The incarceration of people with serious mental illness is of growing interest and concern nationally. Because jails and prisons are not designed to be mental health/substance abuse treatment facilities, diverting individuals with mental illness away from jails toward more appropriate, community-based mental health treatment has become an important component of national, State, and local strategies to enhance appropriate and effective mental health treatment.

Jail diversion provides a structured and well-monitored program designed to reduce incarceration and recidivism among individuals with mental illness by promoting recovery and facilitating linkage to appropriate community resources and supports. With effective linkages to
community-based services, diversion enables individuals with mental illness to live more successfully in the community, thus reducing the risk of homelessness, encounters with the criminal justice system, and institutionalization.

Problem-solving courts—drug court, family court, young adult court—focus more on active rehabilitation while providing some type of support, supervision, and utilization of community resources. More and more communities are adopting the “mental health court” model, which uses a specialized docket, assigned judge, mental health professional, and probation staff—all of whom have mental health expertise. Douglas County, Nebraska, operates a jail diversion model, a process that identifies and diverts individuals with mental illness after they are arrested. According to the National GAINS Center for Jail Diversion (http://gainscenter.samhsa.gov/html/programs/jd_map.asp), there were nearly 500 jail diversion programs operating in the United States as of 2007, compared to only a handful of programs in 1999.

Douglas County Mental Health Diversion (MHD) Program uses post-booking jail diversion to place individuals with a serious mental illness or co-occurring substance abuse disorder out of incarceration and into the community. The program also provides any appropriate supports that were not being accessed at the time of arrest. Jail diversion programs have emerged as a viable solution for individuals with mental disorders, giving judges and prosecutors an alternative to incarceration as well as reducing the social cost of inappropriate or no mental health services.

Origins
With a population exceeding 510,000, Douglas County is the most heavily populated county in Nebraska, representing more than 30 percent of the total State population. This community is served by the Douglas County Department of Corrections (DCDC), which has a capacity of 1,453 beds and an average daily population of 1,160 inmates. In 2005, 20 percent of 199 inmates surveyed during one week at DCDC reported some form of serious mental illness. Many of them were charged with nonviolent property offenses such as trespassing, littering, etc.

Three main risk factors were identified among this population:
• Untreated mental illness.
• Homelessness.
• Unemployment (or lack of structured activity).

These factors most likely increase symptoms for the mentally ill, thereby escalating contact with the criminal justice system and leading to a revolving cycle of recidivism.

Douglas County officials recognized the need for a more appropriate system of caring for the mentally ill as well as better serving public safety. In 2006, the county initiated MHD, a voluntary, post-booking diversion option for mentally ill adults. This initial program was developed after more than 18 months of cooperative planning between Douglas County’s Community Mental Health Center, DCDC, and the Douglas County Attorney’s Office. Community mental health providers, advocates, corrections, law enforcement, courts, and other stakeholders were also involved; the program was grant-funded for three years through a local nonprofit organization. Since its inception, these same community stakeholders continue to provide the support and direction needed for MHD through quarterly advisory committee meetings and various other collaborative efforts. Because of the demonstrated success of MHD, Douglas County will provide ongoing funding after the grant period.

Process
Participation in MHD is voluntary. Individuals who qualify for the program are those who are in contact with the criminal justice system because of mental health or co-occurring disorder issues. Good candidates for MHD are individuals who exhibit an ability and willingness to participate in and receive assistance from the program and agree to develop and work on identified goals and MHD requirements. Other admission criteria require that participants
• Be at least 19 years of age.
• Be charged with a nonviolent offense.
• Live within Douglas County.
• Suffer from a serious mental illness or co-occurring disorder.
• Do not present a risk of danger to self or others.
• Are deemed appropriate for the program by their current mental health provider, if applicable.
• Are authorized for participation by the county attorney and/or city prosecutor.

MHD works with prosecutors, public defenders, community-based mental health and substance abuse providers, and the courts to develop and implement a plan by identifying and diverting some individuals with serious mental illness from the traditional justice system into intensive case management services. Treatment plans are individualized and designed to help participants establish independent living skills, increase management of mental health issues, and reduce contacts with the criminal justice system.

Although the request for participation may be initiated by potential participants, referrals for MHD come primarily from attorneys and officers who do the initial screening at the time of booking. Each person booked into DCDC is asked questions from the Brief Jail Mental Health Screen:
• Have you ever been hospitalized for mental illness?
• Do you now or have you in the past taken medication for mental illness?
• Do you now or have you in the past been in outpatient treatment for mental illness?

