the Tucson Police Department formed a specialized **Mental Health Support Team**, which is composed of dedicated CIT officers whose exclusive role is to respond to mental health crises, and to engage in proactive outreach and serve court orders to individuals with mental illness. In 2017, Tucson also began training all patrol officers in mental health first aid.⁵⁰

In **Salt Lake City**, the police department employs a three-team approach to pre-booking diversion. A **Crisis Intervention Team** works in collaboration with the **Homeless Outreach Service Team** and **Community Connections Center Team** to facilitate access to services and divert individuals to treatment rather than the criminal justice system. The Homeless Outreach Service Team, composed of law enforcement officers and social worker co-responders, performs outreach to individuals in the community and diverts individuals to services. The Community Connections Center Team, comprised of caseworkers and social workers, is based out of the Salt Lake City Police Department's Community Connections Center and connects those individuals and voluntary clients to case management, housing assistance, and treatment.⁵¹ A detective in the CIT Investigative Unit also follows up on mental health calls for service.⁵²

In **Milwaukee**, as of January 2018, all 1,800 police officers had received the full 40-hour CIT training.⁵³ The Milwaukee police department is currently developing a voluntary advanced CIT course.⁵⁴ Additionally, Milwaukee is currently expanding its **"book and release"** program, in which individuals are taken to the local police station, given a court date, and released, rather than transported to the county jail.⁵⁵ "Book and release" enables individuals receiving mental health services to remain connected to treatment during the pendency of the cases and reduces the destabilizing impact of an arrest. Milwaukee's CIT program is also supplemented by three **Crisis Assessment Response Teams (CART)**.⁵⁶ The CART program is a partnership between police officers and mental health professionals that is designed to reduce involuntary hospital admissions. CART is dispatched through the Milwaukee Police Department and currently operates seven days per week from 11:00 a.m. to midnight.⁵⁷

Finally, **Miami's Crisis Intervention Team** program illustrates the substantial reductions in incarceration and public spending that can flow from an effective CIT program. In 2016, CIT officers from the Miami-Dade Police Department and City of Miami Police Department responded to more than 11,000 calls, resulting in nearly 1,700 diversions to crisis units and just 19 arrests. Because of CIT, the average daily census in the county jail system experienced a 39% reduction, resulting in the closure of an entire jail and a cost avoidance of over \$17 million per year.⁵⁸

In sum, many models of pre-arrest intervention exist and can be effective at reducing the number of individuals with mental illness entering the criminal justice system. Prosecutors can work with their law enforcement partners to advocate for such programs, as well as empower law enforcement to divert individuals directly to treatment.

Intercept Two — Arrest, Booking, Initial Detention and First Appearance Hearings

Background

Intercept Two refers to the initial period of arrest, booking, and preliminary court appearances. A validated⁵⁹ risk assessment⁶⁰ is a critical tool for all prosecutors to identify individuals best served by diversion and alternative to incarceration (ATI) programs.⁶¹ Though somewhat counterintuitive, interventions are most effective when focused on higher-risk populations — and intensive interventions can actually *increase* the risk of reoffending when applied to low-risk populations.⁶² Accurate risk assessment is critical for prosecutors' offices and their partners to avoid adverse outcomes, as well as make efficient use of scarce resources.

Likewise, prompt and accurate screening for behavioral health needs and connection to services at the point of booking and arraignment can create early exit ramps from the criminal justice system,⁶³ as well as potentially improve health outcomes, such as overdose-related fatalities.⁶⁴

Other interventions at this intercept include pre-trial diversion programs, charging guidelines that recognize the role of mental health conditions in potentially criminal conduct,⁶⁵ and bail policies that prioritize access to treatment in the community and avoid the conflation of mental illness and risk.⁶⁶

Examples

Several validated (and often free) risk assessments exist which can be used by court systems.⁶⁷ One such tool is the **Criminal Court Assessment Tool (C-CAT)**, a validated,⁶⁸ brief, 25-question instrument which both evaluates risk and flags needs such as substance use or mental health issues.⁶⁹ The C-CAT is used by community courts in Eugene, Oregon; Spokane, Washington; and Olympia, Washington, as well as at several NYC-based ATI and supervised release programs.⁷⁰

