

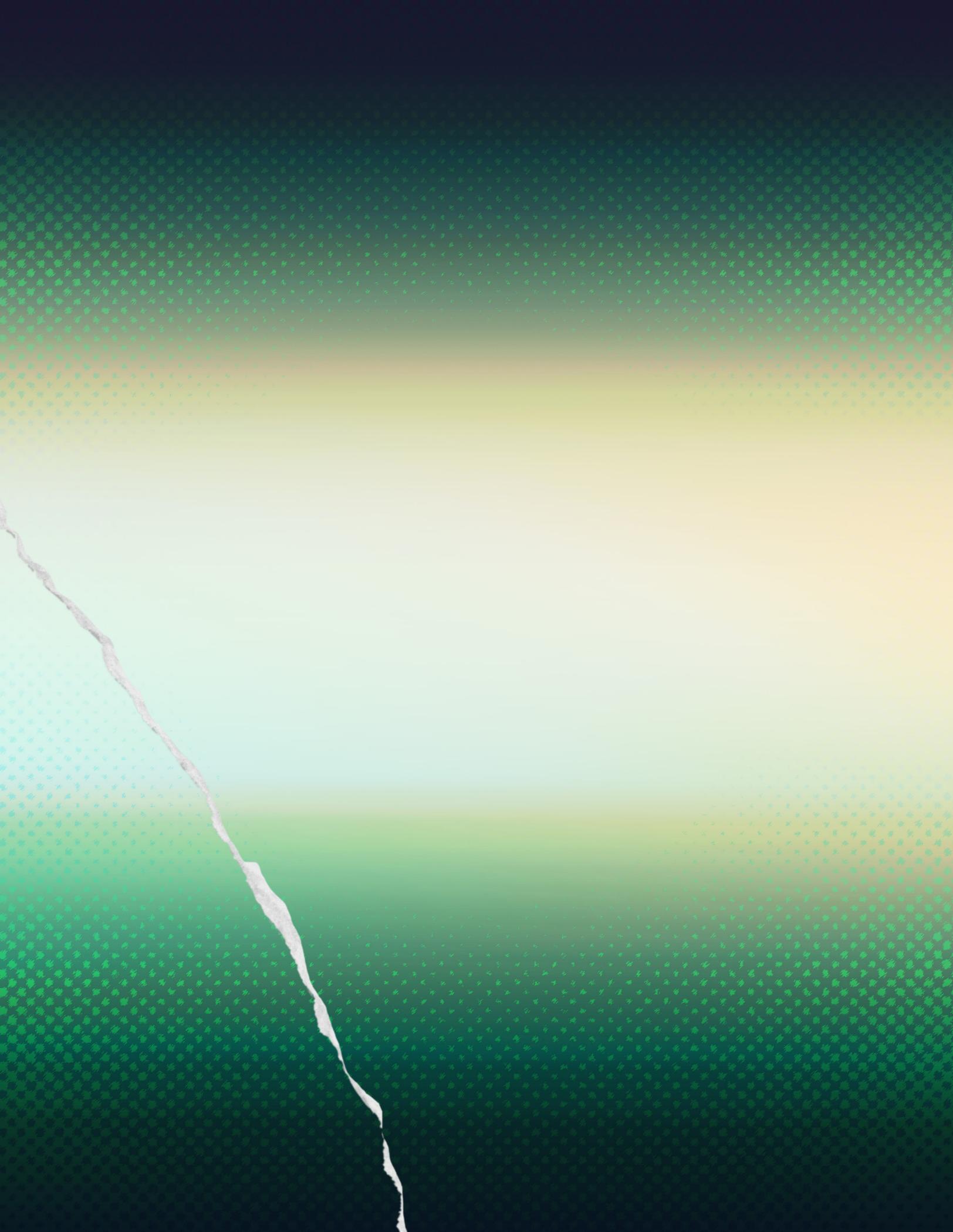
Sheriffs Addressing the Mental Health Crisis

in the Community and in the Jails



COPS
Community Oriented Policing Services
U.S. Department of Justice





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Letter from the Director of the COPS Office

Colleagues:

Since the late 1960s, long-term care facilities and psychiatric beds have been replaced with community-based care options for individuals diagnosed with mental illness. Although the trend toward deinstitutionalization was intended to provide the least restrictive care, an unintended result has been a critical lack of inpatient and secure treatment facilities for people with serious mental illnesses. In communities today, front-line law enforcement officers are called upon to intercede with individuals in mental health crises, de-escalate violent situations that can threaten public safety, and respond to repeated service calls for individuals engaged in nuisance crimes. With limited inpatient and community-based mental health resources available, a growing number of individuals arrested and housed in jails are suffering from serious mental health and psychiatric issues.¹

The Major County Sheriffs of America (MCSA) and the National Commission on Correctional Health Care (NCCHC) partnered with the COPS Office to identify successful practices that local law enforcement can employ to reduce the arrest and incarceration of people living with mental illness in their jurisdictions. MCSA and NCCHC closely collaborated with sheriffs' departments in seven case study sites and engaged all MCSA partners in an optional questionnaire. Sheriffs, deputies, and front-line officers have identified six critical practices that have reduced arrest and incarceration: (1) crisis intervention teams (CIT), (2) arrest diversion, (3) mental health courts, (4) mental health screening during jail processing, (5) mental health treatment in custody, and (6) discharge planning. These practices have demonstrated success in reducing the frequency of arrests of people with mental illness, diverting them from the criminal justice system, and treating them when they are incarcerated.

In addition to the seven case study sites, readers will also find a number of other innovative mental health practices and resources described in this publication. On behalf of the COPS Office, I want to express our appreciation for all the collaborative work by law enforcement agencies and community service providers to address this critical issue. We are also grateful to the MCSA and the NCCHC as well as the seven case study sites and all agencies that contributed to the research and final publication.

With the high level of dedication and openness to new ideas demonstrated by sheriffs and police departments, we believe that local law enforcement leaders and stakeholder agencies across the nation can make significant progress in a proactive response to the current mental health crisis, thereby increasing the safety of our communities.

Sincerely,



Phil Keith
Director
Office of Community Oriented Policing Services

1. "Jailing People With Mental Illness," National Alliance on Mental Illness, accessed July 10, 2018, <https://www.nami.org/Learn-More/Public-Policy/Jailing-People-with-Mental-Illness>.



Letter from the President of the Major County Sheriffs of America

Dear colleagues,

It is not a secret that correctional facilities in the United States are also the nation's largest mental health providers, but it is often not considered a law enforcement priority. On the contrary, the Major County Sheriffs of America believes it is a major priority that needs to be addressed with a sense of urgency. It is our responsibility as sheriffs and community leaders to be the voice for people with mental illness in the criminal justice system.

This report addresses ways our nation's largest law enforcement agencies are addressing this crisis head on. With a goal of improving behavioral health outcomes and reducing recidivism among individuals with a history of mental illness, MCSA member agencies are implementing innovative strategies that are having a positive impact on the lives of people with mental illness in their communities.

These programs, as you will see in this report, aim to eliminate the gap in behavioral health care, strengthen transition into the community, and establish continuous care treatment upon release. Each program's ultimate objective is to connect participants with community behavioral health providers and establish strong and long-term social, emotional, and community support networks.

As law enforcement professionals, we are committed to helping community members who find themselves in unfortunate situations. We are the ones who are called to stand in the gap when all other systems have failed. I encourage you to study the examples in this report and then look for innovative ways to help people with mental illness in the communities you serve.

Sincerely,



Sheriff Grady Judd (Polk County, Florida)
President
Major County Sheriffs of America



Disclaimer

The information regarding the programs, practices, and responses to contacts with individuals with mental disorders is a dynamic process that continues to evolve. This report is a product of examining what several sheriffs' offices were doing at a point in time to identify efforts that are working. These sheriffs

have undoubtedly continued to improve on the successes they have had. A point of contact has been provided for the seven sheriffs' offices highlighted in this report to assist readers in gaining current information and for questions and updates.