In 2010 there were 18,994 individuals booked into DCDC. Per self-report at booking, 2,242 individuals (or 12 percent) responded positively to one or more of these questions.

Any person identified by this initial screening is referred to a clinical screener, who assesses the individual for the MHD program. This additional assessment includes an in-depth interview regarding the individual’s mental health, substance abuse, legal history, and a review of any criminal record. It also involves obtaining releases and making collateral contact with mental health providers, family, and others involved (when appropriate); reviewing the expectations of MHD; and developing potential treatment plan goals.

Based on this assessment, a recommendation is made to the appropriate prosecuting agency (county attorney and/or city prosecutor). Ultimately, acceptance into MHD is obtained from the prosecuting authority after a review of the candidate’s history and if the individual and the community are best served by adjudication through diversion. After a candidate is accepted, a formal, individualized treatment plan is developed that identifies goals agreed to by both the participant and MHD. This provides a guide for the participant and MHD by identifying rehabilitative and supportive interventions with a focus on activities of daily living, education or prevocational activities, budgeting, medication education, relapse prevention skills, social skills, and independent living skills. Once developed, the formal treatment plan is reviewed and signed by the participant and MHD and submitted to the attorneys involved as well as to community providers who have been identified as part of the plan. A progress note is completed quarterly, reviewed and signed by the participant and MHD, and then submitted to those involved.

Participation in MHD is expected to be a minimum of six months; an average length of stay is 7.6 months. Individual charges, needs, and progress on treatment goals determine the overall length of participation; thus, there is no time limit on involvement in MHD if the participant is engaged in the treatment plan. A recommendation for discharge is presented to the prosecuting attorney when:
• Treatment plan goals are met.
• The participant demonstrates independence without extensive support.
• Ongoing formal and informal supports are in place.
• A relapse prevention plan has been completed.
• Mental health providers concur that diversion has been successfully completed.

For participants who successfully complete MHD, charges are reduced or dismissed. Unsuccessful participants are prosecuted for the original charge.

The success rate for completing MHD was a notable 80 percent in 2010 (76 percent since 2006). Reasons for not completing the program in 2010 included participant request, lack of progress/participation in plan, dropped out/could not locate, and the incurrence of additional serious charges.

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Intensive Case Management Model
Connecting people in the criminal justice system to treatment, housing, and support within their own community is an integral part of diversion. MHD utilizes an intensive case management model for treatment. Using the individualized treatment plan as a guide to meet participant needs efficiently, MHD collaborates with both participants and providers in an effort to assess, plan, facilitate, and advocate options and services. MHD currently employs two intensive case management staff members, educated in mental health and knowledgeable about community resources, who work with a small caseload of 15 to 20 participants. New participants are seen more frequently than participants nearing the completion of MHD. Working collaboratively with MHD participants in multiple areas, intensive case managers interact with the supports in the community, use an interdisciplinary approach while providing ongoing assessment of needs, and review participants’ treatment plans. Intensive case management identifies and prioritizes problem areas and also offers a collaborative relationship that is supportive, educational, and trusting.

Intensive case managers work with participants to acquire the necessary support services to achieve independent living, such as securing mental health/substance abuse services; applying for benefits; finding appropriate/safe housing; facilitating prevocational or educational activities, parenting skills, coping skills, and relapse prevention planning; and establishing basic resources that can be maintained independently.

MHD intensive case management is also administered in the community, usually at a participant’s place of residence, although this may vary with participant need. MHD intensive case managers have access to an automobile to transport participants when necessary, ensuring timely arrival at scheduled appointments and access to places where public transportation is unavailable. Although the idea of providing transportation may appear one dimensional, this is an opportunity for case managers and participants to build rapport, practice social skills, and engage in problem solving. The long-term goal is for participants to independently maintain consistent transportation and be able to use city transportation.

MHD also uses peer-support professionals who have experience with mental illness. They are familiar with issues of substance use, incarceration, homelessness, etc., and are actively participating in recovery. Peer-support staff members, with their unique social experiences and specific knowledge, are now viewed as integral to a successful mental health program.

