

IV. Montana Mental Health Needs Assessment in the Adult Criminal Justice System

A. Introduction

This section was prepared by Policy Research Associates, Inc. (PRA) based on site visits and research. The Sequential Intercept Model is the basis for analysis of the mental health needs of adults in the criminal justice system. The model is already being used by Montana as a planning tool in the development of criminal justice/mental health initiatives.

This section will include:

- Discussion of the prevalence rate of persons with co-occurring disorders in the justice system
- Description of population characteristics and special needs
- Strength assessment by and across intercepts - Montana has initiated several cutting edge initiatives in recent years, and strengths of Montana's mental health criminal justice collaboration will be described.
- Gap assessment by and across intercepts – Program/service gaps that cut across intercepts will be identified. Gaps within each intercept will also be identified.
- Recommendations
 - ▶ Action steps.
 - ▶ Relevant resources such as articles, model program descriptions, and evidence-based program descriptions are included in the attachments¹.

The increase in the number of persons with mental illness in the criminal justice system is well documented². Since the late 1960s when deinstitutionalization began, the community criminal justice system and mental health and social services agencies have sought to develop appropriate responses and interventions to effectively provide for a life of recovery in the community. But the reality is that service delivery systems have not been able to adequately meet all needs, and some people are spending more time in jail and prison than in community treatment. This trans-institutionalization takes place against a backdrop of “get tough on crime” and “war on drugs” legislation and policies, along with the underfunding of many states’ community mental health services and a continuing push to reduce state inpatient psychiatric bed capacity. In addition, headlines about violent crime involving persons with mental illness increase suspicion and fear of justice-involved persons with mental illness. Public wariness may indirectly limit community treatment alternatives.

As incarceration rates and costs rise, states and communities are beginning to look for alternatives to incarceration that provide improved service linkage and improves public safety. Programs that have generated cost savings are cited within this report. A study by the Rand Corporation of the Allegany County Mental Health Court found that the program significantly decreased criminal justice costs and after an initial increase in mental health service costs during the first year, mental health service costs decreased significantly in the third and fourth quarters of the second year resulting in taxpayer savings (Rand Corp., 2007).

¹ Attachments mentioned in this section are listed in Appendix G and are available from the Legislative Services Division upon request.

² Sourcebook of Criminal Justice Statistics. (2005). *Adults on probation, in jail or prison, and on parole*. http://www.albany.edu/sourcebook/tost_6.html#6_a.

B. Number and Characteristics of Mentally Ill Offenders

1. Prevalence

Various studies estimate the prevalence of persons with mental illness in the justice system to be anywhere from 8% to upwards of 60%. Discussion of these rates is important if policymakers are to better understand the population and develop targeted strategies for intervention. In September, 2006 the Bureau of Justice Statistics (BJS) issued a report based on a self-report questionnaire consisting of a checklist of mental health symptoms (e.g., “persistent anger or irritability”).³ If a respondent answered yes to having any of the symptoms, he or she was considered to have “a mental health problem.” The positive response to any one symptom was upwards of 60%. In 1999 the BJS issued another report on mental health prevalence based on a survey. This time the self-report questionnaire had asked, “Have you ever had treatment for an emotional condition?” or “Have you ever had an overnight stay in a mental hospital?” The study found a prevalence rate of 16%.⁴ Linda Teplin, studying inmates held in the booking area of Cook County Jail in Chicago, found a 12% prevalence of serious mental illness in women and 6.4% prevalence for men, using the Structured Interview for DSM Disorders (SCID).⁵ The National GAINS Co-Occurring Disorders and Justice Center, a PRA project, regards the Teplin research as the most rigorous study of prevalence for serious mental illness (SMI). The 1999 BJS survey reporting 16% prevalence for any mental illness represents a fair estimate of prevalence when compared to statistical reports reviewed from individual states.

Based on the above data, our expectation regarding prevalence of mental illness in Montana is as follows (Table VI-1):

	Total Population*	Mental Illness**	Severe Mental Illness***
Prison	2,467	395	171
Male	2,258	361	145
Female	209	34	26
Jail	1,521	243	106
Male	1,385	222	89
Female	136	21	17
Parole	844	135	60
Male	743	119	48
Female	101	16	12
Probation	8,770	1,403	680
Male	6,665	1,066	427
Female	2,105	337	253
<p>* Montana DOC, 2007 ** 16% general mental illness prevalence rate among incarcerated individuals per Bureau of Justice Statistics. *** 6.4% prevalence rate of Severe Mental Illness (SMI) among incarcerated men and 12.4% prevalence rate of Severe Mental Illness (SMI) among incarcerated women per Linda Teplin.</p>			

³ James, D.J. & Glaze, L.E. (2006). *Mental health problems of prison and jail inmates*. Washington, DC: United States Department of Justice, Office of Justice Programs.

⁴ Ditton, P.M. (1999). *Mental health and treatment of inmates and probationers*. Washington, DC: United States Department of Justice, Office of Justice Programs

⁵ Teplin, L.A. (1994). Psychiatric and substance abuse disorders among male urban jail detainees. *American Journal of Public Health*, 84 (2): 290-293

Review of the University of Montana study⁶ suggests rates of mental illness for persons who are entering Department of Corrections (DOC) Pre-Release Centers at Helena, Missoula, Great Falls, Butte, and Billings are much higher than prevalence rates discussed above. Prevalence reported in the University of Montana study is 69% for women and 41% for men.

The operational definition of mental illness in the University of Montana study is somewhat broader than in the BJS 1999 survey. The BJS 1999 mental illness criteria included an overnight stay in a mental hospital or a current emotional condition. The University of Montana study includes the BJS criteria and history of an Axis I disorder. The prevalence data from the University of Montana study is broader in that it identifies people as having mental illness if they have either current mental health treatment needs or merely a history of an Axis I disorder.