Executive Summary

This publication is the outcome of a grant from the Office of Community Oriented Policing Services (COPS Office) to the Major County Sheriffs of America (MCSA) and its study partner, the National Commission on Correctional Health Care (NCCHC). The purpose of the grant was to identify successful practices conducted by members of the MCSA related to reducing the arrest and incarceration of people living with mental illness in their jurisdictions. There is both anecdotal and research evidence that the number of people with mental illnesses being contacted by law enforcement and subsequently becoming involved in the criminal justice system is growing (Fellner 2014; James and Glaze 2006; Reuland and Margolis 2003). The increased contact with law enforcement and continual involvement with the criminal justice system creates problems for the individuals being arrested and incarcerated. This is true for the law enforcement and correctional professionals as well, who must try to meet the needs of these individuals in a context and environment not suited to maintaining their safety or mental stability.

The MCSA identified a number of jurisdictions across the United States that could provide expertise in identifying, vetting, and describing current practices by their peers that are demonstrating effectiveness in reducing the arrest and incarceration of people with mental illnesses. The organization then solicited the expertise of the NCCHC for the purpose of developing the structure and process for gathering data, analyzing data, and preparing the final report. Representatives from MCSA member jurisdictions and the NCCHC convened and developed a questionnaire to be sent to all MCSA members inquiring about their

practices related to reducing the number of people with mental illnesses in their local criminal justice system at all points from first law enforcement contact to incarceration and subsequent re-entry to the community.

The questionnaires were sent to all 78 member counties of the MCSA, with 29 percent completing the questionnaires in all three identified areas (sheriff's office, field operations, and jail operations). The responses to the questionnaires were analyzed and the counties with the most effective practices across the board—or with particularly promising or effective practices in specific areas (such as diversion or re-entry)—were identified and selected for site visits by the MCSA and NCCHC teams. Site visits were used to gain more information and a clear understanding of how the effective practices were developed, implemented, and monitored for ongoing performance and improvement.

Across jurisdictions, the site visit teams found that six specific practices were occurring that had a direct impact on reducing the arrest and incarceration of people with mental illnesses:

1. Crisis Intervention Team (CIT) trained emergency responders, case workers, and dispatchers
2. Active diversion of people with mental illnesses from incarceration
3. Mental health / problem solving courts
4. Mental health screening in jail
5. Mental health treatment in jail
6. Discharge planning / re-entry

In terms of site-specific strengths, the following findings were most prominent:

- **Jefferson County, Colorado:** This sheriff's office has developed excellent drop-off centers. Field officers are CIT trained and are therefore able to identify when an individual they encounter may be suffering from mental illness. When it has been determined that there is the possibility of mental illness, the officers are able to take the individual to one of several drop-off centers within the jurisdiction where an evaluation takes place and often diversion away from jail and the criminal justice system occurs.
- **Hillsborough County, Florida:** The sheriff's office has made a concerted effort to implement CIT training, with more than 1,000 officers being trained as of the date of the site visit in fall 2015. The CIT officers are able to assist those with mental illness in enrolling into mental health treatment or other diversion programs.
- **Ventura County, California:** The sheriff's office has implemented a program entitled Rapid Integrated Support and Engagement (RISE), which meets the needs of homeless individuals with mental illnesses who come into contact with law enforcement.
- **Bexar County, Texas:** Through collaboration with private partners, Bexar County provides some funding to Haven for Hope, which is a comprehensive nonprofit program providing a variety of services. This partnership helps law enforcement agencies in Bexar County divert individuals with special mental health needs from the jail to Haven for Hope pretrial programs. Programs also exist to assist posttrial individuals with supportive housing, rehabilitation programs, and training to assist them in moving back into the community.
- **Cook County, Illinois:** The Cook County Sheriff's Office has developed comprehensive treatment services for people with mental illnesses in the Cook

County Jail. Most notably, the emphasis is on maintaining the mental health of all who are incarcerated in the facility rather than primarily stabilizing and treating those with mental illness, although the staff are excellent in this regard as well.

- **Los Angeles County, California:** The Los Angeles County Sheriff's Department is the first sheriff's office in the nation to develop mental evaluation teams, which consist of mental health professionals riding along with field officers, making them immediately available to address issues of mental illness as they are encountered in the community.

The review of these programs and services yielded specific recommendations that counties and sheriffs' offices across the country can follow, which will meet the goal of reducing the arrest and incarceration of people with mental illnesses. To summarize the recommendations, an awareness of the presence and impact of mental illness is essential across the continuum of law enforcement disciplines and agencies. It is critical to immediately identify the potential presence of mental illness from the time of first observation and contact with an individual through the process of incarceration (if this cannot be prevented) and re-entry. The awareness and deliberate planning and implementation of services designed to meet the needs of people with mental illnesses in a context and environment that is not designed or suited for them is critical if they are to maintain stability and avoid future relapse and recidivism.

As a follow-up to this grant project and study, the MCSA is planning to conduct trainings and hold conferences to further the work of improving how law enforcement responds to mental illness. The goal is to address and treat mental illness in clinical settings as much as possible but to also prevent people with mental illnesses from becoming inextricably entangled in the criminal justice system as the result of their mental illness.

Background

Jails and prisons are the largest providers of mental health treatment in the United States today as a result of deinstitutionalization beginning in the 1960s and decreased funding for community-based treatment (Treatment Advocacy Center 2014). While there are critical situations where law enforcement must use their authority to de-escalate violent or potentially violent situations threatening public safety, all too often officers have no other option but to arrest and confine individuals with mental health issues even if order is restored.

In many cases, after arrest and incarceration the criminal justice system—including prosecutors, defense attorneys, and the courts—is unable to address the mental health needs of the individual as a result of the same lack of resources, and the individual will be back in the community and able to re-offend. All too often the cycle of arrest, confinement, and release continues until the individual causes serious harm to themselves or others.

Fortunately, many law enforcement organizations have taken the initiative to interrupt the repetitive process of dealing with individuals who suffer from serious mental health issues at the point of contact either in the community or at the time of detention. Sheriffs' offices have the opportunity to intercede in both environments, given their frequent dual responsibilities of policing in the community and operating jails. This publication presents case studies

and resources from a number of law enforcement agencies that are working effectively to address this challenge and to identify programs and processes that work. Understanding what is working and why and how it works creates an opportunity to document and share the information with other law enforcement agencies throughout the country. As agencies implement these programs and practices or create new initiatives, the odds increase dramatically that individuals with serious mental health problems will get the help they need to break the cycle of arrest and incarceration.

The Major County Sheriffs of America (MCSA) believes that a number of its approximately 80 member sheriffs have developed programs and a criminal justice system to provide mental health care services in the community. The members of MCSA collectively provide law enforcement services to approximately 100 million people and operate the largest jails around the country. Their jails not only have significant capacity but also have an annual turnover rate that processes millions of individuals who are arrested each year, and approximately 15 percent of men and 30 percent of women booked into jails have at least one serious mental health condition (NAMI 2018a). Therefore, sheriffs, their leadership and deputies, and jail and detention officers are the critical points of contact to help identify these individuals and to facilitate referrals to mental health services in lieu of arrest and incarceration when appropriate.



The Mental Illness Challenge for the Community and Law Enforcement

The major theme of this publication is the effective response of law enforcement agencies to mental illness in their communities. In 2014, the Major County Sheriffs of America (MCSA) received a grant from the Office of Community Oriented Policing Services (COPS Office) to identify programs and practices used by its member sheriffs to divert individuals with serious mental health issues from incarceration in their jails to professional mental health providers and networks. The research team examines how the needs of these incarcerated individuals are addressed by the sheriffs and associated stakeholders of the criminal justice system when alternatives to arrest are not available. The operational aspects and project findings are described in detail in the remainder of this report, but a brief overview of mental illness and its complexity are a necessary introduction to the report and will help place the report in its proper context.