Booking is an opportunity to identify behavioral and physical health needs. In 2015, the New York City Health and Hospitals' Division of Correctional Health Services, in partnership with the Vera Institute of Justice, launched the **Enhanced Pre-Arrest Screening Unit (EPASU)** pilot in **Manhattan Central Booking**⁷¹ to increase capacity to provide medical care to people moving through the arrest-to-arraignment process, and improve diversion for individuals with mental health needs.⁷² The EPASU has prevented an estimated 601 trips from central booking to a hospital emergency room from May 2015 to October 2016.⁷³ Defense counsel reported that the clinical summaries assisted them in building trust with their clients and improved arraignment outcomes.⁷⁴

The point of arrest and booking is also an important stage at which to collect data that can assess the number of individuals with mental illness entering the justice system and their needs. In **Johnson County, Kansas**, booking, court, and community supervision data are tracked within Johnson County's **Justice Information Management System (JIMS)**.⁷⁵ JIMS includes data such as notes from the mental health co-responder program as well as results of the Brief Jail Mental Health Screen.⁷⁶ Johnson County also created a similar system for human services data — My Resource Connection (MyRC) — which combines data from health, public health, behavioral health, emergency response, and other human services.⁷⁷ MyRC de-identifies human services data, which permits it to be shared so that mutual clients may be identified across agencies and responses coordinated, without disclosing personal data.⁷⁸

Johnson County also recently partnered with the University of Chicago’s Data Science for Social Good program to develop a **predictive analytics model** to identify people who are most likely to have a police encounter resulting in a jail booking, by combining jail, emergency medical and mental health data from a six-year period.⁷⁹ Initial results have yielded a 52 percent precision rate in predicting which individuals would have future criminal justice contact.⁸⁰ Johnson County plans to use results to prioritize direct outreach, and to help inform future policy and funding strategies.⁸¹

In sum, the arrest, booking and arraignment period is short, but critical. Charging decisions, bail recommendations, screenings, and assessments all shape the life of a case — and it is difficult to assess progress without baseline data. Developing effective procedures at the second intercept is an important means of decreasing the criminalization of mental illness.

Intercept Three — Jail and Court

Background

The third intercept refers to pre-trial detention and court appearances from the point of bail to sentencing. Interventions at this intercept include diversion models like long-term treatment courts — as well as constitutionally-required psychiatric treatment in correctional settings, in-reach programs at jails and prisons,⁸² and improved training for correctional officers, court staff, and line prosecutors.

Over 300 jurisdictions across the United States have mental health courts, and numerous models exist.⁸³ Generally, if they follow risks-needs-responsivity principles,⁸⁴ mental health courts are an effective means of lowering rates of recidivism and/or reducing time spent incarcerated.⁸⁵

Examples

In **Brooklyn**, the **Kings County Mental Health Court**⁸⁶ is unique in its scale and breadth — of the 2,524 individuals referred since the spring of 2002, only 436 were misdemeanor referrals. To participate, individuals must have a serious mental illness which contributed to their criminal justice involvement, they must be willing to enter treatment, and that treatment should help them lead a stable life in the community. All nonviolent felonies are eligible and violent felonies are considered on a case-by-case basis. All misdemeanor offenses are eligible, but the court is not intended for individuals who would spend only a short amount of time in jail if not diverted.

Participation is entirely voluntary but the prosecutor can deny participation to any eligible candidate. At the beginning of their participation, all individuals appear in court once a week, but gradually appearances are reduced as individuals succeed in treatment.

A guilty plea is required to participate; however, upon successful completion, individuals charged with a misdemeanor or a non-violent first-time felony have their charges vacated and dismissed. Individuals charged with predicate felonies or first-time violent felonies have their felony plea vacated and a misdemeanor plea remains. All other individuals receive probation. Participation in the court has been shown to result in a reduction in recidivism, compared to similar individuals with mental illness who undergo conventional court processing.⁸⁷

“We use more deadly force than any other nation. We need to come up with different laws that respect the sanctity of human life.”

— SAN FRANCISCO (CA) COUNTY DISTRICT ATTORNEY GEORGE GASCÓN

In **Miami**, the **misdemeanor and felony mental health dockets** have led to significant decreases in incarceration. In both programs, individuals are screened for mental health, substance use, and criminogenic risks and needs with evidence-based instruments. In both programs, individuals participate in community-based services, their progress in treatment is monitored and reported to the judge in specialized court parts, and the State Attorney's Office may dismiss or modify the legal charges if the individual engages with treatment. The misdemeanor diversion program receives approximately 300 referrals annually and has contributed to a 55% reduction in recidivism rates for participants. Individuals who successfully complete the felony diversion program have a 6% recidivism rate, and, over the past 10 years, the felony jail program is estimated to have saved the county over 15,000 jail days, or over \$2.3 million dollars.⁸⁸

Peer mentoring is also an effective intervention both during the pre-trial period and during reentry.⁸⁹ In **Miami**, the jail diversion team employs several individuals as **recovery peer specialists** who have lived experience with mental illness and the criminal justice system. The peer specialists act as mentors and models, and provide practical assistance with connecting to services, making court appearances, and reentering the community.⁹⁰

Mental health courts or less structured short-term ATI programs are important components of mental health reform, and approachable starting places for prosecutors.

