



True justice

## Mental health intervention vs. incarceration

A rationale for interagency collaboration

# Introduction

States and communities nationwide are increasingly aware of the disproportionate representation of individuals with mental health conditions in courtrooms, jails and prisons. While not intended, correctional institutions have become de facto mental health facilities. Consequently, communities are working to transform the interface among mental health, substance use treatment, juvenile justice and criminal justice systems.

Motivation to fix the system has several drivers. Certainly, it is inefficient and costly—the cost of incarceration and of street officer time responding to mental health crises. However, there is a moral imperative as well: the impact of criminal justice contact for individuals with mental illness is traumatic, and ultimately, unnecessary. Although many criminal justice systems have developed behavioral health services, these systems are simply not best equipped to deliver effective treatment. They also should not be a back-door way to access care. To that end, communities are recognizing the value in identifying the points at which individuals with mental health conditions are coming into contact with the juvenile and criminal justice systems.

This document will propose how state and local governments can coordinate across agencies to reduce and/or divert individuals with mental illness from the criminal and juvenile justice systems; examine how the Sequential Intercept Model can serve as a foundation for such coordination; and increase data-sharing among systems, all in an effort to improve the health of individuals and communities alike.



## Challenge for the courts: Mental illness

Individuals with mental illness are overrepresented in the US criminal justice system, with nearly one-quarter reporting a serious mental health condition. The [2017 report from the Bureau of Justice Statistics](#) on the mental health of US prison and jail populations indicates that from 2011-2012, 37 percent of adult prisoners and 44 percent of jail inmates reported symptoms or a history of a mental health disorder. Approximately 65 percent have primary or comorbid substance use disorders (SUD), according to the [National Institute on Drug Abuse](#).

The vast majority of children and youth in the juvenile justice system have histories of exposure to trauma and mental health conditions that go unaddressed, leading to worsening mental health and long-term involvement in the criminal justice system. While estimates vary, most studies report that [between 65 to 75 percent of juvenile justice-involved youth](#) have at least one mental health or SUD, and [20 to 30 percent](#) report suffering from a serious mental disorder. Rates of similar mental health/SUD among the general adolescent population are far lower.

These numbers call for a criminal justice system that can identify individuals with mental illness/SUD and divert those individuals into community-based care as the right and just alternative to incarceration.

### Unique challenges for a vulnerable population

People with mental illness and SUD are at greater risk of arrest than the general population. They may exhibit behavior that is upsetting to bystanders, especially during a mental health crisis, or engage in acts that appear to be crimes but are not. What happens next depends on how the bystander responds: Do they call 911 and trigger law enforcement, or do they know to contact a mental health/substance use crisis line for a timely treatment response? This bifurcated choice influences the trajectory of the systemic response to the individual in crisis—how the behavior is interpreted, and what the logical next steps are based on that interpretation.

Challenges abound beyond the moment of potential arrest. Social determinants of health, such as housing instability, unemployment, food insecurity, transportation issues and more, negatively affect not only mental health status but also access to mental health care. Stigma around receiving that care compounds the problem. Even when care is available, accessing care can be so complex that people may not know how to navigate available services. This scenario culminates when individuals feel so desperate they plead guilty to charges so they can receive treatment while incarcerated.

Upon release, about [50 percent](#) of those with a mental illness reenter prisons within three years of release, partly due to inadequate community-based treatment or a lack of connection to care. Without care coordination, many begin to experience a return and worsening of their symptoms until they again encounter law enforcement due to a mental health crisis, driving up recidivism.

Additionally, upon incarceration, many states cancel (versus suspend) enrollment in Medicaid. Once released, the individual must reapply for Medicaid coverage, creating a lag in accessing critical health services, including community-based treatment.

## Interagency collaboration core to diversion and coordinated services

Juvenile justice, criminal justice and behavioral health agency leaders understand that treating mental illness improves health and reduces recidivism. In spite of this shared goal, [these agencies too often work at cross-purposes](#), with little or no interagency collaboration. Their different missions and different styles of delivering services can lead to duplicative efforts and unintended gaps in care.