Mental illness is a complex problem that historically has been undetected, unacknowledged, or not treated in a local law enforcement context. Mental illnesses may be more difficult to detect than physical illnesses as the symptoms of mental illness may be misunderstood and may be attributed to personal choices such as substance abuse or nonclinical origins such as poor social skills. When mental illness is suspected or detected by the nonclinical professional, a lack of training and experience on effectively managing patients with mental illnesses may lead to generalization, suboptimal management, and lack of appropriate initial treatment.

In addition to the discomfort and uneasiness the subject arouses in individuals and society, there continues to be much disagreement among mental health experts on even the definition of mental illness (Prins 2010; Williams, Cohen, and Ford 2014; Horwitz 2010). It is no surprise then that professionals in

law enforcement, criminal justice, and even general health care continue to debate the precise definition of mental illness. The fluid nature of definitions and treatment is underscored by the continual revision of the Diagnostic and Statistical Manual of Mental Disorders, now in its fifth formal edition (DSM-5). The fact that professionals from a variety of scientific and medical disciplines, including psychology and psychiatry, have difficulty adequately defining mental illness within and across disciplines illustrates the complexity of mental illness and the need to provide working definitions for the purposes of this report. The following working definition should be kept in mind as descriptions of various programs and processes for addressing mental illness and reducing the arrest and incarceration of people with mental illnesses are reviewed and considered for applicability across the criminal justice system.

For the purposes of this project and this report, it was decided to employ a relatively simple and straightforward behavioral description of mental illness. The description (and definition) of mental illness is as follows:

“Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment,” the latter describing individuals with serious mental illness (NIMH 2018a).

Unlike AMI, “serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI” (NIMH 2018a). Further, individuals with SMI represent the vast majority

of crisis service calls that require de-escalation and alternative responses by law enforcement. An example of SMI is schizophrenia, a psychotic disorder that includes symptoms such as visual and auditory hallucinations or thought disorders that result in dysfunctional ways of thinking (NIMH 2018b).

Law enforcement, criminal justice, and correctional professionals will quickly recognize the connection between mental illness and disruptions in behavioral, emotional, or relational functioning. While mental or cognitive symptoms are not always clear when an officer approaches a suspect on the street, individuals with serious mental illness always display disruptions of varying severity in one or more of the other categories, which are more clearly recognized and may in fact be the reason law enforcement is involved. It is our hope that the broad and general description will provide context and clarity to the remainder of this report.

Following the description of mental illness, the frequently observed connections among mental illness, substance abuse, and criminal behavior must be recognized, as should the linkages with criminal conduct, which leads to the arrest and incarceration of the person with a mental illness. There are several distinct impacts of co-occurring disorders (COD) in criminal behavior. These can be approached from the perspective of how CODs lead to criminal behavior and how CODs affect those who are involved in criminal behavior.

Particularly in the context of criminal behavior, substance abuse that co-occurs with mental illness must be expected (Minkoff 2007; Goss 2016). The available research on the prevalence of substance use on the part of those who are incarcerated indicates that approximately 85–90 percent of inmates (adolescents and adults) have used alcohol or drugs in their lifetime, and approximately 75 percent report using alcohol or other drugs on a regular basis or meet criteria for substance abuse or addiction (Van Voorhis, Schweitzer, and Hurst 2009; Foster et al. 2010; NIDA 2018).

There is a very clear connection between substance abuse and criminal behavior. In most circumstances, including all situations in which underage individuals are using alcohol or other drugs, substance use (meaning use of alcohol or illicit drugs and misuse or abuse of prescription drugs) is criminal behavior, but it also contributes to an overall attitude and pattern of general or broad criminality (Tripodi and Bender 2011; Neff and Waite 2007). Children and adolescents who use alcohol and drugs are doing so illegally, and yet the specific acts of substance use and related behaviors typically precede and contribute to a general pattern of criminal behavior that is very common among those who abuse or are addicted to alcohol and other drugs.

Researchers have identified eight specific behaviors and circumstances that have been labeled “criminogenic” (Andrews and Bonta 2010; Latessa and Lowenkamp 2005), which means behaviors and circumstances that lead to or contribute to criminal behavior and criminality. Despite substance abuse being specifically identified as one of the criminogenic needs, mental illness has not been so identified and yet can contribute to criminal behavior and criminality. There are a number of specific ways that this can occur, including hallucinations and paranoia, general mental disorganization, mania, and depression.

Auditory hallucinations and paranoia can lead individuals to believe they are in danger and so must harm or kill another person in order to protect themselves or that they will improve their life or circumstance by killing one or more other people. An example of this is James Holmes, the shooter at the Century 16 Movie Theater in Aurora, Colorado. According to court testimony, he believed that he would achieve greater self-esteem and personal power by killing other people and that the more people he killed the greater personal enhancement he would achieve (Denver Post 2016).

General mental disorganization often leads to misdemeanor-level crimes and behavior that is a general public nuisance. Examples include loitering,

homelessness, panhandling, trespassing, shoplifting, or other minor theft. The mental disorganization is typically the result of psychotic disorders that do not include paranoid ideation or hallucinations that command the individual to be violent but rather make it difficult for them to accurately perceive reality and effectively solve problems. Tragically, these behaviors often result in people with serious mental illnesses becoming involved in the criminal justice system, where they spend inordinately long periods of time and from which they have difficulty extricating themselves (Bailargeon et al. 2009; Harris and Dagadakis 2004; James and Glaze 2006).

Mania and depression (the two poles of bipolar disorder) can also contribute to criminal behavior. Crimes resulting from mania are often indicative of the poor judgment that is a hallmark of mania and can include theft, excessive speeding, gambling, prostitution, substance abuse, and violence (American Psychiatric Association 2013). Depression is less likely to lead to criminal behavior, but in severe episodes it can contribute to psychoses that result in criminal behavior. Susan Smith, who was convicted of murdering her two young sons in 1995, was believed to be suffering from severe depression that led her to believe she needed to kill them (Chuck 2015).

Effect of mental illness on criminal behavior

Mental illness in almost all cases—and specifically as defined in this document—is manifested in behavioral, emotional, mental/cognitive, and relational disruptions and often a combination of those factors. Mental illness leads to emotional and cognitive disruption of one form or another (Medalia, Revheim, and Casey 2002). This disruption can affect both the individual themselves and others with whom the person is interacting.

The effect of mental illness on a person who is committing or has committed a crime manifests itself in several forms. A lack of self-control has been

proposed as the primary cause for criminal behavior (Gottfredson and Hirschi 1990; Buker 2011; Ronel 2011), and when an individual is experiencing an episode of mental illness they are less likely to be able to appropriately control their behavior. It is also true that many people commit crimes in an inappropriate attempt to manage emotions that are less well regulated or managed in the midst of the experience of symptoms of the mental illness (Miller, Vachon, and Aalsma 2012).

When a person is experiencing intensified anger or anxiety as the result of a mental illness, their behavior becomes less controllable and predictable. The anger, anxiety, depression, or panic experienced by people in the midst of an episode of mental illness can contribute to impulsive behavior, which often exacerbates the circumstances and severity of a criminal act. In addition, the mental illness can lead them to experience higher levels of guilt and hopelessness that can become overwhelming following the commission of a crime and subsequent incarceration, leaving them at greater risk of attempting and committing suicide while incarcerated. Finally, the mental illness and accompanying mental confusion can make it more difficult for a person to determine the appropriateness of their behavior or to choose not to commit a crime because their thought processes and judgment are impaired (Torrey et al. 2010).