Review of mental health service activity at the facilities visited is as follows:

Facility	Population	Psychiatric Meds	SMI Estimate
Yellowstone County Detention Center	350	200 (57%)	50 (14%)
Lewis and Clark County Detention Center	58	8 (13%)	Unknown
Montana State Prison	1,400	384 (27%)	Unknown
Montana Women’s Prison	173	60	Unknown
Passages	155	62 (40%)	Unknown
<i>Source: Montana DOC 207</i>			

Montana’s mental health service utilization rates as reported by the facilities visited by PRA are higher than what might be expected from the prevalence studies reported above.

It should be noted, however, that Yellowstone County Detention Center and Lewis and Clark County Detention Center have insufficient mental health staff to properly assess, diagnose, provide consistent therapy contact or offer more than medication and monitoring services. Service utilization rates at Montana State Prison (MSP) do not seem unreasonably high since it is likely that persons with more severe mental illness might be excluded from pre-release centers or other DOC transitional programming, resulting in a higher percentage of persons with mental illness housed at MSP. Five therapists at MSP treat and monitor almost 400 inmates. The medication caseload of the psychiatrist is 384. Improved treatment capacity at these sites could result in better screening and triage, fewer persons placed on medication, reduced length of time on medication or faster resolution of mental health problems, and reduced need for ongoing mental health services.

While it appears that rates of mental illness in Montana’s jails and prisons are higher than national rates, the high rates might be affected by a lack of treatment capacity resulting in

⁶ Conley, T.B. & Schantz, D.L. (2006). *Predicting and reducing recidivism: Factors contributing to recidivism in the State of Montana Pre-release Center population & the issue of measurement: A report with recommendations for policy change.* University of Montana School of Social Work.

inappropriate utilization of mental health services, inability to provide prompt treatment and follow-up, and inability to determine the acuity of the mental health caseload.

2. Population Characteristics

To intervene effectively, it is important to understand the characteristics of the justice involved population. These statistics pertain to the national population of offenders:

- ▶ Approximately three quarters (72%) of inmates at Cook County Jail have co-occurring disorders, that is, both a mental illness and substance use or substance dependence disorder.⁷
- ▶ Approximately 90% of the men and women with mental illness participating in a jail diversion program have a lifetime experience of trauma, and approximately 50% of men and women report an episode of trauma (an emotional or psychological injury, usually resulting from an extremely stressful or life threatening situation) within the year prior to arrest (unpublished TAPA evaluation data)⁸.
- ▶ Rates of homelessness and unemployment are higher for inmates with mental illness.⁹

At time of arrest, many persons with co-occurring disorders have not received any treatment in the year prior to arrest, and it is unlikely they have received integrated mental health and substance abuse treatment.¹⁰

Justice-involved women have unique needs, and it is important that programs and services be trauma informed and gender specific. That is, they should establish procedures, environments and interventions suited to the specific needs of women that avoid re-traumatizing them and include evidence based treatments for trauma recovery, including skills for self-protection. One of the specific needs of women is the importance, to most, of their role as mother. Nationally, more than 65% of women in state prisons compared to 55% of men in state prisons report being parents of children under 18. About 64% of mothers in state prisons lived with their children before prison, compared to 44% of men. (<http://www.womenandprison.org/facts-stats.html>) New Hampshire passed legislation establishing the position of an administrator of women offenders and family services within the department of corrections and establishing an interagency coordinating council on women offenders (Attachment 2).

A Bureau of Justice Statistics (BJS) report indicates that there were 140,000 veterans in state and federal prisons in 2003. Afghanistan and Iraqi war veterans accounted for 3.4% of the total number of veterans, up from 1.9% two years earlier.¹¹ Trauma and posttraumatic stress disorder (PTSD) in Afghanistan and Iraqi war veterans are well documented. In order to promptly and effectively engage veterans into treatment, it is important to establish screening methods so that they can be identified and referred for institutional and community services upon release. Collaboration with the Veterans Administration and Veterans' groups is essential. In Buffalo, NY, where over 300 veterans reportedly entered the criminal justice system in 2007,

⁷ Abram, K.M. & Teplin, L.A. (1991). Co-Occurring disorders among mentally ill jail detainees. *American Psychologist*, 46 (10): 1036-1045.

⁸ TAPA unpublished TCE data. Technical Assistance and Policy Analysis Center for Jail Diversion. Policy Research Associates. 345 Delaware Ave. Delmar, NY 12054.

⁹ Ditton, 1999

¹⁰ <http://oas.samhsa.gov/NSDUH/2k5NSDUH/2k5results.htm#8.1.4>

¹¹ Noonan, M.E., & Mumola, C.J. (2007). *Veterans in state and federal prison, 2004*. Washington, DC: United States Department of Justice, Office of Justice Programs

City Court Judge Robert T. Russell, Jr. established a Veterans Court in January 2008 (Attachment 3).

C. Resources for Financing Mental Health Services for Offenders

In many states, state and local mental health department planning for justice-involved persons with mental illness is fragmented. Often, criminal justice agencies fund mental health positions or services due to insufficient mental health funding to service the population, and parallel treatment systems are developed.

Federal block grant funds and PATH (Projects for Assistance in Transition from Homelessness) funds are given to states to fund programs for persons with serious mental illness. Most states do not use these funds to develop programs specific to justice-involved persons. Instead, the planning process focuses on persons in the community, without input from criminal justice agencies, and consequently, funded services do not provide outreach to justice-involved persons. Block Grant and PATH funds are nevertheless ideal for use with the justice-involved population to facilitate initial engagement in treatment. This population typically is not enrolled in benefits programs, including Medicaid and Social Security, and access to services is thus restricted. Use of Block Grant and PATH funds can overcome the service access issue and provide transition funding until more permanent funding for services can be arranged.

Input from police, courts, jails, prisons, and probation and parole should be sought in developing statewide mental health planning to utilize Block Grant and PATH funding.