### More on recidivism

The [National Institute of Corrections](#) provides seven ways to reduce recidivism. One applicable to individuals with mental illness is to “deliver services in natural environments where possible”. Community-based services – mental health and others – help bond formerly incarcerated persons’ connection to the community.

Therefore, diversion programs that include an intervention help to reduce recidivism. Examples of policy implications include:

- Referral to community-based mental health services by law enforcement, as well as by judges and prosecutors when community safety is not jeopardized
- State and county leaders ensure funding for community-based services
- Community law enforcement and other stakeholders review existing resources to ensure a full continuum of services

State and county leaders must collaborate to first identify systemic challenges and then develop common solutions. Through information-sharing, they can define priorities and coordinate solutions and leverage shared resources to improve the breadth and depth of services.

Collaboration between behavioral health and criminal justice agencies is key to successfully improving the identification of people who have behavioral health needs, developing a range of treatment and services, and improving quality.



### Improve screening and assessment

Increases identification of people who have behavioral health needs

Increases connection to treatment services

Diversion into behavioral health care



### Develop and bolster funding of treatment and services

Reduces gaps in service

Expands range of treatment services



### Boost quality

Tailors services to address multiple needs

Uses evidence-based practices



### Require information sharing

Reduces gaps and redundancies

Promotes care coordination

Involves technology solutions

Adapted from: <https://50statespublicsafety.us/part-1/strategy-2/action-item-4/>

## Connecting the dots for interagency collaboration

With the shared view that collaboration is key for coordinated services, agencies must start to develop processes to drive high-functioning collaboration. Carelon Behavioral Health views braided funding as the framework's forcing function, supporting shared responsibility and liability; pooled resources; systematic information-sharing; and general equity among participating agencies. Further, quality management and oversight, buoyed by outcomes measurement, drive collaboration success.

### Braided funding

Simply defined, braided funding is braiding multiple funding streams that are originally separate, and brought together (by a "payer" or administrative services organization [ASO]) to pay for more services than any one stream can support. At the same time, the funding streams must be carefully disaggregated with separate fund-source accountability to report to funders on how the money was spent, thus promoting both individual and shared accountability.

This approach maximizes Medicaid to make available non-Medicaid funding sources, sources that can be redirected to fill gaps, build infrastructure and support services and populations (i.e., a released inmate) that Medicaid does not. Funding sources can include Medicaid, state

or local Department of Corrections (DOC) agencies, non-profit grants and state governments. Disparate funding sources can pay for services not reimbursed by Medicaid, such as transportation, housing, outreach, skills training and more.

## Quality management and oversight

Braided funding is critical to driving agency participation and accountability and opening up access to diverse services, but the day-to-day, month-to-month functioning of interagency work must be overseen. Are goals being met? Are services being accessed? Is the quality of those services high?

With the ASO as the coordinator of services, that organization is best positioned to ensure quality of those services. With its providers, the ASO engages in traditional quality management practices, ranging from monitoring compliance to tracking quality performance indicators to promoting the evidence base.

While the ASO does not have the contractual authority to ensure the quality of ancillary (non-contracted) providers, it partners with these groups through collaboratives to improve service coordination. To do so, typically the ASO invites all stakeholders to the collaborative (contracted providers are required to attend) to discuss programs and share data to help remove barriers to care.