Mental illness and the related emotional disruption represent a risk to others who interact with the person living with the mental illness. The elevated anger, anxiety or panic, and impaired judgment can lead the person who is in the midst of an episode of mental illness to overreact to perceived slights. They may become aggressive and violent towards those around them and ultimately commit crimes they would not have committed (or that would have been less serious) in absence of the episode of mental illness. Individuals who are experiencing mental illness are also less likely to appreciate the

impact of their behavior on others and so are more likely to commit crimes that affect others when they are experiencing episodes of mental illness.

There is a complex relationship between mental health problems and crime and the impact of mental health problems on criminal behavior. This complex relationship is made more complicated by the presence of substance abuse as described earlier, which is appropriately conceptualized as a mental health problem and a criminogenic need (Andrews and Bonta 2010; Latessa and Lowenkamp 2005). Mental health problems (including substance abuse) can lead to specific types of crimes that are often directly related to the symptoms of the mental illness, can lead to specific effects on the individuals with mental illness who commit crimes, and can have specific effects on those who are in relationships with or interact with such individuals.

The impact of mental health problems as they relate to crimes can be directly seen in emotional and cognitive processes (judgment, decision-making, problem solving). Emotions are less well regulated and managed during an episode of a mental illness. The impaired cognitive functioning makes it less likely the individual will respond appropriately to the emotional dysregulation, so they often make choices (to commit crimes and harm others) that they would not make in absence of the mental illness.

Mental +/-CODs in the community

The Substance Abuse and Mental Health Services Administration (SAMHSA) collects data on the prevalence of substance use and abuse and mental illness across the United States. The latest year for which data is available is 2014, and it indicates the following:

- Prevalence of illicit drug and alcohol abuse or dependence among those 18 years or older: approximately 8%

- Prevalence of illicit drug or alcohol abuse or dependence among those 18 years or older: 9.5%
- Prevalence of those needing but not receiving treatment for alcohol abuse: 6.5%
- Prevalence of those needing but not receiving treatment for illicit drug use: 2%
- Prevalence of any mental illness among those 18 or older: approximately 19%
- Prevalence of those with co-occurring disorders: approximately 2-3%

SAMHSA does not provide data on the number of people in the United States who need treatment for a mental illness and do not receive it. However, the National Alliance on Mental Illness estimated that in 2009 less than 33 percent of individuals who needed treatment for a mental illness would receive it (Aron et al. 2009).

These data present the scope of the problem as it relates to law enforcement and having to contact or address those with mental illnesses, substance use disorders, or both. A considerable percentage of the population experiences a substance use (alcohol or illicit drug) disorder, a mental illness, or both, and these people are more likely to come into contact with law enforcement than are those in the population with neither substance use disorders nor mental illnesses. It has been estimated that 7 to 10 percent of all law enforcement contacts involve people with mental illnesses (not specifically substance abuse) (Reuland and Margolis 2003). Our survey showed that 24 to 28 percent of persons incarcerated are individuals with mental illness. This figure accounts for those who have self-reported or have been identified through medications prescribed and from incidents observed by correctional staff.

Effect of not providing mental health services in the community

It is well established that the availability of mental health treatment in the community has decreased since the 1980s as a result of cuts in Medicaid reimbursements for mental health care, non-Medicaid cuts in funding for mental health treatment by states and local jurisdictions, and the shuttering of state mental hospitals and other treatment resources (Honberg et al. 2011; Candisky 2011). This reduction in provision of mental health services, which began with deinstitutionalization of people with mental illnesses in the 1960s, has been proposed as a major contributor to what has been called the “criminalization of the mentally ill.” As a result, the current estimated prevalence of people with mental illnesses in jails or prisons is 14 to 31 percent, depending on demographics, community treatment supports, and state statutes (Fellner 2014; James and Glaze 2006; Steadman et al. 2000). Although it is not currently possible to identify a causal relationship between decreased availability of treatment resources and increased calls for service, it is logical to deduce a connection, and various research has identified a correlation (NAMI 2018b). The reality has become, as noted earlier, that law enforcement field officers are regularly encountering those with mental illnesses (and even more regularly encountering those with substance problems), which is contributing to the growing percentages of those with mental illness and CODs being incarcerated.

Negative impacts associated with incarcerating people with mental illnesses

The oft-cited 2006 Bureau of Justice Statistics report (James and Glaze 2006) stated that only one-third of inmates reported receiving mental health treatment in state prisons and a much lower percentage (17.5 percent) of those incarcerated in jails reported having received mental health treatment. In addition, a study

done in Michigan found that 65 percent of inmates identified as having a severe mental illness had not received mental health treatment services in the past year (Fries 2010).

A number of other issues and problems have been reported related to the incarceration of people with mental illness. There is disagreement in the professional literature over the frequent claim that inmates with mental illness are incarcerated for longer periods of time than neurotypical inmates. However, the most common findings are somewhat dependent on the type of crimes for which inmates with mental illness serve extended sentences, as compared to those without mental illness (Bailargeon et al. 2009; Harris and Dagadakis 2004; Greenberg and Rosenheck 2014; James and Glaze 2006).

Inmates with mental illness have also been subjected to higher levels of sexual abuse while incarcerated, a higher number of disciplinary infractions than those without mental illness, and higher recidivism rates (Gibbons and Katzenbach 2006; Fellner and Abramsky 2003; National Prison Rape Elimination Commission 2009).

Summary

In conclusion, mental illness is a complex problem with many variables, which is difficult for even scientific professionals—even psychologists and psychiatrists—to understand completely. For that reason, arriving at an operational definition of mental illness that provided context was necessary to make this publication and its content clear.

The impact of reduction in treatment resources for people with mental illness, particularly SMI, over the past several decades has certainly contributed to the number of people with mental illness who have been contacted by law enforcement field officers and the corresponding increase in people with mental illnesses who are involved in the criminal justice system and incarcerated. Law enforcement is on the front lines of

A major objective [of the project] was to describe successful efforts to divert people with mental illnesses from the law enforcement system and assist them in moving toward recovery and reclamation of their lives.

interacting with people with mental illness (including substance users and those with CODs) and should have resources for diverting those with mental illness and CODs into environments where they can receive the treatment they need. As this occurs, people with mental illness (those whose primary reason for law enforcement contact is the direct effects or sequelae of mental illness) will be able to avoid ongoing involvement and entanglement with the criminal justice system.

Diagnosis and treatment of people with mental illness should not be a primary or even significant portion of the duties of law enforcement field professionals. As is the case with substance abuse and mental health problems (or CODs), crime and mental health problems must be recognized as interrelated but separate problems. Individuals with other mental health problems become addicted to alcohol and drugs and then continue to use those substances addictively because of the nature and effect of the addiction—not solely because of the mental health problems they experience. Similarly, individuals with mental health problems commit crimes for a host of reasons that may be unrelated to the symptoms or effects of mental illness. Criminal behavior has multiple determinants and can be either the direct or indirect result of the symptoms of mental illness. However, criminal activity can also be perpetrated by an individual with a mental illness because of criminal determinants and in the absence of clear symptoms or effects of a mental illness.

This report identifies a number of jurisdictions that are developing, identifying, and implementing specific programs and processes for reducing the involvement of people with mental illnesses in the criminal justice system. It is hoped that other agencies can review these programs, identify elements that are appropriate for them, and implement with the idea of contributing to a national reduction of people with mental illnesses in the criminal justice system and a corresponding increase in proper and effective treatment for those who are among the most vulnerable in our society.

