House Bill 843
Criminal Justice / Behavioral Health Work Group

Introduction

The process utilized by the work group started with some general education regarding the purpose and intent of HB 843, as well as a review of some model programs and services from around the country. The group met on four different occasions, and evolved into four smaller subgroups with each focusing on one of the following: diversion, treatment in the jails, reintegration into the community and juvenile justice issues. There was excellent cross-systems representation which included consumers and representatives from the Kentucky Chapter of the National Alliance for the Mentally Ill, Department of Mental Health, Department of Corrections, Administrative Office of the Courts, Kentucky State Police, Criminal Justice Council, the Judiciary, Regional Planning Councils, Sheriffs' Association, Jailers' Association, County Attorneys, Public Defenders, Protection and Advocacy, Department of Juvenile Justice, Community Mental Health Center staff, Kentucky Correctional Psychiatric Center staff, Kentucky Association of Regional Programs (KARP), and the Kentucky Mental Health Coalition. The four smaller subcommittees' final analysis is what has comprised this work group report.

Overview: Lack of an Integrated System and Lack of Funding

Currently in Kentucky, the response to the relapse-arrest-incarceration cycle of persons with severe mental illness is at a local level with varying degrees of collaboration among various stakeholders. An individual with serious mental illness involved in the criminal justice system crosses many systems' boundaries as he moves from life in the community to incarceration and back again. Historically, approaches have been created within each system, rather than across systems. These approaches do not address the fragmentation of service delivery when a person moves from one system to another. These approaches only address portions of the individual's needs as well as offering "band-aid" solutions to the community's concerns. The integration of services within community-based mental health and substance abuse treatment systems and the criminal justice system is the only practical approach. This is a problem which must be addressed at multiple levels and across multiple systems; only through collaboration will we be able to create a truly integrated system which will meet the needs of those individuals at the interface of criminal justice and behavioral health.

Each of the Regional Planning Council reports noted the ongoing confusion as to who has the responsibility for paying for mental health/substance abuse evaluation, treatment and services for individuals at every step of the continuum of services within the criminal justice system. While there are examples of outstanding programs and collaborative efforts in a number of the regions, the lack of adequate funding continues to plague these programs. Often, there is a lack of funding for start-up costs of any program which may be initiated to meet the needs of these individuals. The lack of funding has led to many individuals in the criminal justice system not receiving the behavioral health care they so desperately need.

Prevalence and Background

Over 10 million adults each year are booked into U.S. jails. Approximately 700,000 of these 10 million individuals enter the criminal justice system with a severe mental illness and 75% of these individuals also have a co-occurring substance abuse disorder. These national statistics reflect an increase, over the last 30 years, in the number of persons with severe mental illness who have contact with the criminal justice system. The de-institutionalization movement coupled with the ongoing stigma related to mental illness, the lack of adequate financial resources to fund behavioral health services in the correctional setting and in the community, fragmentation of services between the criminal justice system and the behavioral health system and the advent of managed care have all contributed to the "criminalization" of mental illness.

The Commonwealth of Kentucky began to address the criminalization of mental illness over ten years ago by drafting legislation to address the involuntary hospitalization process and attempting to gain federal funding for jail diversion programs. In 1993, the Governor signed an Executive Order which appropriated funding designed to eliminate the incarceration of individuals awaiting involuntary hospitalization procedures for nine pilot projects affecting 22 counties. In July of 1994, HB 207 became law; it prohibited the jailing of any individual awaiting evaluation for involuntary hospitalization. These efforts have been successful statewide at eliminating the incarceration of individuals pursuant to KRS 202A. There remains, however, the issue of persons with severe mental illness who have contact with the criminal justice system in the form of misdemeanor violations of the law.

Of the 15,500 persons currently incarcerated in Kentucky's prison system, approximately 16% suffer from a severe and persistent mental illness; 59% suffer from a substance abuse disorder. The current number of persons with severe mental illness housed in county jails is unknown. There are currently four times as many persons with severe mental illness incarcerated in Kentucky prisons than are hospitalized in the state psychiatric facilities.

A "revolving door" cycle of relapse, arrest and incarceration has led to a multitude of systemic problems for individuals with a severe mental illness and for their families, as well as for their local communities. Many of these individuals commit non-violent crimes as a result of symptoms of their illnesses (e.g., in response to auditory hallucinations). Rather than receiving the treatment that could ameliorate these symptoms, these individuals are incarcerated in the criminal justice system, which is not equipped nor designed to provide the rehabilitation and treatment that could minimize the symptomology of these illnesses. In addition, the processes involved in prosecuting and incarcerating these individuals utilizes resources in the criminal justice system that could be better spent on the treatment of offenders who have a mental illness, substance disorder or dual diagnosis who are currently incarcerated or on the identification and prevention of criminal acts by individuals who do not have mental illness, but rather a true criminal intent.