## Measuring outcomes

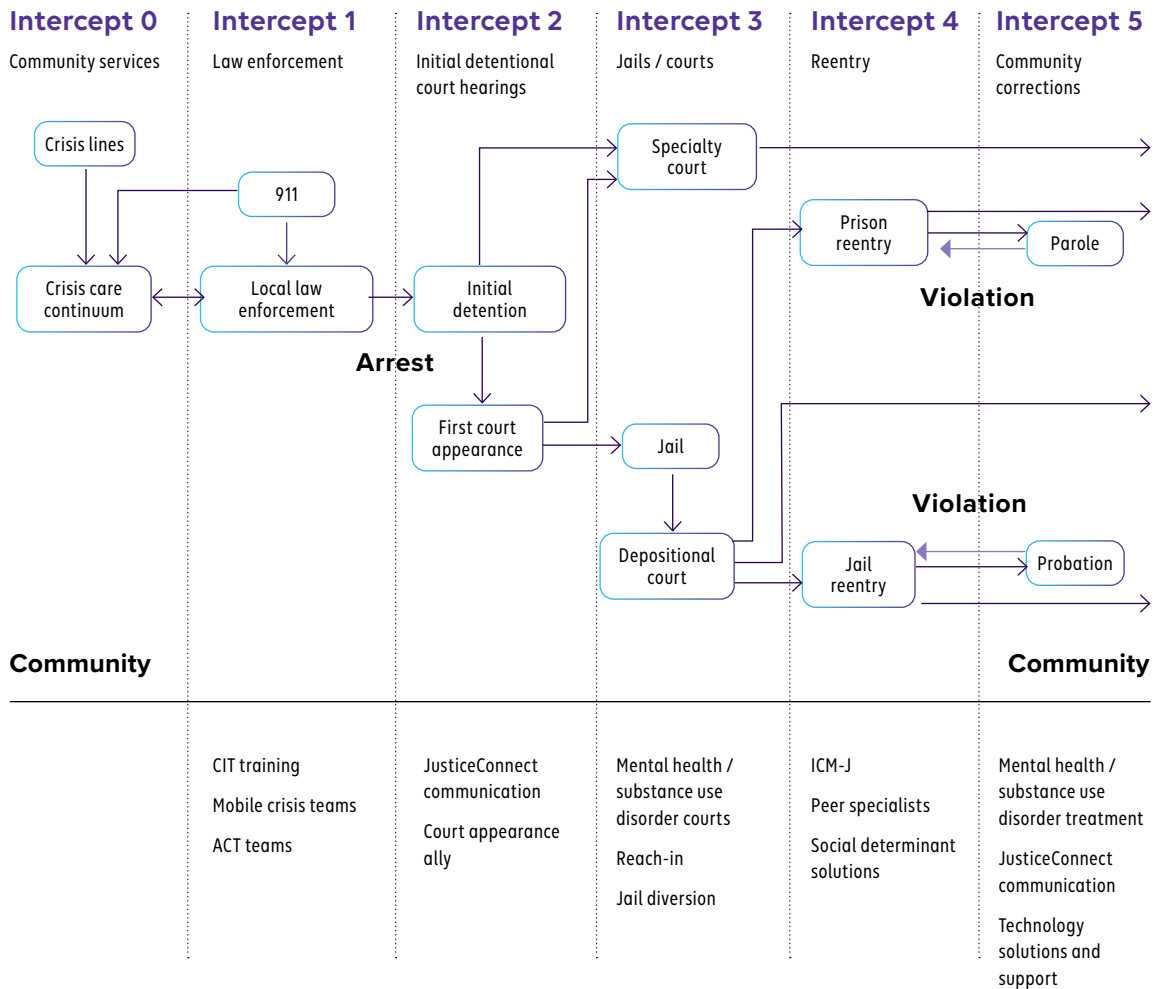
Measureable outcomes are necessary to inform whether individuals needing care are improving; whether clinical and other programs are achieving promised results; and whether the management process is achieving expected performance. In summary, they enforce accountability.

Metrics include utilization management measures, recidivism rates and person-centered metrics. As a data-driven organization, the ASO measures these outcomes with its contracted providers, and in turn, shares this data with other members of the collaborative to help inform their own quality management efforts. Further, the ASO shares this data with the customer – typically the state or county – to identify utilization trends and any corresponding gaps in services.