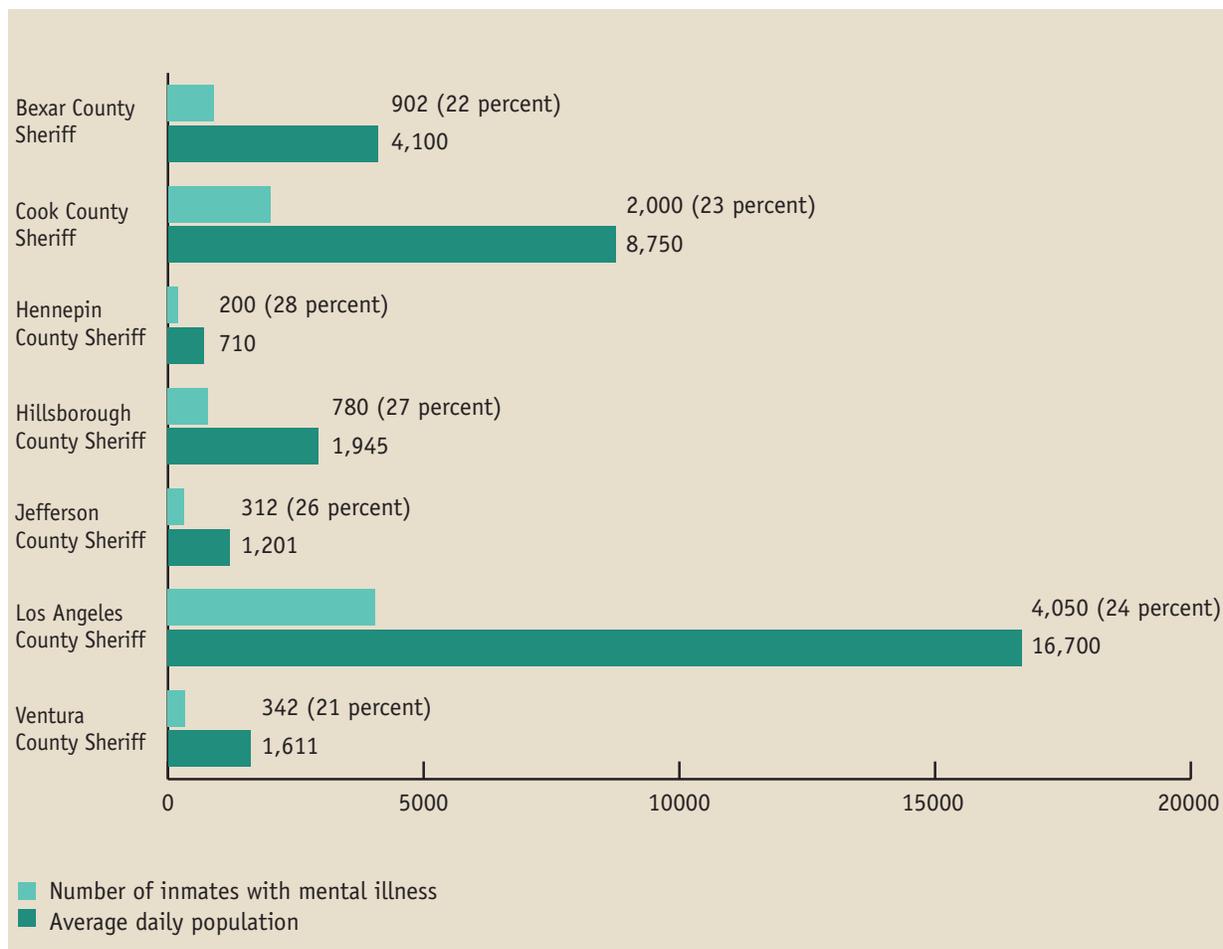
The goal of this project was not only to acknowledge the presence and reality of mental illness in our society as it relates to law enforcement but also to draw attention to the increasing number of individuals with mental illnesses who commit crimes. Another goal is to estimate the scope of the problem of people with mental illnesses encountering the criminal justice system based on information by the MCSA respondents. A final major objective was to describe successful efforts to divert people with mental illnesses from the law enforcement system and assist them in moving toward recovery and reclamation of their lives.

Jails are the Largest Mental Illness Facilities

A jail is no place for a person with a mental illness. Riker's Island in New York, the Los Angeles County Jail, and the Cook County (Illinois) Jail are the largest mental health facilities in the United States (Treatment Advocacy Center 2014). The Los Angeles County Jail has a daily average population of more than 16,700 inmates in its jails. More than 4,050, or 24 percent, have been identified as having special mental health needs. The Cook County Jail has a daily

average population of more than 8,750 at one site. Of these, more than 2,000, or 23 percent, have been identified as having special mental health needs. The fact is that our nation's jails have become de facto warehouses for people with mental illnesses. Figure 1 shows the population of inmates with mental illnesses as a percentage of the average daily population of county prisons and jails in the seven counties studied for this publication.

Figure 1. Population of inmates with mental illnesses as a percentage of the average daily population in seven U.S. county jails



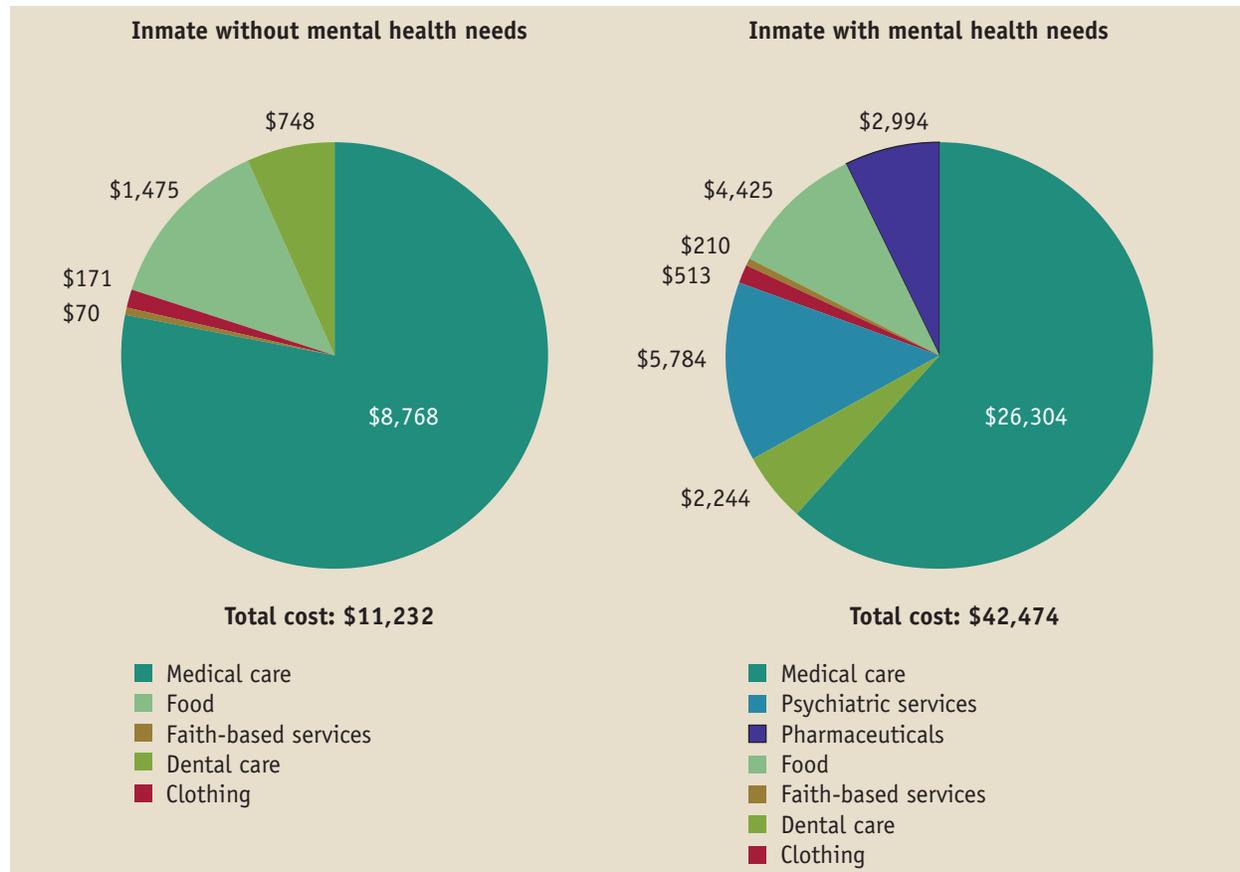
Source: National Commission on Correctional Health Care