D. Strengths and Gaps in Montana Sequential Intercepts

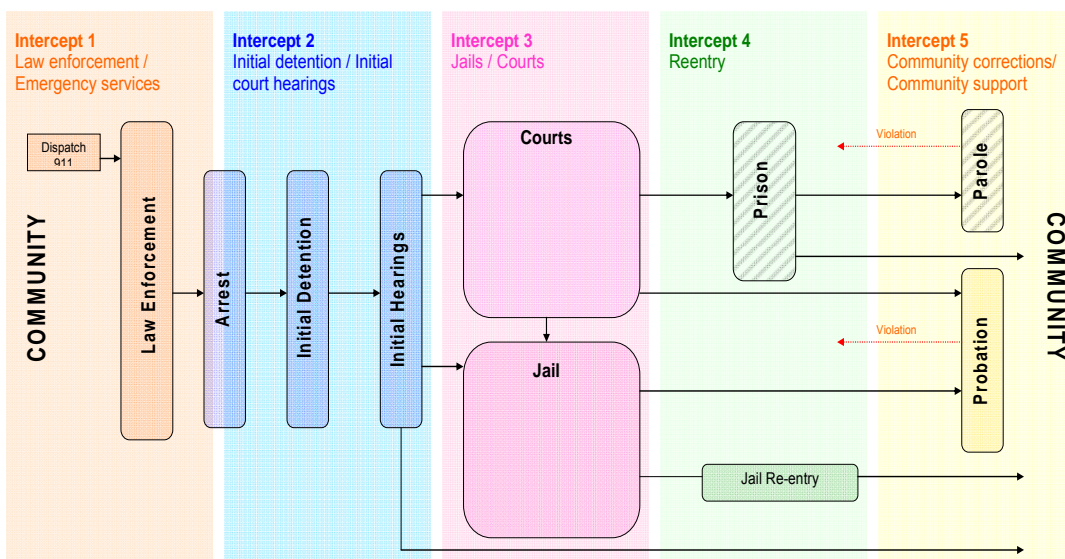
1. Sequential Intercept Model

People with mental illness who come in contact with the criminal justice system cycle through it in predictable ways. A visual and conceptual model of this process has been developed by Patricia A. Griffin, Ph.D., and Mark Munetz, M.D.¹² The Sequential Intercept Model (See Figure IV-1) highlights the concept that at any juncture in the criminal justice system there is opportunity to “intercept” with diversion. The use of this model is helpful to identify the points of intervention where people can access treatment services so jail or prison can be avoided.

Regardless of the entity providing the service, diversion involves identifying eligible individuals, screening and assessing their needs, engaging them in a services plan, negotiating the terms of services, and linking them to those services. The reduction of recidivism is the ultimate objective.

¹² Munetz, M.R., & Griffin, P.A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57 (4): 544-549.

Figure VI-1
Sequential Intercepts for Change: Criminal Justice - Mental Health Partnerships



The Sequential Intercept Model provides a template for discussion and exploration of the innovative work being conducted across the country to provide diversion. Each intercept involves different community agencies that have a significant role in identifying people with mental illness and linking them to services designed specifically to respond to their identified needs. It is important to note that justice agencies whose primary roles have little to do with the treatment of mental illness now are addressing the needs of people whose clinical condition is unstable. Heroic efforts are seen at every juncture.

- ▶ Intercept 1: Intervention by local law enforcement, local emergency services
- ▶ Intercept 2: Arrest, initial detention/initial court hearings
- ▶ Intercept 3: Jails/courts/specialty courts
- ▶ Intercept 4: Reentry following stay in jail or prison
- ▶ Intercept 5: Community corrections/community support

2. Strength Assessment Across Intercepts

a) Strengths of the Correctional System as a Whole

Behavioral Health Program Facilitator. Establishing the role of Behavioral Health Program Facilitator as a staff position shared between DPHHS and DOC has been a key factor in improving criminal justice collaboration, coordination, and planning. This boundary spanner role is key to integration of two complex systems with different missions and cultures but sharing the same population. Through the Facilitator’s efforts, improved collaboration and coordination was evident as we toured Montana and spoke to criminal justice and mental health program staff.

The Law and Justice Interim Committee (LJIC). Key to initiating, implementing, and sustaining change in a state is a coordinating body, a group of stakeholders from across state and community agencies and the provider community that have the focus and authority to identify problems, prioritize action, and initiate and sustain change. The LJIC took the lead as a coordinating body in this legislative interim.

b) Intercept I: Intervention by Local Law Enforcement and Emergency Services

Police Crisis Intervention Team Initiatives and Billings Crisis Stabilization Center. Two police Crisis Intervention Teams (CITs) currently operate in Montana, one in Billings and one in Helena. The program in Billings is exemplary in that a crisis stabilization unit is available as a drop-off center. Yellowstone County Detention Center regards the police CIT program and the crisis stabilization unit as significant factors in the reduction of the Center's census over the past year. In addition, Yellowstone County Detention Center allowed some corrections officers to take part in the police CIT training. Corrections officers reported that it was the best training they ever had and jail administrators reported the training improved response to persons with mental illness. The GAINS Center has heard similar reports in other jurisdictions where corrections officers received police CIT training, with similar benefits reported.