Intercept Four — Reentry

Background

The fourth intercept is the point of reentry into the community after incarceration. Smooth transitions among treatment providers — without gaps or waiting periods — are a critical concern at the time of reentry. Prosecutors can be powerful public advocates for improving reentry services, such as programs which emphasize a continuity of care from jail-based services to community-based services, connections to Medicaid and Medicare, peer navigators to create recovery-oriented circles of support and offer models of recovery, “housing first” programs, and initiatives that improve access to employment.⁹¹

Examples

In **Chicago**, Cook County Jail aims to promote smooth reentry into the community via its **Mental Health Transitions Center (MHTC)**. The MHTC creates a community support system for individuals with substance use and/or mental health disorders through mental health and substance use treatment, educational opportunities, and vocational training and assistance. A Sheriff's Department van staffed with a mental health professional is available to perform mental health checks on former clients of the program and provide transportation to treatment. Cook County Jail is also home to a unique program that permits individuals to apply for Medicaid and be connected to psychiatric services while incarcerated.⁹²

The MHTC is now also supplemented by the **Supportive Release Center (SRC)**, which gives formerly incarcerated individuals identified as high risk a safe place to sleep, have a meal, wash clothes, and make phone calls on the night of their release. SRC also connects people to the services they need to stay out of jail, including an on-site nurse and caseworker who can order prescription refills, make follow-up appointments at community clinics, and provide referrals to service providers for housing assistance and mental health counseling.⁹³

Prosecutors are important advocates for effective reentry programs, both in the community and with local government and other key stakeholders. DAs should become aware of local reentry services and deficits, and advocate for filling voids and developing effective interventions.

Intercept Five — Community Corrections

Background

The fifth intercept is probation and parole. Prosecutors should avoid excessively lengthy probation sentences.⁹⁴ Furthermore, both prosecutors and probation and parole officers should be cautious to not conflate mental illness with an increased risk of reoffending, and thus impose more conditions on individuals with mental illness.⁹⁵ Specialized probation for individuals with mental illness is also a promising practice in which designated probation officers have specialized training in mental illness and lower caseloads, in order to accommodate the higher needs of individuals with mental illness on probation.⁹⁶ Research indicates that community supervision services specifically designed for individuals with mental illness decrease rates of re-incarceration.⁹⁷ DAs should also use the influence of their office to call for such programs and services in their communities.

Examples

In **Multnomah County** (Portland, Oregon), the **Mental Health Unit (MHU)** of the Department of Community Justice provides supervision to individuals on probation or parole who have been diagnosed with a severe and persistent mental illness.⁹⁸ The MHU partners with organizations including community treatment providers, the state department of corrections, police, the sheriff's office, the public defender, the National Alliance for Mental Illness, Aging Services, and advocacy groups.⁹⁹ These stakeholders work together to help participants meet their basic needs like obtaining healthy and stable housing, adhering to medication, and developing a pro-social support network.¹⁰⁰

Mental health probation may also take the form of a problem-solving court. In **Bexar County**, Texas, the **Mental Health Court** is a voluntary 12-month program of supervised probation.¹⁰¹ Participants in the program receive treatment, medication, intensive case management, and supervision. The judge, court staff, probation and treatment providers collaborate to monitor and support compliance with treatment and medications, abstinence from drugs and alcohol, and successful completion of probation conditions.¹⁰² Care should be taken, however, to create a supportive — rather than a punitive — response to relapse over the course of any ongoing court or probationary supervision.

In sum, prosecutors are key advocates and stakeholders in effective community supervision programs. As such, DAs should begin by familiarizing themselves with the nature of services already available in their community and should use their credibility on public safety measures to call for improvements when needed.

“We’ve all struggled in every city and throughout the county with homelessness, mental health and substance abuse disease. These are difficult, complex situations that didn’t happen overnight and won’t be solved overnight. But they will be solved if we work together.”