Since the deinstitutionalization of people with mental illnesses in the 1960s and the closing of state hospitals in the 1970s and 1980s all across the nation, county jails have been used as substitutes for hospitals, veterans’ homes, or homeless shelters. Deinstitutionalization happened primarily because of the advent of better, more effective psychotropic medications and a desire to reduce state budgets. The community mental health centers were developed as a response to the closing of the state mental hospitals, with community living and treatment thought to be a more humane way to treat those with mental illness. The county placement options envisioned in the 1980s, options that seemed so logical when coupled with advancements in treatment and medications, were never funded to the extent promised or needed. In the legislative analyst’s office in California Legislature’s Nonpartisan Fiscal and Policy Advisor in 2008–09, psychologists determined that inmates

with special mental health needs spend three times the number of days in jail per booking and three times the number of times booked as inmates without special mental health needs. If programs are adequately funded and if there are still state mental hospital beds (or the equivalent of them) to treat those who cannot function in the community, county placement options are still a viable solution.

That means an inmate who does not require special mental health needs would cost the county about \$11,200.00 annually. An inmate with special mental health needs would cost the county an estimated \$42,500.00 annually. As shown in figure 2, the cost of housing an inmate with mental health issues is two to three times that of housing an inmate without mental illness and accounts for the cost of security, health care, operations, administration, support, and rehabilitation programs.

Figure 2. Housing cost comparison of inmates with and without mental health needs



Source: National Commission on Correctional Health Care

As a result of these very complex problems, the nation's sheriffs have been leading the charge in insisting upon much-needed changes in making services available to people with mental illnesses in the criminal justice system.

A continuum of care, such as that advocated by the Dual Diagnosis Capability in Addiction Treatment Toolkit (SAMHSA 2009; SAMHSA 2014) and others who have written on co-occurring disorders (COD) (Minkoff 2007), would result in treatment being provided to a wider range of individuals and fewer county residents suffering from untreated mental illnesses.

Chronic low-level offenders get arrested and booked in our jails for trespass, vagrancy, nuisance, and crimes of survival (bus or train fare evasion, shoplifting for food). Many of these criminal behaviors are a function of chronic or co-occurring problems (or both): mental illness, alcohol or chemical dependency, homelessness, and poverty. These individuals cycle over and over through our courts and criminal justice system, adding criminal records to their mounting burdens. One need only look in our jails to see that the jails have become a convenience in far too many cases.

For a case in point, "Robert" was recently held in a county jail infirmary because he was identified as vulnerable considering his age, physical appearance, and diminished mental status. Robert has been booked in the jail 31 times—15 times just since 2012. He has been a defendant in 59 criminal cases, but he has never had a felony charge. Robert's most common offenses are trespass, vagrancy, and disorderly conduct; even worse, most of Roberts arrests were for bench warrants for failure to appear in court.

In November 2013, a civil commitment action was filed against Robert. He was committed as chemically dependent in January 2014 and discharged in August 2014. But then he was booked four times again in the following year.

Robert has no place to live. His Social Security payments are not enough to pay for housing, and although he is a veteran he cannot afford the housing options available to him. By the time the county social worker came to see Robert in jail, Robert was planning to be released the following day. She tried to schedule a follow-up meeting with Robert a few days later, but he had no glasses, so he could not read her business card, and he did not have a cell phone so he could not follow up with her. He had no place of residence before his arrest and no place to go after release.

The county knows of Robert's problems and his medical and mental health history, but there was no intervention. There were no solutions, and nothing changed for him except that he was scheduled for yet another follow-up criminal court date—a court date that he is likely never to get to without another intervening arrest or bench warrant.

The jail environment is not conducive to maintaining mental health. This fact can be seen in the higher rate of suicide for those in jail than those in the community or in prison and that those who are incarcerated in jail from one week to one month are now the group at highest risk of suicide in jail (Hayes 1983; Hayes 2012). It is further demonstrated in the research that the rate or incidence of mental illness in the jail is higher than the incidence of mental illness at the time of booking. Finally, there is a significant body of research indicating that incarceration in its many forms erodes the mental health of those who experience it.

Conversely, those individuals who have mental illnesses and are booked into jails can be stabilized and receive effective treatment for their mental illness. Most of the jurisdictions that participated in this study reported providing screening, assessment, treatment, and discharge planning for those with mental illnesses in their jails and that these processes were effective in stabilizing those with mental illnesses.

As a result of these very complex problems, the nation's sheriffs have been leading the charge in insisting upon much-needed changes in making services available to people with mental illness in the criminal justice system. As peace officers, we swear an oath to serve and protect—including and especially the most vulnerable among us, who have lost their liberty and are confined to prisons and jails.

Everyone knows that law enforcement officers serve as first responders; calling 911 gets an immediate response from law enforcement. But more and more they are responding to people exhibiting symptoms of illness. And more and more we house and manage inmates who suffer from mental illness. Accordingly, a number of jurisdictions have implemented crisis intervention training in our nation's law enforcement agencies, implementing de-escalation techniques and developing innovations and initiatives to make improvements in the way we respond to calls and manage inmates. Law enforcement agencies have been working to address the crisis on a broader level and have proposed reforms in three general categories:

1. Develop arrest and jail alternatives for low-level or chronic offenders (instances of overincarceration).
2. Advance the sequential interceptor model that helps to identify the pivotal points in the criminal justice system where we have the best chance of successfully intervening to provide the services

3. needed. Can we intervene before the crisis, as an alternative to arrest, or before these inmates are released from jail?
4. Develop strong transition and re-entry programs that help to reduce recidivism, and provide offenders the best opportunity for success in the community.

The Major County Sheriffs of America (MCSA) is leveraging its national influence by partnering with like-minded associations such as the National Association of Counties, the Council of State Governments, the American Psychiatric Association, the National Alliance on Mental Illness (NAMI), and others. One such collaborative effort is the Stepping Up Initiative, which engages a wide range of stakeholders at the county level to reduce the population of people with mental illnesses in the jails by providing appropriate and timely intervention and treatment.

A project team from the MCSA, comprising selected subject matter experts from the correctional health profession and law enforcement practitioners supervising jails and field operations, focused on identifying the catalysts for change in the sheriffs' offices visited. In a few cases, it seemed the catalyst was a federal investigation or legal challenge resulting in prompt and immediate action to avoid further legal action or a consent order for agreed-upon reforms. The bottom line in every county visited: Getting the right people with decision-making authority to the table and motivated to work together was the real catalyst for change. All of these counties had in some way or another successfully engaged key stakeholders in partnerships (the County Mental Health Services provider(s), the County Board of Commissioners, courts, sheriff, prosecutor and public defender, public/private hospitals), and in some cases, the business and nonprofit community played key roles in accomplishing transformation.

Jails as mental illness facilities not a new issue

There has been a decades-long practice of relying on sheriffs and other law enforcement organizations to address mental health issues in the community through arrest and detention. While there are critical situations where law enforcement must use its authority to de-escalate violent or potentially violent situations threatening public safety, all too often the only recourse after order has been restored is arrest and confinement.

Unless action is taken after arrest and incarceration by elements of the criminal justice system (prosecutors, defense attorneys, and the courts) to address the mental health needs of the individual, it is highly likely the individual will be back in the community to reoffend. Law enforcement action, arrest, and confinement will start the cycle all over. All too often the cycle continues until the individual causes serious harm to themselves or others.