Basic Demographics
From its inception in 2006 through December 31, 2010, MHD has served 184 individuals; 157 have been discharged, and 27 are currently active with MHD. The average age of participants is 35. A majority of
MHD participants are female (58 percent) and Caucasian (62.5 percent). Other races served include African-American (33 percent), Asian (2 percent), Hispanic (2 percent), and Native American (0.5 percent). The main Axis I mental health diagnoses provided by psychiatrists are Mood Disorder (60 percent), Psychotic Disorder (35.5 percent), Anxiety Disorder (3 percent) and other diagnoses (1.5 percent). An Axis II diagnosis indicated a secondary diagnosis of developmental disability (8 percent).

According to self-reports at the time of initiation, MHD participants indicate that they have issues with substance abuse (53 percent), a history of trauma (71 percent), and, at some time, they were committed to treatment against their will by the Board of Mental Health (36 percent).

Outcomes
MHD has demonstrated high levels of success. Of the 184 individuals served, 76 percent have successfully completed the program. Each participant involved in MHD, whether successful or unsuccessful, is contacted after discharge from MHD at intervals of 30 days, 90 days, 6 months, and 12 months. This allows the case manager to assess stability and offer support or referrals as needed. Information obtained during follow-up contact also involves hospital and jail days and participation in evidence-based practice models such as substance abuse treatment, employment, community support, illness management and recovery, and family education. In 2010, 160 such follow-up contacts were made: 131 contacts with successful participants and 29 contacts with unsuccessful participants.

In the first year following discharge, individuals who had completed the diversion program spent 76 percent fewer days incarcerated, and they cost $38,340 less (at $90 per day) than those who did not complete MHD. Cumulatively since 2006, individuals who completed MHD spent 91 percent fewer days incarcerated, and cost $480,600 less than those who did not complete the diversion program. These numbers reflect a fairly small group of individuals: 157 discharges in the past five years. The minimum expectation of any jail diversion program is reduced recidivism and improved safety in the community; long-term goals of MHD participants include stable housing, ongoing use of appropriate mental health and/or substance use services, enhanced quality of life and control of symptoms, meeting court dates and legal obligations, and meaningful engagement as productive members of the community.

Summary
Individuals who are incarcerated while experiencing crises in addition to homelessness, substance abuse, and mental illness are still in crisis when released if treatment is not offered and resources are not provided. As the results of MHD and similar alternatives to incarceration demonstrate, the provision of individualized treatment planning and intensive case management in lieu of confinement, when appropriate, reduces criminal justice costs by focusing on treatment resources. By placing mentally ill individuals in jail rather than in treatment, society loses the contributions that people can make when they are appropriately treated.

Considering the impact of savings in incarceration costs, the expansion of programming like MHD should be an easy decision for the justice system; it is a frequently cited fact that jails have fast become the largest institution serving the mentally ill. Even though MHD and similar programs are quite small compared to the volume of mentally ill individuals in the legal system, it is hoped that ongoing evidence of cost savings will indicate that such programming is a viable option for some offenders and that more funding for continuing such programs will follow. Ongoing statistics indicate that a system that focuses on treatment and promotes recovery through program options like MHD:

- Helps with overcrowding.
- Reduces cost.
- Provides direction to participants accessing needed mental health and/or substance abuse treatment.
- Provides support and incentive for individuals to remain in treatment.
- Helps end the cycle of incarceration and crisis.
- Decreases homelessness.
- Demonstrates an increase in employment, job training, or education.

Improved public safety, cost savings, and increased quality of life result when appropriate treatment for individuals experiencing mental illness is offered as an alternative to incarceration. Community-based services provide much more comprehensive coordination of treatment as well as a better system to address the multiple issues that these individuals face.

In the words of one participant, “The stigma of being diagnosed with schizophrenia was so great I ignored it for four years. The felony charge against me I could not ignore. Mental Health Diversion gave me my life back.”

Resources


Cynthia A. Boganowski is a licensed clinical social worker and has worked for Douglas County Community Mental Health Center since 2006. She helped develop and now manages the Douglas County Mental Health Diversion Program. She received her master’s and bachelor’s degrees in social work from the University of Nebraska at Omaha and has more than 20 years’ experience working with individuals of varying ability, including those experiencing severe and persistent mental illness and co-occurring disorders. For more information, contact the Douglas County Mental Health Diversion Program, c/o Department of Corrections, 710 South 17th Street, Omaha, NE 68102. Or call 402–599–2338, or e-mail