Aside from the established programs, there are ongoing plans to expand police crisis intervention training across the state and to enhance mental health training at the Montana Law Enforcement Academy.

c) Intercept 3: Jails, Courts, Specialty Courts

Missoula Mental Health Court. Operating since 2006, the Missoula Mental Health Court was initially funded by a Criminal Justice Mental Health Collaboration Grant and is now supported by Missoula County. It provides important diversion options for persons with co-occurring disorders who are charged in either the district court or justice court. Staffed by one case manager/coordinator with in-kind staffing contributions from probation, county attorney and public defender, and Winds of Change, a mental health provider, has current program capacity of 24. Program need is estimated to be twice that, meaning an additional case manager is required. Program staff report that some persons from neighboring counties have asked to enroll in the Missoula Mental Health Court program as an alternative to incarceration in their home counties, where mental health services and diversion alternatives were not available.

d) Intercepts 4 and 5: Re-entry After Release, Community Corrections and Community Support
Department of Corrections Assessment and Sanction Units at Billings (BASC) and Missoula (MASC). We visited the BASC unit and reviewed materials on the MASC unit. We found these programs to be innovative in that they provide both prison diversion options for persons committed to DOC and a violation diversion option for persons who have violated conditions of probation or parole. Further, the centers provide transition programming for those nearing release from prison. The programs have capacity to provide mental health treatment to program participants. While persons with serious mental illness and low functional ability may not be able to meet the functional demands of the programs, program staff felt that few would be unable to participate. At BASC, a contract with Billings Clinic enhances continuity of care and facilitates transition planning to the community.

Gap Funding for medication and case management services between prison release and Medicaid approval. Montana joins only a few states that have taken the initiative to provide gap funding to assist persons with mental illness in transition from jails and prisons to the community. Gap funding is essential because Medicaid eligibility typically takes several weeks to determine, making it impossible for people reentering the community to immediately obtain needed medications and pay for community services. During our visit it was apparent the program's implementation was just beginning, but field staff were appreciative of the initiative. Gap funding provides medication for persons released from secure facilities and under community corrections supervision for up to 60 days subsequent to release or until Mental Health Services Plan (MHSP) or Medicaid funding becomes available. Funding also provides a

clinical staff position that supports treatment and case management services for probation/parole offices at up to six sites across the state. Again, these positions are not all filled, but when hiring is complete will enhance service linkages and promote engagement in services.

Cross Systems Integration. Cross system integration was apparent as we traveled among programs operating in Intercepts 4 and 5. Cross system integration initiatives included:

- ▶ Mental health training of probation and parole officers
- ▶ Establishing clinical staff positions at probation and parole offices
- ▶ Integrating the discharge planner from Montana State Prison into the Admission, Discharge, Review Team meetings held at Montana State Hospital to insure that individuals with mental illness who are released from prison have appropriate access to community resources

Trauma Screening and Assessment at Montana Women's State Prison and Passages Program. Programs at the Montana Women's Prison and at Passages both addressed screening and assessment of trauma in their medical records and incorporated trauma-specific interventions. Under contract to DOC, Passages provides a 65-bed pre-release center, 40-bed alcohol and drug treatment unit and 50-bed assessment, sanction and revocation center.

The above initiatives are considered exemplary and demonstrate Montana's commitment to and innovation in improving recovery-based outcomes and enhancing public safety by addressing critical issues for justice-involved persons with mental illness.

E. Gap Assessment Across Intercepts

1. Gaps in the Correctional System as a Whole

a) Data

We found no organized method or strategies for collecting data on mental health populations except at Montana State Hospital. Both Yellowstone County and Lewis and Clark County Detention Centers, for example, had contracts with local mental health centers but no organized data collection regarding numbers seen, diagnostic profiles, or transition planning. While the state prison programs had some information regarding current mental health service recipients, diagnostic and acuity information was lacking, as was systematic reporting on transition planning.

Similarly, the DOC lacked a centralized database of persons receiving mental health care in the state prisons. The absence of such a database impedes service planning, implementation of quality assurance initiatives, and continuity of care.

b) Information Sharing

Access to treatment records is critical to continuity of care and yet lack of access to records appeared to be a widespread problem. Yellowstone County Detention Center reported they did not receive referral information from Montana State Prison when prisoners were transferred to Yellowstone County for court appearances for other pending charges. While neither Lewis and Clark nor Yellowstone County had a systematic method for obtaining community treatment records for new admissions, both could obtain some treatment records if the person had

previously been seen at the local mental health center. At Yellowstone County Detention Center, due to liability and confidentiality concerns, a formal treatment record is not even maintained, although the services are actually provided by the Billings Clinic.

c) Lack of Forensic Intensive Case Management (FICM), Program for Assertive Community Treatment (PACT) and other Evidence-Based Practices

FICM provides case management by staff who have special training in the processes and requirements of the forensic system and the special needs of individuals released from correctional facilities so that they can provide appropriate services to this population. The level of service intensity can be high so that clients' needs can be fully met. PACT teams composed of multi-disciplinary mental health professionals and paraprofessionals provide support in the community at an even higher level of intensity. Staff at Yellowstone County and Lewis and Clark County Detention Centers, and at Montana State Hospital, commented on the lack of access to generic case management and PACT for their population and felt the lack of case management contributed to incarceration and unnecessary hospitalization.

Transition planning from jail is limited to telling consumers to walk into local clinics. Forensic Intensive Case Management and Transition Case Management are emerging as best practices in many communities due to the complexity of the needs of the population and the multiple system coordination required to develop plans for effective and safe reentry. There were no specialized community forensic case management teams identified.

d) Lack of Integrated Dual Disorder Treatment

An impression was conveyed by programs visited that community services lacked Integrated Dual Disorder Treatment Programs to address both mental health and substance use disorders. Prison-based programs had well-designed chemical dependency programs, which reported a significant number of persons with co-occurring disorders. We were unable to determine over the course of our visit how effectively both disorders were being addressed in prison-based programs. Mental health and chemical dependency programs at Passages and the Montana Women's Prison appeared to be integrated, with treatment of both disorders considered, and medical records included a supplemental assessment of co-occurring disorders. Mental health and chemical dependency staff at Montana State Prison spoke about the need to work more closely to address issues pertaining to co-occurring disorders.

e) Lack of Trauma Screening and Assessment in Jails and Montana State Prison for Men

Trauma screening and assessment were not addressed in either of the detention centers visited, although Yellowstone County Detention Center had an outside provider come in to facilitate a weekly anger management group for women. At Montana State Prison, there was an acknowledged need to focus more on trauma issues in their population.

f) Screening and Care Coordination for Veterans

There is no consistent screening for veterans at the jails visited. It was noted, however, that at both the Lewis and Clark County Detention Center and Montana State Prison there is a linkage to veterans' services. Lewis and Clark County Detention Center staff report that some Iraq and Afghanistan war veterans are beginning to come through. An article in the May 30, 2008 edition of the Bozeman Daily Chronicle (Attachment 4) highlights the need for screening and organized response for returning veterans who may become justice involved as a consequence of combat stress and trauma.