## Sequential Intercept Model

The Sequential Intercept Model has led to substantial and often groundbreaking change within communities. Shining a light on the overrepresentation of individuals with mental health and substance use conditions in the criminal justice system, it provides a schematic for change that organizes collaboration across the multiple systems that justice-involved individuals often touch.





**The Sequential Intercept Model:**

- Requires cross-sector partnerships and collaborations
- Builds strategies for multiple stages of intervention (with emphasis on upstream interventions preventing big harms and high costs to person in crisis, the community, and the system)
- Relies on strong logistical capability
- Employs wide-ranging competency development across multiple sectors
- Is built to address the public nature of the problem being addressed
- Must understand where the mental health and criminal justice system must necessarily intersect and collectively works on strategies to uncouple this response when they do not

# A closer look at the Intercepts

## Bolstering community services: Intercept 0

The goal of Intercept 0 is to align systems and services and connect individuals with treatment before a behavioral health crisis begins or at the earliest possible stage of system interaction. Therefore, the most effective means of reaching this goal is to have an accessible community-based treatment continuum, including: clinicians; community support services, such as case management, medication management, vocational and peer support; safe and affordable housing; and a critically important coordinated crisis services continuum that includes the following eight components:

1. 1-800 hotlines for people in crisis
2. Mobile crisis units that can be dispatched to anywhere in the community to address a crisis in real-time, ideally without law enforcement accompaniment unless absolutely necessary
3. Community-based locations for law enforcement drop-off and crisis walk-in
4. Crisis stabilization centers or peer living rooms, which offer an alternative to emergency department and psychiatric hospitalization admission by providing crisis respite in the community
5. Crisis and community collaboratives, including law enforcement, local community organizations, faith-based organizations and more, which focus on prevention and post-acute crisis recovery
6. Integrated substance use disorder/medication-assisted treatment solutions
7. Providers for all levels of care, available for urgent access
8. System oversight and management by an administrative services organization or other entity

## Law enforcement and mobile crisis teams: Intercept 1

A community or public health-like response must become the expectation through crisis systems that include mobile crisis intervention – onsite, real-time behavioral health mediation that promotes diversion. If law enforcement officers are trained to recognize mental illness and substance use disorders, or have a mental health professional accompanying them on an encounter, they can identify the symptoms of behavioral health challenges and connect that individual to care. Two such trainings include [Crisis Intervention Training](#) (CIT) and [Mental Health First Aid](#). CIT is now practiced in 2,700 jurisdictions across the country.





### Mobile Crisis Intervention (MCI)

A primary goal of MCI is to make emergency behavioral health services accessible in the community, offering viable alternatives to emergency departments. MCI provides behavioral health crisis assessment, intervention and stabilization services, 24/7/365. These trained behavioral health professionals respond quickly to behavioral health emergencies and only with law enforcement if necessary. Doing so helps to de-escalate cases and divert from EDs, incarceration or inpatient care.

Sometimes referred to as “pre-booking diversion”, this approach links the individual to community-based services before he or she is “booked”, thus preventing entrance into the criminal justice system.

Specific to juveniles, Intercept 1 is particularly important as a means to keep youth from becoming first-time offenders. Schools have an important role to play here. Instead of being expelled for “bad behavior” or even involving law enforcement, after-school programs designed to reinforce positive behavior are excellent forms of diversion.

### Examples of Carelon Behavioral Health crisis systems of care

Program name	Description
<b>Washington State</b>	As part of the Washington Health Care Authority’s Integrated Managed Care model, Carelon Behavioral Health administers a program for 1.5 million people that provides behavioral health crisis services, regardless of insurance status or income level.

Program elements	Outcomes
911 patches calls to crisis lines	<b>Crisis line calls</b> Volume doubled in 12 months
Both youth and adult mobile crisis with peer specialists response within 2 hours	<b>Mobile crisis teams</b> 80% completed in person 90% include peer support 90% diverted from ED 70% get follow-up within 7 days 5% recidivism
24/7 immediate access to a crisis clinician	<b>Access to crisis clinician</b> 80% resolved

Program name	Description
<b>Georgia Collaborative ASO</b>	Comprised of 3 companies, the ASO and its providers deliver integrated behavioral health and developmental disabilities services for 200,000 Medicaid and state-funded recipients.