— SAN JOAQUIN (CA) COUNTY DISTRICT ATTORNEY TORI VERBER SALAZAR

CONCLUSION

There are myriad opportunities for prosecutors to act to embrace a supportive treatment model and reduce the number of individuals with mental illness in the criminal justice system. While some jurisdictions may be better equipped to embark on ambitious and comprehensive cross-system reform, there are also many effective low- or no-cost steps that prosecutors can take to address mental illness in their jurisdictions — such as convening partner agencies to develop treatment options rather than punitive responses, speaking out on these issues, and changing internal procedures. Regardless of their resources, prosecutors can and should take steps to decriminalize mental illness given effective mental health interventions that improve public safety, decrease burdens on taxpayers, and are a key component of a humane and compassionate justice system.

ENDNOTES

1. The term “district attorney” or “DA” is used generally to refer to any chief local prosecutor, including state’s attorneys, prosecuting attorneys, etc.
2. Estimates vary widely, but the research is clear that the prevalence of mental illness among incarcerated populations is higher than that in the community, sometimes by large margins. Prins, S. (2014), *Prevalence of Mental Illnesses in US State Prisons: A Systematic Review*, Psychiatric Services, <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201300166>; Bureau of Justice Statistics (2006), *Mental Health Problems of Prison and Jail Inmates*, <https://www.bjs.gov/content/pub/pdf/mhppji.pdf>.
3. Swanson, J. W., McGinty, E., Fazel, S., & Mays, V. M. (2015), *Mental illness and reduction of gun violence and suicide: Bringing epidemiologic research to policy*, *Annals of Epidemiology*, 25(5), 366-376, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4211925>.
4. In part, this cycle of over-incarceration is driven by higher levels of homelessness and drug addiction associated with untreated mental illness. See U.S. Department of Housing and Urban Development (Nov. 2017), *HUD 2017 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations*, https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_NatTerrDC_2017.pdf; Vera Institute of Justice (2015), *First Do No Harm: Advancing Public Health in Policing Practices*, https://storage.googleapis.com/vera-web-assets/downloads/Publications/first-do-no-harm/legacy_downloads/First-Do-No-Harm-FINAL-12032015.pdf; Substance Abuse and Mental Health Administration (2015), *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>.
5. Steadman, H., Osher, F., Robbins, P., Case, B. and Samuels, S. (2009), *Prevalence of serious mental illness among jail inmates*, *Psychiatric Services*, 60 (6), 761-765, <https://csgjusticecenter.org/wp-content/uploads/2014/12/Prevalence-of-Serious-Mental-Illness-among-Jail-Inmates.pdf>.
6. Treatment Advocacy Center (Dec. 2015), *Overlooked in the Undercounted*, <http://www.treatmentadvocacycenter.org/storage/documents/overlooked-in-the-undercounted.pdf>; Sullivan, J., Anthony, Z., Tate, J., and Jenkins, J. (Jan. 2018), *Nationwide, police shot and killed nearly 1,000 people in 2017*, *Washington Post*, https://www.washingtonpost.com/investigations/nationwide-police-shot-and-killed-nearly-1000-people-in-2017/2018/01/04/4eed5f34-e4e9-11e7-ab50-621fe0588340_story.html?noredirect=on&utm_term=.6eb4fb461156.
7. “For example, research in epidemiology indicates that had the U.S. incarceration rate remained at its 1973 level, then the infant mortality rate would have been 7.8 percent lower than it was in 2003, and disparity between black and white infant deaths nearly 15 percent lower.” Vera Institute of Justice, *On Life Support: Public Health in the Age of Mass Incarceration*, https://storage.googleapis.com/vera-web-assets/downloads/Publications/on-life-support-public-health-in-the-age-of-mass-incarceration/legacy_downloads/on-life-support-public-health-mass-incarceration-report.pdf.
8. Fair and Just Prosecution (FJP) (2018), *Improving Justice System Responses to Individuals with Mental Illness*, https://fairandjustprosecution.org/wp-content/uploads/2018/07/FJP.Brief_.MentalHealth.pdf.
9. U.S. Department of Justice, National Institute of Corrections (2002), *Guidelines for Developing a Criminal Justice Coordinating Committee*, <https://info.nicic.gov/nicrp/system/files/017232.pdf>; National Association of Counties (2015), *Resources on Criminal Justice Coordinating Councils*, <http://www.naco.org/blog/resources-criminal-justice-coordinating-councils-cjccs>.