The extent of coordination of behavioral health services with Veterans Administration programs, Vet Centers, and other groups was unclear from our visit. Reports from around the country describe incidents of arrests of veterans suffering from combat stress and PTSD and highlight the need for proactive service relationships and coordination with law enforcement and justice agencies.

g) Lack of Local Planning Capacity to Address Diversion Options

Effective diversion and reentry programs require a broad range of community partnerships. While there is evidence that effective partnerships are being forged at the state level and in Billings, it is not clear that local advisory councils have sufficient awareness of diversion issues or have established partnerships to initiate local responses to increase diversion opportunities for justice-involved persons with mental illness. Stakeholders at the community level would include behavioral health providers, law enforcement, probation/parole, Veterans Administration and veterans groups, social services and Social Security Administration field offices, housing providers, judges, prosecutors, public defenders, consumers, and local National Alliance on Mental Illness (NAMI) affiliates.

h) Lack of Funding for Community-Based Services

While this is addressed in the DMA Health Strategies portion of the report, jail staff, Montana State Hospital staff, and Missoula mental health staff report waiting lists for treatment, delays in accessing MHSP and Medicaid, and insufficient access to PACT team slots for the justice-involved population.

2. Intercept 1: Intervention by Local Law Enforcement and Emergency Services

a) Insufficient Pre-Booking Diversion Options

The Billings Police Department CIT team and newly opened crisis stabilization unit are described by jail staff as very effective and contributing to a decrease in jail census. However, the police CIT program in Helena, according to jail staff there, while improving police response to persons with mental illness, has few alternatives to arrest or hospitalization since there is no crisis stabilization center. Police must transport individuals to St. Peter's Hospital emergency room. Processing procedures are not timely and police must wait for extended periods for an evaluation. There are no local inpatient psychiatric beds, so if hospitalization is needed transport to Warm Springs is required.

3. Intercepts 2 and 3: Arrest, Initial Detention/Court Hearings, Jails, Courts, Specialty Courts

a) Lack of Post Booking Diversion Options

We identified no communities offering diversion at Intercept 2, and there is only one mental health court in the state. There appears to be a lack of organization and collaboration at the community level to initiate the implementation of diversion programs. Consequently, persons who could be released on bond with referral to community services remain in jail. Documents reviewed and discussion at the stakeholders meeting indicate there has been discussion of funding additional mental health courts, but funding is not available to date.

b) Lack of Consistent Jail Screening and Treatment Capacity in Jails

Yellowstone County and Lewis and Clark County Detention Centers were the only Montana Jails visited. These jails were selected by region (one from the eastern part of the state and one from

the western part of the state) and by size. One (Yellowstone) has a capacity of approximately 300 and one (Lewis and Clark) has a capacity of approximately 60. Information from the stakeholders' meeting and from jail administrators at Yellowstone County and Lewis and Clark County Detention Centers, suggests that both Centers are similar to others in the state, although smaller jails may have even fewer resources.

Both Yellowstone County Detention Center and Lewis and Clark County Detention Center contract with local mental health centers to provide basic crisis assessment, medication, and monitoring services. Both jails routinely screen for mental health needs and refer to mental health center staff. Mental health staff are responsive but have limited capacity to provide treatment, close monitoring and supervision of care, and meaningful transition planning services. Both jails have high supervision areas, restraint chairs, and some inpatient access which is used sparingly. Mental health screening and assessment services for Yellowstone will be increased from 24 hours a week to 40 hours a week. Yellowstone reports that 200 of 350 inmates are on medication and 50 of the 200 have a serious mental illness, so while increasing mental health coverage will help, capacity to provide meaningful treatment and transition planning will remain limited.

There is no one state entity that collects information on jails so it is difficult to determine level of need in other counties but if impressions are accurate, most counties are struggling to meet the needs of persons with mental illness in their jails. Of particular concern is lack of collection of annual suicide numbers for jails and a mechanism to monitor and correct custody/program deficiencies that may have contributed to the event.

c) Secure Forensic Treatment Unit and GBMI population

Both Montana State Hospital staff and Montana State Prison staff acknowledge the need for a secure forensic unit for guilty but mentally ill (GBMI) persons or state prison inmates who require hospital-level care. Physical security is one issue since there is no perimeter fence. Staff safety is a second issue since there is a history of assaults on staff by this population.

The Secure Treatment and Examination Program (STEP) Unit was a proposed but unsuccessful solution to the problem in the 2007 Legislature. Some GBMI persons have been moved to Montana State Prison when clinical condition and security needs permitted. The GBMI population at Montana State Prison requires close monitoring. Given current mental health staffing and psychiatric coverage, appropriate care for this population presents a challenge.

4. Intercepts 4 and 5: Re-entry After Release, Community Corrections and Community Support

a) Lack of Jail Transition Planning

Neither Yellowstone County Detention Center nor Lewis and Clark County Detention Center had capacity to do transition planning. Transition planning was limited to telling a person to walk into the local community mental health clinic.

b) Lack of Funding for Psychiatric Medication for Jail Releases

Lewis and Clark County Detention Center does not have capacity to provide psychiatric medication upon release. Yellowstone County Detention Center provides seven to ten days of psychiatric medications upon release. However, unless an individual is under probation supervision and covered by the Medication Assistance Program, paying for medication following

release is a problem, since it takes longer than seven to ten days to be enrolled in Medicaid and thereby have subsequent prescriptions paid for.

c) Insufficient Treatment Capacity at Montana State Prison

As noted above, lack of a centralized database for prison-based mental health services detracts from informed service planning and quality services. Available data suggests the mental health services at Montana State Prison for men, in particular, are understaffed.