Work Group Findings and Recommendations

Specific recommendations for intervention, drawn directly from the HB 843 Regional

Planning Councils' current reports are listed below. These are organized along the continuum and are not prioritized in any other fashion than by the continuum of an "ideal array." Each regional Criminal Justice/Behavioral Health Planning Group could then develop their own ideal array to meet the needs of individuals in their specific region. (See Menu/Chart on p. 7).

Diversion

The goal is to decrease the number of individuals with mental illness, substance abuse disorders and dual diagnoses being held in jails.

A. Pre-booking Diversion

1. Need for improved community crisis options; i.e., crisis stabilization beds, medical detox beds, mobile crisis teams and specialized intensive case managers.
2. Where needed and desired, development of local agreements between the law enforcement agencies and community mental health centers (CMHCs) as to appropriate dispositions for individuals other than jail. (Pre-booking jail diversion)
3. Specialized training for law enforcement officers as to available community resources, crisis de-escalation techniques, and recognizing and dealing with clinical symptomology. (Crisis Intervention Teams).
4. Development of shared databases between the CMHC, police, and local jails to facilitate communication, but with appropriate safeguards to protect confidentiality.

B. Post-booking Diversion

1. Improved identification and assessment of persons with mental illness, substance abuse and co-occurring disorders. Uniform assessment procedures in county jails to be completed by a mental health professional.
2. Establish court liaisons to expedite cases into diversion and community based treatment options, utilizing staff who move across systems.
3. Establish mental health courts.
4. Establish or expand drug courts.
5. Training of jail personnel on behavioral health issues; Kentucky jails currently provide little or no training to staff on dealing with these issues.
6. Provision of specialized case management services at the earliest point of identification (ideal caseloads of 10-15).
7. Remove the barrier related to communication between the behavioral health community and jails and prisons.
8. Wrap-around funds need to be made available, where dollars follow the client to meet emergency needs and other support services.
9. Assure that assessments and treatment plans are culturally sensitive.
10. Allocate funds to increase access to transportation.
11. Set time limits on the validity of 202A orders.
12. Examine the efficacy of a central location for triage and "drop-off" center.
13. Allocate "start-up" funding for pilot projects.
14. Provide technical assistance for consultation available in each region.

Incarceration

1. Ongoing confusion related to responsibility for the payment for mental health evaluation, treatment and services has lead to many individuals not receiving the care they so desperately need. There is no linkage back to the community mental health center for individuals when they are released, thus increasing the likelihood of reoffending.
2. Widespread concern regarding the lack of treatment for individuals being housed in the county jail was expressed in virtually every Regional Planning Council report. One possible approach would be the development of specialized regional jails in some areas of the state. The inmates identified as needing mental health and/or substance abuse services could be sent to these specialized facilities and receive treatment by trained behavioral health professionals. As an incentive, these jails could receive an increase in the per diem payment from the Department of Corrections for housing special-need inmates and for the provision of specialized services. A number of services would be offered in these jails, including detox beds, crisis intervention services, individual and group counseling, psychiatric services, medication management and case management services.
3. Implement a “triage” system with a manned 24-hour answering system and an 800 number that local jails/law enforcement can call when faced with a subject displaying signs of mental illness. This “triage” system could identify the proper resource/provider in that area to assess the subject and determine any immediate treatment needed (i.e., detox, medication, Crisis Stabilization Unit, etc.).
4. Implement mandatory, consistent statewide training for all corrections, law enforcement and judiciary staff. This training would instruct them in the identification of mental illness, proper de-escalation techniques, and the proper use of the triage system.
5. Provide incentives to local facilities to implement six-month substance abuse programs and mandate that at least one jail in each region, and preferably more, be required to have such a program. Also, provide incentives for these “Regional Drug Treatment Facilities” to have a detoxification unit with properly trained staff.
6. Mandate that in-house drug treatment be made available to misdemeanant offenders first, then class D felons, then class C felons. This would provide drug treatment to individuals before their criminal activities increase to a higher level.
7. Provide programs to ease the transition from substance abuse programs or “boot camps” to the streets. This would require participants to live in a halfway house or “step down” program before being completely paroled or probated. Currently, there appears to be too much culture shock when taken from incarceration and placed directly back on the streets. A “step down” program would decrease the rate of recidivism.
8. Provide funding to implement these programs, perhaps having the provider charge fees to insurance companies, medical cards, etc.

Reintegration into the Community

1. Pre-release planning, both for county jails and the Kentucky State Reformatory . to be done prior to the individual’s release into the community; it would include a functional assessment and a systemic assessment geared to the individual’s needs; i.e., housing, eligibility for entitlements, transportation, family supports, etc.
2. Linkage to and communication with the community mental health centers needs to be assured prior to release.