10. For example, the Johnson County, Kansas Criminal Justice Advisory Council (CJAC) is composed of members from organizations including the sheriff's office, the health department, the bar association, and the district attorney's office. See Johnson County (2018), *About CJAC*, <https://www.jocogov.org/dept/county-manager-office/criminal-justice-advisory-council/home>. The Johnson County CJAC makes their governance documents and minutes publicly available to both increase transparency and serve as a model to other jurisdictions. See Johnson County (2018), *Governance*, <https://www.jocogov.org/dept/county-manager-office/criminal-justice-advisory-council/governance>.
11. The Sequential Intercept Model was developed by Policy Research Associates for the Substance Abuse and Mental Health Administration's GAINS Center for Behavioral Health and Justice Transformation. For further information, see Substance Abuse and Mental Health Services Administration (2017), *SAMHSA's Efforts on Criminal and Juvenile Justice Issues*, <https://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts>.
12. For an example of a mapped system, see this sequential intercept map from Multnomah County. Oregon Center on Behavioral Health and Justice Integration (2016), *Multnomah County Sequential Intercept Map*, http://www.ocbhji.org/wp-content/uploads/2017/10/Multnomah-County-System-Map-Final_11-6-16.pdf.
13. For example, the 11th Judicial Circuit Criminal Mental Health Project in Miami, Florida, which now spans all intercepts, began with a post-booking diversion program. Buntin, J. (Aug. 2015), *Miami's Model for Decriminalizing Mental Illness in America*, *Governing Magazine*, <http://www.governing.com/topics/public-justice-safety/gov-miami-mental-health-jail.html>.
14. Bexar County's "Diversion 1.0" program began in 2003 by focusing on pre-arrest early intervention and constructing a 24/7 mental health crisis drop-off center. Bexar County's "Diversion 2.0" initiatives, begun in 2014, focus on improving responses to people with mental illness at intercept two, initial detention, via improved screening and courtroom practices. Bexar County Mental Health Department, *Update Slideshow*, <https://www.equitasproject.org/wp-content/uploads/2018/02/2017-07-08-Update-MH-Department-overview.pptx>.
15. See Fair and Just Prosecution (FJP) (2017), *Promising Practices in Prosecutor-Led Diversion*, <https://fairandjustprosecution.org/wp-content/uploads/2017/09/FJPBrief.Diversion.9.26.pdf>.
16. For instance, research indicates that mental health treatment alone is likely an insufficient intervention — rather, mental health treatment should be tailored to also address criminal justice risk factors such as "antisocial thinking, addiction, and stress." Vera Institute of Justice (2016), *First-Episode Incarceration: Creating a Recovery-Informed Framework for Integrated Mental Health and Criminal Justice Responses*, https://storage.googleapis.com/vera-web-assets/downloads/Publications/first-episode-incarceration-creating-a-recovery-informed-framework-for-integrated-mental-health-and-criminal-justice-responses/legacy_downloads/first-episode-incarceration-integrated-mental-health-criminal-justice-responses.pdf.
17. *Id.*
18. Without the input of individuals with lived experience, even well-intentioned programs may damage public trust. For example, in 2005, leaders in Marseille, France, implemented an outreach program composed of social service workers and local police to address homeless individuals with mental illness. However, participants described outreach workers as even more coercive than the police to evaluators, given the threat of involuntary hospitalization. Girard, V., Bonin, J., Tinland, A., Farnarier, C., Pelletier, J., Delphin, M., Rowe, M. and Simeoni, M. C. (2014), *Mental health outreach and street policing in the downtown of a large French city*, *International Journal of Law and Psychiatry*, 37 (4), 376-382, <https://www.sciencedirect.com/science/article/pii/S0160252714000193?via%3Dihub>.
19. National Association of Counties (2016), *Data Driven Justice Playbook*, http://www.naco.org/sites/default/files/documents/DDJ%20Playbook%20Discussion%20Draft%2012.8.16_1.pdf.
20. It is particularly critical to monitor risk tools for racial disparities. Picard-Fritsche, S., Adler, J., Menyard, Y. and S. Bala (2017), *Race and Risk Assessment: Would We Know a Fair Tool If We Saw It?* *Perspectives*, 41(2), 47-51, <https://www.courtinnovation.org/publications/race-and-risk-assessment-would-we-know-fair-tool-if-we-saw-it>.
21. Mobile crisis teams respond to mental health emergencies in the community and can provide crisis stabilization and psychiatric assessment services to individuals in their homes or at other sites. See Substance Abuse and Mental Health Services Administration (2014), *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies*, <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>.
22. "Crisis stabilization" refers to a type of direct mental health service that is focused on de-escalating an individual's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization centers may take different forms. Common models are 23-hour observation facilities or short term residential facilities, usually operated by psychiatric professionals. At these centers, individuals may be connected to long-term outpatient services or referred to inpatient care if necessary. "Crisis stabilization centers" may be used as "drop off" points by police officers diverting individuals