Current staffing includes:

- ▶ Clerical: 1
- ▶ Administrative: 1
- ▶ Nursing: 2
- ▶ Therapists: 5
- ▶ Mental Health Technicians: 5
- ▶ Discharge Planner: 1
- ▶ Activity Therapist: 1
- ▶ Psychologist: 1
- ▶ Psychiatrist: 1 at 40 hours/week

Current caseload is 384 for Dr. Schaeffer. The unit caseload is 400 plus.

Except for individuals housed on the mental health unit, most persons receiving services receive group therapy or brief monitoring services. Two high-risk classes of service recipients are currently being served: persons who have had forced medication orders in place and persons found GBMI and transferred to prison from Montana State Hospital. Although numbers are small, monitoring for compliance with management protocols for this group is essential.

F. Recommendations

1. Data management requires improvement across systems.

We recommend that the state facilitate standardized collection of mental health data across intercepts to improve planning. Attached are screening forms for police CIT encounters, and the Brief Jail Mental Health Screen (Attachments 5 and 6), which can be used by jail staff or probation staff. Once reliable screening information is collected, input into a database with predetermined data elements will aid in planning and development of services for this population. Data elements should include specific information about special populations, including veterans and Indians, to facilitate planning and development of behavioral health programs that are geared to meeting their needs.

One suggestion is for the state to fund pilot sites in police CIT programs or jail programs at the largest jails. The grants would provide money for hardware, software, and technical support to aid in the development of a mental health database or integration of mental health data into an existing database. Each grant recipient would be required to submit an annual report describing system implementation issues. These sites would then be used as learning sites for other communities.

2. Information Sharing Procedures are Required

Procedures are required to insure flow of clinical information for continuity of care. Attention should be given to building capacity to match justice system data with mental health databases to improve screening and information for police, jails, and prisons.

Flow of treatment data, to jails in particular, is lacking. Texas (SB 839), Illinois Mental Health Jail Data Link Project, and Kentucky Mental Health Crisis Network (see Attachment 7), employ matching of mental health and criminal justice databases to identify persons with past or current treatment histories who are incarcerated. These programs report prompt screening and triage of high risk cases and increased opportunity for diversion and have added funding for case management services to facilitate diversion.

3. Expand Crisis Stabilization Capacity

We are aware of the work done by of the LJC this interim to study expansion of crisis capacity across the state. Montana joins Washington State, Colorado, Florida, and the District of Columbia in seeking to expand crisis stabilization units to divert people from hospitalization, provide alternatives to incarceration for low-level misdemeanor crimes, and improve efficiency of law enforcement by reducing emergency room wait times and visit costs. Stabilization units are essential elements of police CIT Team response. Especially innovative is a suicide prevention proposal to link jail services to crisis stabilization centers through videoconferencing links, which is similar to the successful Kentucky Crisis Mental Health Network program. We recognize that Montana is currently studying proposals mentioned above, and would like to emphasize that the state is on the right track and in step with other states in addressing these service gaps.

San Antonio, Texas, has a model crisis stabilization program and has assisted several communities in the development of crisis stabilization units. The CMHS National GAINS Center has worked with the San Antonio site to provide technical assistance to Washington State in planning and implementing its crisis stabilization unit initiatives. A site visit to San Antonio may be instructive to Montana's efforts.

4. Expand Post Booking Options

The Missoula Mental Health Court reports over 90% of participants have co-occurring mental health and substance use disorders. Reports reviewed indicate federal funds are received for drug courts in Montana. Given the high prevalence of substance abuse among the mental health court participants, perhaps drug court dollars could be used to fund an additional mental health court or supplement services in the Missoula Mental Health Court. If regulations allow, supplementing existing drug courts with mental health staff or adding substance abuse staff to mental health courts might be a cost efficient strategy to expand capacity for persons with co-occurring disorders.

While mental health courts are proving to be an important diversion option, other diversion options should also be considered to provide opportunities earlier in the justice process. Diversion can take place as early as the first court appearance and at bail or pre-trial probation proceedings. Criminal sanction is not always required for diversion. In one jurisdiction, low-level charges are dismissed on the condition a person attend a 3-hour treatment assessment and

orientation session. Following completion of the session, participants can accept the case management services offered or not. (See Attachment 8)

Expansion of diversion options can take many forms. Grant and foundation funding is used in many states. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Bureau of Justice Assistance (BJA) have funded Mental Health and Justice collaborations for the past several years. Congress is moving forward with continuing to fund programs through the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) in 2009.

States such as Florida, Texas, Michigan, and Washington direct local mental health authorities to plan for jail diversion programs:

- ▶ Michigan: Michigan Mental Health Code 330.1207, Section 207 (diversion)
Each community mental health services program shall provide services designed to divert persons with serious mental illness, serious emotional disturbance, or developmental disability from possible jail incarceration when appropriate.
- ▶ Texas (2003): House Bill No. 2292 (diversion)
The department shall require each local mental health authority to incorporate jail diversion strategies into the authority's disease management practices for managing adults with schizophrenia and bipolar disorder to reduce the involvement of those client populations with the criminal justice system.
- ▶ Florida (1999): House Bill 2003
Directs the Department of Children and Family Services to develop cooperative agreements with local agencies for diverting persons with mental illness arrested for a misdemeanor from criminal justice system to civil mental health system

In addition, Florida recently appropriated \$4,000,000 for planning, implementation, or expansion grants for jail diversion programs. A 100% county match is required except for "fiscally constrained" counties where a 50% match is required.

- ▶ Washington (2007) SB5533
SB 5533 authorizes counties to levy a 0.1% sales tax for criminal justice/mental health initiatives with a focus on establishing crisis stabilization units. The bill also expands authority of the police to divert non-serious misdemeanor cases to crisis stabilization units.