Program elements	Outcomes
Single point of dispatch for state-funded mobile crisis teams	92-95% of the time, 2 professionals respond to a crisis w/o law enforcement
Real-time tracking of service availability	5-8% of the time, law enforcement is dispatched with mobile crisis teams
24/7 crisis and access line	Only 2% of crisis calls result in emergency services deployment
Coordination of access to crisis stabilization units statewide	

## Initial detention/court hearings: Intercept 2

Technology solutions that facilitate the coordination of care between systems play a critical role at this juncture. For example, Carelon Behavioral Health’s JusticeConnect was designed to promote the continuity of care and treatment of Medicaid beneficiaries living with serious mental illness who are held in the state’s detention centers. This online communication tool permits authorized jail and community behavioral health agency clinical staff to communicate relevant behavioral health information. It provides several critical benefits:

1. **Early identification.** Detainees with mental health and SUD can be more quickly and accurately identified, aiding jail decisions on classification, housing, and behavioral health treatment during incarceration.
2. **Improved jail discharge-planning.** Planning for jail discharge starts almost immediately after jail arrival, which helps in
  - a. Successful reintegration into the community
  - b. Linkage to a community-based treatment provider



[The Washington State Institute for Public Policy](#) found that mental health courts' benefits to both the taxpayer and non-taxpayer totaled \$19,080 for 2016, with a 99 percent chance that the benefits will exceed the costs.

- c. Adherence to follow-up care
- d. Reduction in both state hospital and jail recidivism

The JusticeConnect platform integrates daily census files provided by the jail, Medicaid enrollment and eligibility information, and claims data. Since JusticeConnect automatically updates data daily, Carelon Behavioral Health clinical staff have real-time access to important information that facilitates discharge and follow-up care planning.

## Jails and courts as intercept points for mental health: Intercept 3

[Mental health and drug courts](#) are treatment-oriented courts that divert offenders with mental illness and SUD into mandated, community-based treatment. Like pre-booking diversion, the goal of these courts is to divert this group of offenders away from the criminal justice system, thus reducing recidivism.

[One study cited by the Institute of Corrections](#) shows that offenders with a mental illness who have gone through mental health courts have significantly reduced arrest rates 12-months post-enrollment compared to the arrest rate in the year prior to enrollment. They also lead to decreased emergency room visits for crime-related injuries, fewer child welfare interventions, improved success in treatment programs and more.

Intercept 3 with its specialty courts is another critical juncture for the juvenile justice system. Juvenile mental health courts divert youth with mental health and SUD problems from the standard trial process to community-based mental health services. These courts are able to demonstrate that mental health and/or SUD challenges are at the root of the problematic behavior where treatment – not incarceration – is the preferred path. Below is a state case study that reflects the value of diversion programs.

## Reentry: Intercept 4

Justice-involved individuals with mental health and/or SUD challenges face many barriers accessing behavioral health services. Often unable to reconnect with treatment providers, many return to substance use, criminal behavior, or experience housing insecurity upon reentry into the community.

As noted in Intercept 2, JusticeConnect helps to identify those people entering the criminal justice system who need behavioral health services. Once those individuals are identified, proven support models, such as peer support specialists and intensive case management, help them to reintegrate into the community, as described in Intercept 5.

## Community corrections: Intercept 5

This intercept focuses on community-based corrections and support. For former inmates, this period includes probation and parole, and today these functions focus on engagement in mental health treatment as a means to improve health and reduce recidivism.

While most probation officers are inadequately prepared to manage individuals with mental illness in the community, some agencies have developed programs to help this population. “Specialty mental health probation” is a program in which probation officers, trained in mental health, use a more individualized, treatment-oriented approach. The result is improved monitoring of special release conditions, such as mandates for mental health treatment. While officer training is essential to this program, there currently is no standardized/centralized training for these officers. However, many programs have tapped into a crisis intervention training curriculum (CIT).