3. Require all individuals released from county jails or prisons who have been identified as mentally ill or having a substance abuse disorder to have an appointment at the local mental health center within 14 days of release.
4. Develop step-down treatment facilities to ease the transition from jail to the community.
5. Specialized housing for persons being paroled or released from jail or prison needs to be developed. Many felony offenders are "automatically" eliminated from eligibility for low income housing by virtue of their criminal histories. The unavailability of decent, affordable housing with varying levels of support, such as case management, may be the greatest contributing factor to the revolving cycle of arrest, incarceration, release.
6. Probation and Parole needs to have staff specially trained in working with persons with mental illness, substance abuse disorders and co-occurring disorders and have access to the resources available in the community to meet the needs of these individuals.
7. Develop a procedure where an individual who has a history of mental illness or substance abuse problems could be paroled one to two years prior to serve-out and sent to a therapeutic half-way house which would be defined as a correctional facility. Engaging in treatment would be a condition of their parole. Otherwise, they will serve their sentence out, but then have no "legal incentive" to engage or remain in treatment. This therapeutic parole would also address the situation where an individual is denied parole solely on the basis of their behavioral health diagnosis.
8. Uniform valid risk assessment procedures need to be developed and utilized in decision-making across systems.
9. Appropriate vocational assessment and training services should be part of the support services made available prior to release or in therapeutic parole facilities.
10. Medicaid policies regarding application for services or reinstatement of services upon release need to be re-evaluated.

Juvenile Justice System Issues

Prevention

1. Early identification and intervention services do prevent later involvement with the juvenile justice system. Therefore, it was suggested that the criminal justice and behavioral health communities should support the Early Childhood Program passed by the 2000 General Assembly, in particular, the HANDS program and other home-based interventions. It should be noted that this specific language was not included in any of the Regional Planning Council reports.
2. The other prevention measure discussed was the expansion of services to substance-abusing pregnant women. This recommendation was included in Regional Planning Council reports primarily as a Medicaid expansion to cover substance abuse services. The significance of this recommendation would be healthier babies who are better equipped to achieve their developmental milestones and learning goals.
   As a corollary to this recommendation, it may be prudent to either pass legislation or promulgate administrative regulations which ensure that pregnant women who are abusing substances are not prosecuted for committing an illegal act, provided they are receiving treatment. In addition, if the women remain in treatment, the risk of having their children removed from the home would be minimized.

The Juvenile Justice subgroup then focused on collaboration issues as a mechanism to improve services to the juvenile population and their families.

Recommendations

1. It was recommended that there be an increase in school-based services in an attempt to identify children at risk before they become involved with DJJ. It was specifically recommended that the Bridges grant be continued and expanded throughout the Commonwealth and mental health services available in schools be expanded. The Bridges grant currently is operating in the Mountain, KY River and Cumberland River regions. It should be noted that the recommendation to expand school-based services was included in Regional Planning Council reports.
2. It was recommended that the Family Resource Youth Service Centers (FRYSC's) be developed in any school which is currently without one but has expressed an interested in having a FRYSC. This service has both a collaboration and prevention perspective since some children may be identified early and thereby may not later become involved in DJJ.
3. It was recommended that drug courts be expanded to all communities expressing a desire to have a drug court. The subgroup stressed the value of drug courts and in particular, juvenile drug courts. The expansion of drug courts was included in Regional Planning Council reports.
4. Consideration should be given to the establishment of juvenile detention/safe center in some of the regions, where evaluation and treatment would be readily available.

In conclusion, the juvenile justice subgroup stressed the importance of focusing upon community and home-based services versus high-end and high-cost services.

KRS 202A and KRS 504

These two statutes, which deal with involuntary commitment and competency to stand trial respectively, are mentioned frequently in the Regional Planning Councils' reports and are described as problematic and in need of further exploration. There appears to be a gap between the criteria for civil commitment and the criteria for being declared competent to stand trial—with the result in some cases of individuals being released to cycle repeatedly through the community mental health and the criminal justice systems or their being confined without either treatment or prosecution. Further study of these statutes and development of recommendations could be directed in a later phase by the HB 843 Statewide Commission.

Funding for Program and Systems Change Initiatives

See Menu/Chart of Regional Service Array Components on next two pages.

MENU OF REGIONAL SERVICE ARRAY COMPONENTS

- Adequate resources made available to each region
- Funded by pooling of resources across systems
- Decisions about choice of and structure for service array components to be made by the Regional Planning Council, upon recommendation of the Regional Criminal Justice/Behavioral Health Planning Group, if one is established by the Council

Cross-System Education & Training

Comprehensive Crisis Intervention Training (CIT) for Police
Education of Judges and Attorneys on Behavioral Health issues
Cross-training for Behavioral Health professionals on Criminal Justice issues
Education of Jailers and Other Corrections Personnel on Behavioral Health issues

Diversion

Implementation or Expansion of Drug Courts
Pilot Implementation of Mental Health Courts

Crisis Stabilization Services

Mobile Crisis Team 24/7

Staff

Special Intensive Case Manager
Community Resource Coordinator

Residential Facility/Service Delivery Site

Behavioral Health Evaluation
Alternative to Jail
Emergency Housing
Transitional Reintegration Housing from Jail or Prison
Community-Based Treatment

Specialized Regional Behavioral Health Jail

Behavioral Health Evaluation
Mental Health Treatment
Substance Abuse Treatment
Medication Management