The National Association of Counties (NACo), through a grant from Eli Lilly, awarded counties up to a \$5,000 seed grant to form a planning committee to address mental health/criminal justice issues. In Montana, Yellowstone County, was a recipient of a grant and successfully implemented a police CIT and crisis stabilization unit.

Recognizing Montana's fiscal limitations, it is noteworthy that a relatively small award from NACo facilitated successful planning and implementation of a police CIT Team and Crisis Stabilization Center. State strategies could include funding relatively small local projects designed to improve local planning infrastructure and encourage planning for jail diversion programs.

5. Expand jail-based treatment capacity

Discussion at Yellowstone County Detention Center, Lewis and Clark County Detention Center, with the Missoula Mental Health Court Team, and with stakeholders, indicated that a lack of jail standards makes it difficult to identify statewide jail mental health needs and access to services. Further, there is no guidance for local jail administrators around staff training or service provision for persons with mental illness. States having statewide jail standards include: Kentucky, Maryland, New York, Ohio, Texas, and Idaho.

As jail standards are developed, there will be opportunity for particular attention to mental health standards. State jail standards can address reporting of suicides, suicide attempts, special watches, restraints, the number of persons on psychiatric medication, staff training, and other performance measures that might help assess mental health needs in the state jails and improve services.

Currently, responsibility for providing mental health services in jails is not fixed. County sheriffs are often left to pay for services through contracts although other arrangements may exist. Current contract funding appears to provide for only minimal services and does not allow for transition services nor pay for medication upon release. Mental health services in the jails should be addressed by LACs to insure that mental health needs of all local residents can be addressed in statewide planning.

6. Consider expanding gap funding to jails and diversion programs for transition planning

Gap funding initiatives provide funding for persons transitioning from institutional services to the community until Medicaid and other benefits can be arranged. Montana's "Mentally Ill Offender Drug Program" and "Services for Mentally Ill Offenders Program" are examples of gap funding. These programs provide funding for medication and services for persons released from the state hospital or prison or persons under probation or parole supervision. Uncovered populations include persons participating in mental health courts, other jail diversion, or persons released from jails. Expansion of funding would provide necessary support to bridge persons to services upon release from jail and insure sufficient medication were available until community aftercare services were in place. Funding available for jail diversion participants would insure that participants would not have to be placed on probation to access funding for medication. Both Alaska and New York developed methodologies to determine how much funding was required to implement programs that provide transition medication and case management assistance for inmates being released from jail and prison. Montana's Medication Assistance Program, though new, should also help in developing a methodology to estimate funding need for expanding the Medication Assistance Program.

7. Develop specialized Forensic Case Management and Transition Case Management Teams. Increase PACT team capacity

Insufficient case management resources in the community likely puts additional burdens on emergency rooms and scarce inpatient beds and likely results in increased recidivism for persons who are justice involved. Case management is the backbone of any mental health service system and can help compensate for system deficiencies and fragmentation.

Case management for the justice-involved population often requires additional expertise and funding to effectively manage transition from jails to the community and to maintain close collaboration with criminal justice professionals.

While achieving funding for additional case management is likely difficult, many communities have justified additional funding by analyzing the cost of not having essential services in place.

As a result of the multiple needs of the population, the fragmented systems of care and poor access to care, persons with co-occurring disorders tend to cycle from the streets, to various treatment services, to shelters, and to jail. A New York Cost Study¹³ documented that approximately \$36,000 a year is spent on someone who cycles through various service providers, shelters, jails, and prisons. A study by the Nebraska Coalition of Homelessness (see Attachment 1) estimates that it costs almost \$600,000 a year for the top 13 homeless users of emergency services. Thirteen is about the size of a single intensive case management caseload. It costs \$7,443 a year to house someone in a supportive housing bed in Nebraska. In other words, it costs more not to provide someone with coordinated and effective services.

United States Interagency Council on Homelessness recently highlighted innovative strategies that focus on increasing services to high users, which results in cost savings. (See Attachments 9 and 10)

8. Training the community mental health workforce on successfully working with justice-involved persons with mental illness should include an overview of the criminal justice system and specific characteristics of the justice-involved population.

Working with a justice-involved population requires a familiarity with and understanding of the criminal justice system. Providers must be aware of existing criminal justice sanctions or pending charges to be able to support compliance with justice system mandates. They should understand the need of the justice system for treatment information and have procedures developed for information sharing. Providers also need to understand the characteristics and program needs of the justice-involved population. Integrated Dual Disorder Treatment, trauma-specific interventions and emerging use of cognitive behavior treatment are a key focus for this population.

In addition, persons with significant history of incarceration may have developed a cultural behavioral response to the experience of incarceration. Adaptive behaviors learned in the jail or prison setting may be antithetical to adaptive behaviors in the community or in community treatment settings. (See Attachment 11.)

9. Facilitate partnership building at the community level.

LACs are uniquely positioned to address criminal justice/mental health issues. Discussions with stakeholders suggest that not all advisory councils have sufficient criminal justice representation, nor are they sufficiently familiar with diversion and reentry literature. Reviewing

¹³ Metraux, S., Culhane, D., & Hadley, T. (2001). *The New York/New York Agreement Cost Study: The impact of supportive housing on services use for homeless persons with mental illness in New York City*. Philadelphia, PA: Center for Mental Health Policy and Services Research, University of Pennsylvania.

the membership of local advisory councils and developing a training curriculum for them may facilitate improved community collaboration and action.

10. Review staffing and programming at Montana State Prison.

With the mental health contract for the Montana State Prison expiring and positions reverting to state-funding, an opportunity exists to critically examine mental health staffing levels, mental health performance measures and data management, psychiatry recruitment issues, DOC staff mental health training, and refining and expanding current mental health programming.