## Ohio’s Behavioral Health/Juvenile Justice initiative: Case study

Due to many justice-involved youth having mental health or SUD challenges, the state of Ohio funded local pilot projects to divert these youth from incarceration into community-based treatment. Although operated in only three counties, the pilot project was successful in reducing the number of youth with behavioral health issues committed to the Ohio Department of Youth Services.

In 2005, the state allocated new resources to the Behavioral Health/Juvenile Justice (BHJJ) project and funded several counties to expand upon the pilot’s work. The BHJJ project aimed to transform the local systems’ ability to identify, assess, evaluate, and treat these youth and their families and to identify effective programs, practices and policies.

As of June 30, 2017, 4,338 youth had been enrolled in the BHJJ program, whose notable success includes:

- A 55% reduction in risk for out-of-home placement
- Reduced cost of about \$5,000 per youth compared to \$180,000 to commit a youth to ODYS
- More than 96% of youth are not sent to an ODYS institution following services



When transitioned into the community, access and engagement in community-based treatment is critical. Intensive case management (ICM) and peer support promote that access and engagement. ICM clinicians help coordinate medical, substance use, behavioral health and community services and communication among providers. In turn, peer specialists’ lived experience supplies the knowledge and credibility that can help these individuals in ways that others cannot. They share experiences; help change the attitudes and behaviors learned in a jail or prison environment; and support the engagement into community-based mental health and SUD treatment.

JusticeConnect, as described in Intercept 2, improves service coordination upon release from incarceration and supports ICM and other care coordination efforts. The data for follow-up care tell an important story. Below is a chart that shows – pre- and post- data sharing due to JusticeConnect – that the rate of individuals getting an appointment within 14 days of release has gone up while the rate for appointments made beyond 14 days has gone down.

The result is a more successful reintegration into the community at large; improved adherence and linkage to follow-up care; and compliance to conditions of release, all leading to reduced recidivism.

<b>Year</b>	<b>Appointment within 14 days</b>	<b>Appointment beyond 14 days</b>
2013: Prior to data-sharing	31%	52%
2016: 3 years after	51%	33%