- experiencing mental health crises, as an alternative to emergency rooms. See Substance Abuse and Mental Health Services Administration (2014), *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies*, <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>.
23. "Crisis respite center" refers to an alternative to emergency hospitalization for individuals experiencing a psychiatric crisis, generally in a welcoming home-like setting. Models vary and individuals may be permitted to remain at the respite for multiple days or weeks. Respite centers are often staffed by peer professionals, and provide a safe landing place to connect or reconnect to treatment, while maintaining ties to the community, usually at a much lower cost than hospitalization. See Substance Abuse and Mental Health Services Administration (2014), *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies*, <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>.
 24. Harm reduction is a public health philosophy that does not seek to eliminate drug use; rather it focuses on minimizing the "personal and social harms and costs" associated with drug use and spread of HIV and other infectious diseases. Harm reduction approaches include syringe exchanges, supervised consumption facilities, and medication assisted treatment such as methadone. Hilton, B., Thompson, R., Moore-Dempsey, L., and Janzen, R. (2008), *Harm reduction theories and strategies for control of human immunodeficiency virus: a review of the literature*, *Journal of Advanced Nursing*, 33 (3), 357-370, <https://onlinelibrary.wiley.com/doi/pdf/10.1046/j.1365-2648.2001.01672.x>.
 25. Vera Institute of Justice (2017), *Minimizing Harm: Public Health and Justice System Responses to Drug Use and the Opioid Crisis*, https://storage.googleapis.com/vera-web-assets/downloads/Publications/for-the-record-public-health-justice-system-responses-opioid-crisis/legacy_downloads/Minimizing-Harm-Evidence-Brief.pdf.
 26. Vera Institute of Justice (2015), *First Do No Harm: Advancing Public Health in Policing Practices*, https://storage.googleapis.com/vera-web-assets/downloads/Publications/first-do-no-harm/legacy_downloads/First-Do-No-Harm-FINAL-12032015.pdf.
 27. White Bird Clinic (2018), CAHOOTS, <https://whitebirdclinic.org/cahoots/>.
 28. CAHOOTS (2016), *Crisis Assistance Helping Out on the Streets Fact Sheet*, https://truthout.org/wp-content/uploads/legacy/documents/starting_a_MCIP.pdf.
 29. National Association for Counties (2017), *Bexar County Mental Health and Jails Case Study*, <https://www.naco.org/resources/mental-health-and-criminal-justice-case-study-bexar-county>.
 30. Id.
 31. Id.
 32. Id.
 33. The Parachute program was based on the Finnish "open dialogue" model, a treatment for people with serious mental illness which engages the person's social network. Parachute was funded from 2013 to 2016 by a \$17.6 million grant from New York State and was run by separate providers including Riverdale Mental Health Association and Community Access. See Pew Trust: Stateline (May 2015), *Keeping the Mentally Ill Out of Hospitals*, <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/15/keeping-the-mentally-ill-out-of-hospitals>; Sykes, J. (Oct. 2015), *New York 'Parachute' Programme for People with Acute Mental Distress Lands in the UK*, *The Guardian*, <https://www.theguardian.com/society/2015/oct/20/parachute-therapy-psychosis-new-york-uk>.
 34. NAMI National Convention (2016), *Crisis as Opportunity: Parachute NYC as a Promising Crisis Alternative Practice*, <https://www.nami.org/getattachment/Get-Involved/NAMI-National-Convention/2015-Convention-Presentation-Slides-and-Resources/B-2-Crisis-as-Opportunity-Integrating-Peers-into-Crisis-Alternatives-in-Parachute-NYC.pdf>.
 35. Id.
 36. Id.
 37. Id.
 38. Results indicated decreased rates of hospitalization, jail, shelter use or homelessness and participants reported overall improved mental health and well-being. Participants also reported higher levels of perceived agency compared to individuals receiving conventional services. Id. The New York City Department of Health and Mental Hygiene estimated that for every patient who used the service, it saved \$13,500 a year by averting hospitalizations. Sykes, J. (Oct. 2015), *New York 'Parachute' Programme for People with Acute Mental Distress Lands in the UK*, *The Guardian*, <https://www.theguardian.com/society/2015/oct/20/parachute-therapy-psychosis-new-york-uk>. In its first two years, Parachute served 700 people at its respite centers, 600 through its