Without a better understanding of the acuity of the current mental health caseload, it is difficult to make specific recommendations regarding enhanced staffing for Montana State Prison. Certainly additional psychiatric coverage is needed. One psychiatrist prescribing for over 380 inmates is insufficient. Telemedicine can be an option as discussed below. During our visit, the onsite psychiatrist reported he felt he could recruit an additional psychiatrist if funds were available and pay attractive. Some states have provided pay differentials to attract psychiatrists to hard-to-recruit areas.

Programmatically, 16 residential psychiatric beds at Montana State Prison would seem insufficient, considering the active caseload for the mental health unit is over 400 inmates, approximately 30% of the total prison population. Communication with DOC mental health staff indicates that an assessment of the need for step down beds is underway. The current caseload should be reviewed to identify individuals with repeated residential admissions, frequent disciplinary infractions or who are not able to meaningfully participate in prison programs. Mental health residential programs in prison settings have been shown to decrease disciplinary infractions, reduce suicidal behavior, reduce mental health crises, and reduce the need for hospitalization.¹⁴

Improving integration between the mental health services and the chemical dependency programs should also be considered. Staff from both units cited the need for improved program integration and collaboration.

11. Continue to explore use of telemedicine to address provider shortages.

We are aware that Montana is exploring the use of telemedicine, but implementation is limited by lack of providers. Still, telemedicine is being used successfully in state corrections in other states. Review of attached articles indicates that telemedicine is used in federal prisons, state prisons, jails, and for forensic evaluations. Telemedicine is also a valuable resource in transition planning from jails, prison, or the state hospital where distance may preclude face-to-face interviews or assessment by community providers. Telemedicine is also used to support primary physicians practicing in rural settings. Articles report both physicians and patients accept the practice. (See Attachments 12-17.)

Implementation requires the telemedicine units be strategically placed and that separate agencies, for example, DPHHS and DOC, consult on equipment requirements to insure that telemedicine equipment is compatible. State psychiatric resources are meager. Perhaps

¹⁴ Condelli, W.S, Bradigan B., & Holanchock H. (1997). Intermediate care programs to reduce risk and better manage inmates with psychiatric disorders. *Behav Sci Law*. Autumn; 15 (4):459-67. PMID: 9433748 PubMed - indexed for MEDLINE

arrangements could be made with an out-of-state university medical center or with out-of-state practitioners.

12. Explore use of peer services in transition planning and community services.

Peers can be used as “bridgers” in reentry planning or as part of multidisciplinary teams. Peer-delivered programs such as Wellness Recovery Action Planning (WRAP) have proven effective with the justice-involved population in many communities (See Attachments 18 and 19). Similarly, peer drop-in centers or support centers that are justice informed can provide additional support to persons with justice involvement.

13. Develop trauma informed systems and implement trauma specific services

Approximately 90% of the men and women with mental illness participating in a jail diversion program will have a lifetime experience of trauma, and approximately 50% of men and women report an episode of trauma within the year prior to arrest (unpublished TAPA evaluation data).

- ▶ States are beginning to develop statewide initiatives to address trauma issues.
- ▶ In New Hampshire, SB 262 (see Attachment 20 and 21) established the position of an administrator of women offenders and family services within the department of corrections and established an interagency coordinating council on women offenders.
- ▶ Maryland, Maine, and Connecticut have established statewide trauma initiatives that have also been implemented with justice-involved populations.
- ▶ At the Correctional Center of Northwest Ohio trauma training led to trauma-informed practices, which improved inmate management (see Attachment 22).

14. Involve veterans groups in planning for their constituents

Involve the Veterans Administration, Veterans Centers, and Veterans support groups in planning activities at all levels to insure appropriate screening and response is available across intercepts for veterans who become justice involved.

Both California and Minnesota have passed legislation authorizing jail diversion for veterans whose crimes are related to combat stress. (Attachment 23 and 24)

V. Conclusion

DMA Health Strategies and our consulting partners, Policy Research Associates and independent consultants John O'Brien and Leslie Schwalbe, are pleased to have had the opportunity to work collaboratively with the leadership of Montana's mental health system in order to document prevalence and community needs and develop structural and financial recommendations for systems transformation. In comparison to many other states, Montana has made great progress, yet the needs for expanded community based services and supports are significant in a state challenged by poverty, a culturally diverse population and service access issues typical of rural and frontier states. Examples of the range of systems issues faced by Montana leadership include a limited range of provider agencies, a critical shortage of psychiatric providers for children and adults, needs for improved crisis response and gaps in transitional case management and intensive community based treatment options for serious mental illness and co-occurring disorders. These are true in the general and especially in the corrections population.

The state, however, has a strong track record for creative and effective use of state and federal resources that can be strengthened in a number of ways. Some options for Medicaid Waivers can augment the current HIFA Waiver, which will increase federal matches for administrative Medicaid costs. Broadened Medicaid eligibility and enrollment will permit expanded health care access for people with SDMI and transition age youth. The community service system for adults and children needs to support access to care in the community rather than in more restrictive and higher cost services such as residential placements for children, the state hospital for adults, and Corrections for youth and adults. The system will be improved through rate enhancements in targeted areas such as psychiatry, and through the development of a broader range of intensive community based services that include paraprofessional and peer supports.

Stronger coordination of and/or consolidation of child and adult mental health agencies will address systems fragmentation, and increased standardization and consistency of data reporting across state agencies and local advisory groups will assist all stakeholders in informed systems planning and evaluation. At the heart of these changes is the recommended coordination of service delivery, reimbursement and regular, standardized cross-system data reporting by a Care Coordination Organization, in a quasi-public arrangement that includes state/CCO risk sharing as well as performance incentives for providers and the CCO. Adherence to guiding principles of transparency and accountability in collaboration with all stakeholders, including consumers, local advisory groups and providers will enhance joint ownership and alleviate historical concerns about managed care. While this level of change may appear dramatic, we believe that it is necessary to achieve the promise of the President's New Freedom Commission. It is clearly achievable through the vision that Montana leadership has shown in significant system of care transformation efforts to date.