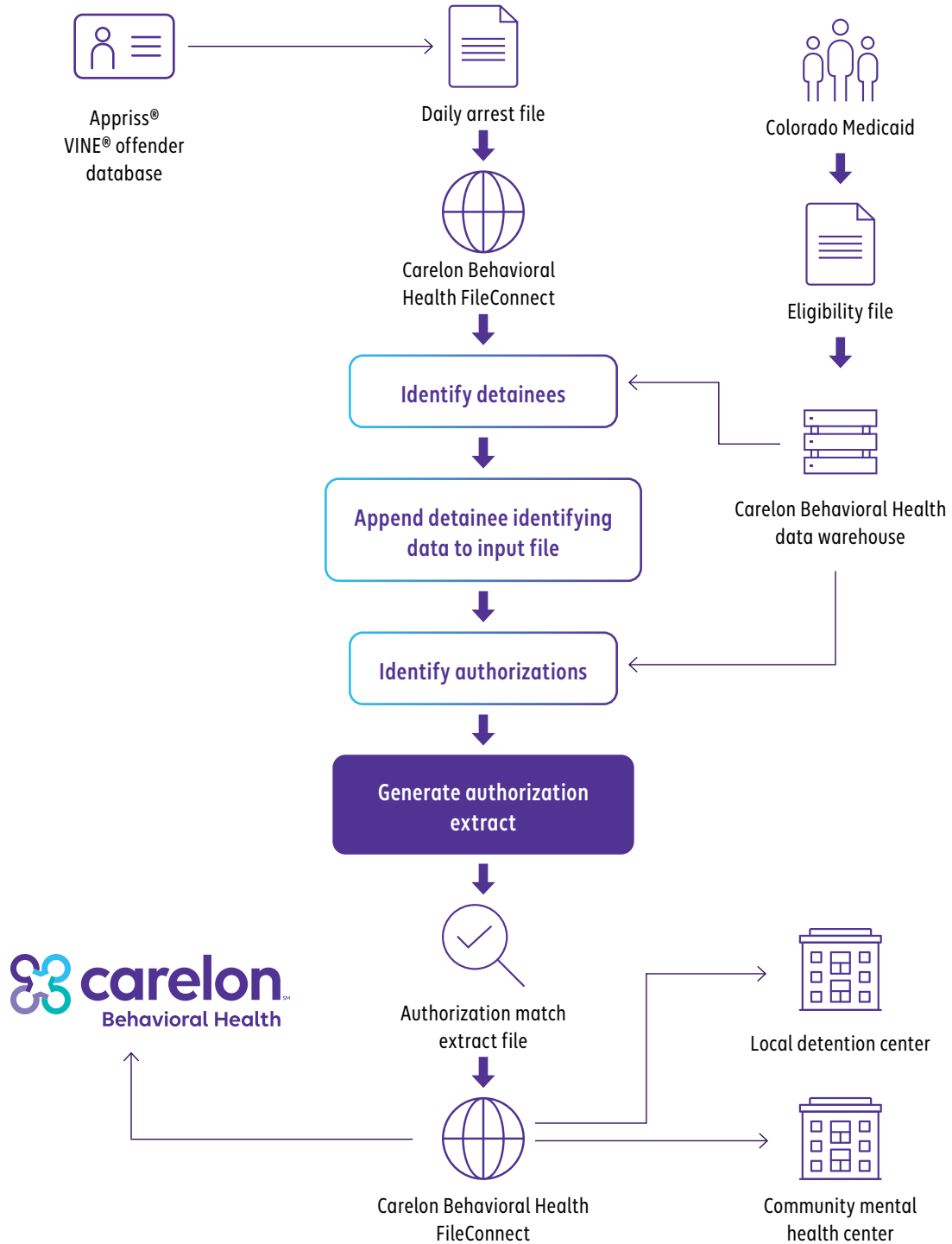
# Best practice: The state of Colorado

JusticeConnect in Colorado is designed to promote the continuity of care for Medicaid beneficiaries with mental illness who are detained in Colorado county jails. It disseminates to community mental health centers demographic information for these members, identified at booking, as having had a mental health service. Additionally, it disseminates pharmacy data to two rural county jails, strengthening care coordination with jails' treatment staff and members' regular treatment providers.

Specifically, the process is as follows:

1. Carelon Behavioral Health uploads a member directory for Medicaid-eligible adult members to Appriss, who manages a data warehouse with all jail booking and release information.
2. Appriss sends Carelon Behavioral Health a weekly file with Medicaid members who were booked into one of Colorado's 54 county jails within a seven-day period.
3. JusticeConnect uploads the Appriss file with matches and identifies members who have received a behavioral health service within the prior 12 months.
4. Once a match is identified, the process looks for a provider who last treated the member, and an alert is sent to the care coordinator assigned to that provider practice.
5. Simultaneously, the pharmacy data and prescriber information is shared with two of the rural county jails for members detained in those jails.

## Colorado JusticeConnect process flow diagram







## Conclusion

Individuals with serious heart disease or cancer do not end up in prisons or jails; they receive treatment in hospitals. The same should be true for people with mental illness and/or SUD. They too deserve to get treatment in their home community. Because of the prevalence of mental illness among incarcerated individuals, it's only common sense that communities' criminal and juvenile justice systems link to behavioral health. That linkage starts with on-the-street interventions such as diverting appropriate 911 calls to a statewide crisis and pre-booking diversion – to prevent criminal justice system involvement in the first place – and ends with ongoing, community-based supports. Individual lives improve; communities become healthier; and states and counties enhance their responsibility as public stewards.