Fortunately, there are law enforcement organizations and related stakeholder groups that have taken the initiative to interrupt the repetitive process of dealing with individuals with serious mental health issues at the point of contact, either in the community or at the time of detention. In the case of sheriffs' offices, they have the opportunity to intercede in both environments given the frequent dual responsibilities of policing in the community and operating jails. It would therefore seem appropriate to study what sheriffs' offices are doing to address this challenge and to identify programs and processes that work. Understanding what is working and why and how it works creates an opportunity to document and share the information with law enforcement agencies and other stakeholders throughout the country. As agencies implement these programs and practices or

create new initiatives the odds increase dramatically that individuals with serious mental health problems will get the help they need to break the cycle of arrest and incarceration.

One of the primary purposes of this grant from the COPS Office is to identify what is working in some of the largest sheriffs' office operations around the country, particularly those ideas that are transportable and scalable.

What are sheriffs doing to address this critical issue

The MCSA, at the direction of an advisory board comprising Sheriff-Coroner Sandra Hutchens (Orange County [California] Sheriff's Department), Sheriff Richard W. Stanek (Hennepin County [Minnesota] Sheriff's Office) and Sheriff Michael Chapman (Loudoun County [Virginia] Sheriff's Office) and a team of professionals from these agencies studied a number of practices, processes, and strategies MCSA sheriffs' agencies are using to successfully reduce arrest and incarceration of people with mental illnesses.

These law enforcement professionals were complemented by expertise from the National Commission on Correctional Health Care (NCCHC) in an effort to provide a broader perspective to the assessment of what is being done currently by sheriffs and in the larger community of mental health specialists.

Further, these subject matter experts reviewed program information to identify potential weaknesses, risks, and opportunities for improvement. Consultants with expertise in field operations, jail management, crisis incident management, and de-escalation techniques, as well as law enforcement administration, were used in conjunction with expertise in the field of law enforcement and correctional mental health issues.

The project was broken down into four phases as follows:

Phase I – Hold an initial planning and organizational meeting resulting in a detailed list of activities and actions to be taken during different phases of the project and responsibilities assigned; develop a data collection instrument and process focused on problem identification and initiatives designed to address the problem; analyze the data collected.

Phase II – Organize and execute site visits to locations identified in phase I having initiatives in place that meet criteria established by the Sheriffs' Advisory Board for programs worth further review; analyze and organize data and information collected; and produce an interim report of findings.

Phase III – Based on the interim report in phase II identifying sheriffs' office programs, analyze results and prepare a draft report. After examining the results of phase II, report on sites visited and review the data collected from all sites and develop the outline for the final report. Develop a briefing outline of the project results to present to the MCSA at their winter meeting in Washington, D.C., in February 2016.

Phase IV – Prepare final report, project deliverable.

As a result of the initial meeting, a survey instrument was developed and distributed to the 78 members of the MCSA. Each agency received three separate survey tools: one designed for the sheriff or elected official, one for field operations, and one for jail operations, with instructions for each element to complete the survey independently. The surveys that were sent appear in appendix A of this report.

Each survey consisted of topics dealing with mental health training, drop-off facilities, CIT teams, alternatives to arrest, mental health databases,

community stakeholders, mental health responses and use of force, points of contact, collaboration with the justice system, mental health screening, mental health resources, average daily population of facilities, significant events involving mental illness events in communities, and what resources agencies wish they had.

There was great success with the survey distributed to the MCSA for Sheriffs' Response to Mental Illness in the Jails and Community. Nationally, the average response rate on surveys sent in this manner is 10 to 20 percent. The response rate for complete surveys across all three tracks was 29 percent. If the partial response rate was included, 58 percent of the agencies targeted was achieved.

Complete with a rubric and instructions on how to score the surveys, these team members reviewed surveys pertinent to their particular law enforcement track and returned those to the NCCHC team. Dr. David Stephens, PsyD, and a team from the NCCHC analyzed and aggregated the data from all of the surveys and the team's scores.

The NCCHC team used both qualitative and quantitative data in identifying the sheriffs' offices selected for site visits on the basis of providing demonstrably effective overall programs or particularly effective program components. The quantitative data was analyzed by means of assigning a point value to each response and then obtaining an overall score for each of the sheriffs' office respondents. The qualitative assessment consisted of reviewing narrative responses and coding them to identify the responses reflecting effective programs or practices.

Once the overall scores were calculated for both the qualitative and quantitative data, the respondent's scores for each category (sheriff or elected official,

field operations, and jail operations) were broken into quartiles, with the top 25 percent of scores in each category being the first quartile, the second 25 percent of scores in each category being the second quartile, and so on.

To qualify for the site visit, each category of response from each MCSA member had to fall into either the first or second quartile compared to the scores of all respondents in each category. In addition, if a program reported the presence of a particularly outstanding practice in a given area, that was included in the final analysis of top programs.

It was the responsibility of the project team members to review the data in an effort to identify six sites that appeared to have interesting approaches, were able to describe some level of success, involved outside stakeholders, and were committed to reducing the number of people with mental illnesses who were incarcerated and were frequently brought to the attention of law enforcement.

The consulting team from the NCHC took the input and developed a list of sites worthy of additional review. Quantitative and qualitative data were analyzed in addition to specific individual site specific programs in an attempt to identify programs capable of being replicated. Based on specific quartiles, the team identified the following counties' sheriffs' offices as the top four agencies:

1. Hennepin County, Minnesota
2. Hillsborough County, Florida
3. Ventura County, California
4. Jefferson County, Colorado

Additional substantive and personal knowledge of specific agencies was discussed within the team. Based on this information, Cook County, Illinois, and

Bexar County, Texas, were added to the site visit list. These six initial sites were selected by the MCSA. In addition to the six sites that were ultimately identified, a seventh location, the Los Angeles Sheriff's Department, was added to the list based on documented ongoing efforts to reduce the inmate population of inmates with mental illnesses, develop a comprehensive approach to mental illness in the field, and the sheer size of its jail population.

Once the sites were identified, each selected agency received a letter indicating that the COPS Office grant team would like to schedule a site visit to request important documents relating to their approach to addressing individuals with mental disorders in the community and in the jails. Information such as relevant policies and procedures, training, evaluation protocols, and partnership agreements was requested. These documents were then reviewed by the site visit team to develop an understanding of what the sheriff was doing to formulate appropriate lines of inquiry, and to identify individuals for potential interviews.

Teams looked at how the program or practice was initiated and to what extent has there been development and maintenance of collaborative relationships with community services. In addition, they looked at what costs, training, policies, and related resources were needed to start and maintain the program. Were there "red flags" that raise questions about the success, viability, ethical practice, or appropriateness of the program, and how can the program be improved upon, expanded, or further developed?

Ultimately, teams looked to see if programs as a whole could be used as model programs and whether there were individual program components that are particularly noteworthy and deserving of acknowledgement in addition to or independent from the overall program.

Site visit teams looked to determine the extent to which the program being reviewed meets these criteria:

- **Can it be replicated?** Can this program or practice be repeated in other jurisdictions, given inconsistencies in resources, policies and procedures, and facility design and operations?
- **Is technology being used** that allows the program to be maintained and replicated, and is it being used appropriately?
- **Can the development of the program be identified and sustainable?**
- **Is the methodology of the program sound?** This means it meets acceptable law enforcement, criminal justice and jail, and community mental health standards. In addition, it should not include practices or procedures that introduce risk or require active and high levels of risk management processes and procedures to be implemented.