- mobile treatment teams and more than 20,000 through its peer-operated telephone support service. Vestal, C. (May 2015), *Keeping the Mentally Ill Out of Hospitals*, Pew Trust: Stateline, <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/15/keeping-the-mentally-ill-out-of-hospitals>.
39. City of New York (2017), *NYC Thrive Initiative*, <https://thrivenyc.cityofnewyork.us/>.
 40. NYC Department of Health (2017), *Crisis Respite Centers*, <https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-respite-centers.page>.
 41. Community Access (2017), *Our Work*, <http://www.communityaccess.org/our-work>.
 42. NYC Department of Health (2017), *NYC Well*, <https://www1.nyc.gov/site/doh/health/health-topics/nyc-well.page>.
 43. NYC Department of Health (2017), *Mobile Crisis Teams*, <https://www1.nyc.gov/site/doh/health/health-topics/crisis-emergency-services-mobile-crisis-teams.page>.
 44. Eleventh Judicial Circuit Criminal Mental Health Project (2017), *Programs and Outcomes*.
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 48. Spotlight Team (Dec. 2016), *San Antonio became a national leader in mental health care by working together as a community*, Boston Globe, <http://apps.bostonglobe.com/spotlight/the-desperate-and-the-dead/series/solutions>.
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 50. City of Tucson, (2017), *About the Police Mental Health Support Team*, <https://www.tucsonaz.gov/police/about-tucson-police-mental-health-support-team>.
 51. Salt Lake City Police (2017), *Community Connection Center*, <http://www.slcpd.com/resources/ccc>.
 52. Council of State Governments Justice Center (2017), *Salt Lake City Police Department*, <https://csgjusticecenter.org/law-enforcement/learning-sites/salt-lake-city-police-department>.
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 59. “Validation simply means that the items, risk scores, and risk categories in a tool are confirmed to have a statistically significant relationship with recidivism (a statistically significant relationship is one that cannot be attributed to chance).” Picard-Fritsche, S., Rempel, M., Tallon, J., Adler, J., and Reyes, N. (2017), *Demystifying Risk Assessment: Key Principles and Controversies*, Center for Court Innovation, https://www.courtinnovation.org/sites/default/files/documents/Monograph_March2017_Demystifying%20Risk%20Assessment_1.pdf.

60. A risk assessment evaluates a subject's risk of recidivism, whereas a screening or needs assessment evaluates treatment or service needs. Risk and need are not equivalent and should not be conflated — for instance, an individual may be both low risk and high need. See Center for Court Innovation, (2018), *Understanding Risk and Needs in Misdemeanor Populations*, https://www.courtinnovation.org/sites/default/files/media/document/2018/Misdemeanor_Populations_Risks_Needs.pdf (finding that need factors such as "receiving mental health treatment, flagging for PTSD on the trauma checklist, and other measures of mental illness had no relationship to recidivism").
61. Center for Court Innovation (2017), *Demystifying Risk Assessment: Key Principles and Controversies*, 12-13, https://www.courtinnovation.org/sites/default/files/documents/Monograph_March2017_Demystifying%20Risk%20Assessment_1.pdf.
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64. *America's first opioid court is working well* (2017), *The Economist*, <https://www.economist.com/usa/2017/10/19/americas-first-opioid-court-is-working-well>.
65. For example, some research indicates that individuals with mental illness are more likely to resist arrest, because they may not understand police instructions or may be experiencing paranoia or delusions. Therefore, a prosecutor's office could develop charging or declination guidelines for cases where the sole or primary charge is resisting arrest and there are indications of mental illness. Kerr, A., Morabito, M., and Watson, A. (2011), *Police Encounters, Mental Illness and Injury: An Exploratory Investigation*, *Journal of Police Crisis Negotiation*, 10(1-2), 116-132, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2991059/>.
66. Adults living below the poverty line are twice as likely to be diagnosed with a serious mental illness. SAMHSA (2016), *Serious Mental Illness Among Adults Below the Poverty Line*, https://www.samhsa.gov/data/sites/default/files/report_2720/Spotlight-2720.html. Therefore, eliminating money bail and the "poverty penalty" is a critical component of reducing the number of individuals detained pre-trial with mental illness. For further recommendations regarding bail policies, see Fair and Just Prosecution (FJP) (2017), *Bail Reform*, <https://fairandjustprosecution.org/wp-content/uploads/2017/09/FJPBrief.BailReform.9.25.pdf>.
67. See CSG Justice Center (2013), *Executive Summary of Risk Assessment Instruments Validated and Implemented in Correctional Settings in the United States*, <https://csjusticecenter.org/wp-content/uploads/2014/07/Risk-Instruments-Guide.pdf>.
68. The C-CAT was developed by the Center for Court Innovation in response to the challenge of implementing both a risk tool and needs assessment in a high-volume environment. It was field-tested in Chicago, Los Angeles, Washington state, Oregon, and New York City and the final version was validated in Brooklyn, New York. The final C-CAT is undergoing local validation in Spokane. Local validation is recommended for any jurisdiction that intends to use the C-CAT. Center for Court Innovation (2018), *The Criminal Court Assessment Tool: Development and Validation*, https://www.courtinnovation.org/sites/default/files/media/documents/2018-02/ccat_validation.pdf.
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71. Vera Institute of Justice (2017), *The Enhanced Pre-Arrest Screening Unit Improving Health Services, Medical Triage, and Diversion Opportunities in Manhattan Central Booking*, https://storage.googleapis.com/vera-web-assets/downloads/Publications/the-enhanced-pre-arrest-screening-unit/legacy_downloads/Enhanced-Pre-Arrest-Screening-Unit-full-report.pdf.
72. The EPASU is staffed by a patient care associate (PCA), a nurse practitioner (NP), and a "diversion liaison," who is a licensed social worker. An electronic screening tool asks a wide array of questions, including screening for psychosis and withdrawal. The EPASU staff also have access to jail health records, if individuals coming through booking have been incarcerated in the last five years, as well as New York State Office of Mental Health's Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) database, which provides information on diagnoses and services used by Medicaid beneficiaries. All individuals who pass through Manhattan Central Booking receive a preliminary screening from the PCA, and then may receive additional screening by the NP as needed. The NP can diagnose conditions, determine whether hospitalization is appropriate, and prescribe common medications. The EPASU's diversion liaison identifies people with behavioral health needs and, with the person's consent, shares the relevant information with defense counsel prior to arraignment. Defense counsel is the gatekeeper for whether that information is ultimately shared with the prosecutor and court. Id.

73. Id.
74. Id.
75. The Brief Jail Mental Health Screen (BJMHS) was developed by Policy Resource Associates and is an eight-question booking tool designed as a preliminary screening for mental health needs. Policy Resource Associates (2017), *Brief Jail Mental Health Screen*, <https://www.prainc.com/wp-content/uploads/2016/07/BJMHS-2016JMHD.pdf>.
76. National Association of Counties (2017), *Data Driven Justice Case Study: Using Mental Health Screening and Assessment to Serve Individuals with the Most Needs*, https://www.naco.org/sites/default/files/documents/SAMHSA%20Case%20Study%20-%20Johnson%20County%20Kan_FINAL.pdf.
77. Id.
78. Id.
79. Id.
80. Id.
81. Id.
82. “In-reach” generally refers to treatment which takes place in a correctional, rather than community setting.
83. See Center for Court Innovation (2015), *When Research Challenges Policy and Practice: Toward a New Understanding of Mental Health Courts*, https://www.courtinnovation.org/sites/default/files/documents/JJ_SP15_54_2_Fisler.pdf.
84. Risk-Needs-Responsivity (RNR) refers to the three primary principles of evidence-based intervention. Specifically, that the intensity of treatment should vary by risk level; that interventions should target the “Central Eight” risk factors/needs for recidivism; and that treatment is most effective when it employs a cognitive-behavioral approach tailored to the learning style and attributes of the individual. See Center for Court Innovation (2014), *Evidence Based Strategies for Working With Offenders*, <http://www.courtinnovation.org/sites/default/files/documents/EvidenceBasedStrategiesForWorkingWithOffenders.pdf>.
85. “Compared to defendants in traditional courts, mental health court defendants have lower rates of re-offending, longer times in the community before committing new offenses, and fewer days of incarceration.” Center for Court Innovation (2015), *When Research Challenges Policy and Practice: Toward a New Understanding of Mental Health Courts*, https://www.courtinnovation.org/sites/default/files/documents/JJ_SP15_54_2_Fisler.pdf.
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88. Eleventh Judicial Circuit Criminal Mental Health Project (2017), *Programs and Outcomes*.
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90. Eleventh Judicial Circuit Criminal Mental Health Project (2017), *Programs and Outcomes*.
91. See NYU Center on the Administration of Criminal Law (2017), *Disrupting the Cycle: Reimagining the Prosecutor’s Role in Reentry a Guide to Best Practices*, http://www.law.nyu.edu/sites/default/files/upload_documents/CACL%20Report.pdf.
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