Teams made every attempt to interview individuals such as the sheriff, designated members of the sheriff's executive team as recommended by the

sheriff, sheriff's command staff for patrol, jail staff, and community law enforcement as they have involvement in addressing people with mental illnesses and issues related to mental illness. This included deputies and officers who are involved in the identification, diversion, referral, or management of people with mental illnesses; CIT-trained officers if they are present in the county; community partners as designated or referred by the sheriff or others in the sheriff's office; and jail health care and mental health care administrators and providers.

Site teams reviewed the processes and documents. These included policy and procedure manuals, program manuals and documents, memoranda of understanding or intent (MOU/MOI), and related documents. When available, the teams looked at annual reports if those reports addressed issues related to the identification, diversion, referral, or management of people with mental illnesses; financial reports (as available) of the impact of addressing people with mental illnesses and issues of mental illness; process of interacting with people with mental illnesses from first contact on the street through incarceration and re-entry; documents or forms used for all aspects of the programs and processes; and program marketing or public awareness documents or literature.

Survey Results

On March 27, 2015, 78 sheriffs' offices were surveyed from around the United States. Of those, 40 different sheriffs' offices responded; however, not all sheriffs' offices responded to every question. The responses from those who responded to the survey were distributed to the entire COPS Office grant team for review and analysis. Initial observations were as follows:

- Of those responding, 34 (87%) stated that they have a specialized program in place. Only five (13%) of the respondents stated that they do not have a specialized program.
- The length of time agencies had a program in place varied. Of those responding, 21 (61%) stated that they have had a program for more than 10 years. Six (17%) stated that they have had a program between 5 and 10 years. Seven (20%) stated that they have had a program between one and five years. None of those responding stated that they have had a program one year or less.
- Four agencies (11%) stated that they have met resistance to their mental health program. Thirty (88%) stated that they have not met resistance to their mental health program. Those who have met resistance include various agencies refusing to assist with any type of fund-sharing. They also noted cost factors to build more facilities or have more beds rather than jail cells. They also reported that community resources are lacking including funding for training and staffing.
- A respondent from an agency who has not met resistance stated, "In and out of custody mental health care treatment/support is critical to success. Our program includes all of the stakeholder resources previously documented in this survey. Adequate local facilities that are safe and secure, with a primary focus of programming

and treatment are also critical to success. Sheriffs need adequate, appropriate facilities to provide mental health care treatment. Engaging both inmate medical/mental health care providers as well as mental health care clinicians is part of our program services. Our in-custody mental health care programs deploy deputy sheriffs who are specifically and exclusively assigned to working with mental health care providers. Those team members work together to provide services necessary for in-custody mentally ill offenders."

Responding agencies are very interested in continuous improvement of their programming if sufficient resources are available. The sheriffs recognize they need the commitment of relevant stakeholders to ensure success in addressing mental illness issues. Following are some of their comments on how they envision the best strategies to effectively deal with special mental health needs:

- We would increase the number of mental evaluation teams in the field. We would collaborate with hospitals, rehabilitation centers, churches, and community groups. In the custody environment, we would work with organizations designed to assist with reintegration for inmates with mental health needs. A dedicated drop-off center with bed space will be the most effective service to better our program. All of our partnering stakeholders support this effort, but funding and approved bed space is the key element needed.
- Use crisis intervention teams (CIT) and add more training early on in the Police/Corrections Academy with refresher courses that are already in the works.
- We need a program that links incarcerated individuals with mental illness with programs and support once released.

- Such programs should foster an environment that encourages employees to deal with persons in street contacts and during interviews with an understanding of and attention to the problems they may be experiencing with mental or emotional difficulties or substance abuse. Employees should be able to recognize that such individuals may require law enforcement assistance and access to community mental health and substance abuse resources.
- I would envision a specific mental health (MH) unit located within the jail with sufficient staffing of MH and correctional professionals. This population assigned to this unit could receive specific MH programming and other services specific to their needs while residing in a secure and safe setting.
- It is our opinion that the best option for individuals with mental illness is to divert them from jail if possible. Because of state laws and limited resources, there are far more options and resources available to persons who are not incarcerated. For those individuals that are incarcerated, forensics staff should focus on their treatment as well as developing a plan for when the individual is released back to the community. This will help ensure their success and continue their treatment post incarceration.
- Community mental health agencies, county commissioners who provide funding, and other community leaders would be stakeholders and would need to take part in a program that effectively identified those in need, provided immediate MH care, and provided a long-term plan of care.
- I believe that the best services are wrapped around services that continue even after the inmate is released. Ideally, I would love to see this happen

- in every instance where an individual with mental health needs has been released back into the community.

As expected, most law enforcement agencies around the country conduct mental health screenings at time of arrest or booking. Of the sheriffs surveyed, all of the respondents reported they conduct mental health screenings on all arrestees, commitments, and bookings. Of this same group of reporting sheriffs, 97 percent conducted mental health screening for co-occurring substance use disorders. Most screenings are conducted during classification or during the time of arrest or at the time of the medical screening. Of those responding, five (12%) stated that they screen at the time of arrest. Thirty-five (88%) stated that they screen at booking.

Survey responses reveal some individuals' mental illnesses are recorded and the information is shared with pretrial services, prosecutors, defense counsel, and the courts in an effort to promote safety for both arrestee and staff. Twenty-one agencies (53%) stated that they share with pretrial services, prosecutors, defense counsel, and the courts. Ten agencies (25%) stated that they do not share this information. Eighteen agencies (46%) stated that they share this information in one of the following manners:

- We share information in response to any request with a signed release.
- What information is shared and with whom is situation-based. There is no specific "notification tree."
- We share information with county behavioral health services and the court-appointed psychiatrist.

- Information is verbally communicated to court staff so precautions can be made to protect the arrestee and other staff.
- This information is not shared on a regular basis but can be upon request. Our mental health staff works cooperatively with other agencies and the courts system.
- We do not share information on a routine basis, but we will share information with court personnel when there is a specific concern.

The current prevalence of individuals with mental health needs in facilities surveyed varied. The range varies so widely for a number of reasons including the lack of a consistent definition of mental illness; reporting mental health needs versus mental illness; individuals come to jail with a high number of diagnoses; some facilities report diagnoses self-reported by inmates at intake while others wait to determine if an assessment reveals mental health needs or a mental illness; and some facilities only report and count those with a severe and persistent mental illness (SPMI), which typically includes only depression, bipolar disorder, and schizophrenia and neglects diagnoses such as panic disorder, PTSD, etc.

Divergent screening and assessment processes, differences in the training level of those who assign diagnoses or identify individuals as having a mental illness, inclusion or exclusion of personality disorders as mental illness, varying definitions of serious mental illness (SMI) versus mental illness, varying practices across jurisdictions related to the detainment and booking of those with mental illness, and counting only those on psychotropic medications accounts for most of the other variance in rates of mental illness in individual jails.

The average daily population of facilities responding to the survey varied. Based on the responses received, the daily population average was 2,659. However, there was a significant difference between the numbers within the facilities of the respondents. The highest recorded average daily population was more than 18,000. The lowest recorded average daily population was 380 in Loudoun County, Virginia.

Twenty-seven agencies (69%) stated that the percentage of individuals with mental illness needs in their facilities has increased in the last two years. Thirteen agencies (33%) could not provide this information. On average, agencies reported the rate has raised between 5 and 20 percent from 2016 to 2018.

Of those responding, 24 agencies (61%) stated that they have adequate resources to support the mental health needs of the inmate population in their facility. Sixteen agencies (41%) stated that they do not have resources to adequately support this initiative. Some of those who do not have adequate resources gave the following reasons for the shortfall:

- Our jail is a pretrial facility, so emphasis is on medication maintenance of inmate MH condition. Treatment, per se, is a missing element.
- We need additional bed spaces, treatment areas, offices, and discharge planning.
- The recently established Mental Health Transition Center needs the resources to expand to provide services to more individuals as well as supplemental services to those individuals who are not enrolled in one of our existing programs. Resources are desperately needed to provide additional services.

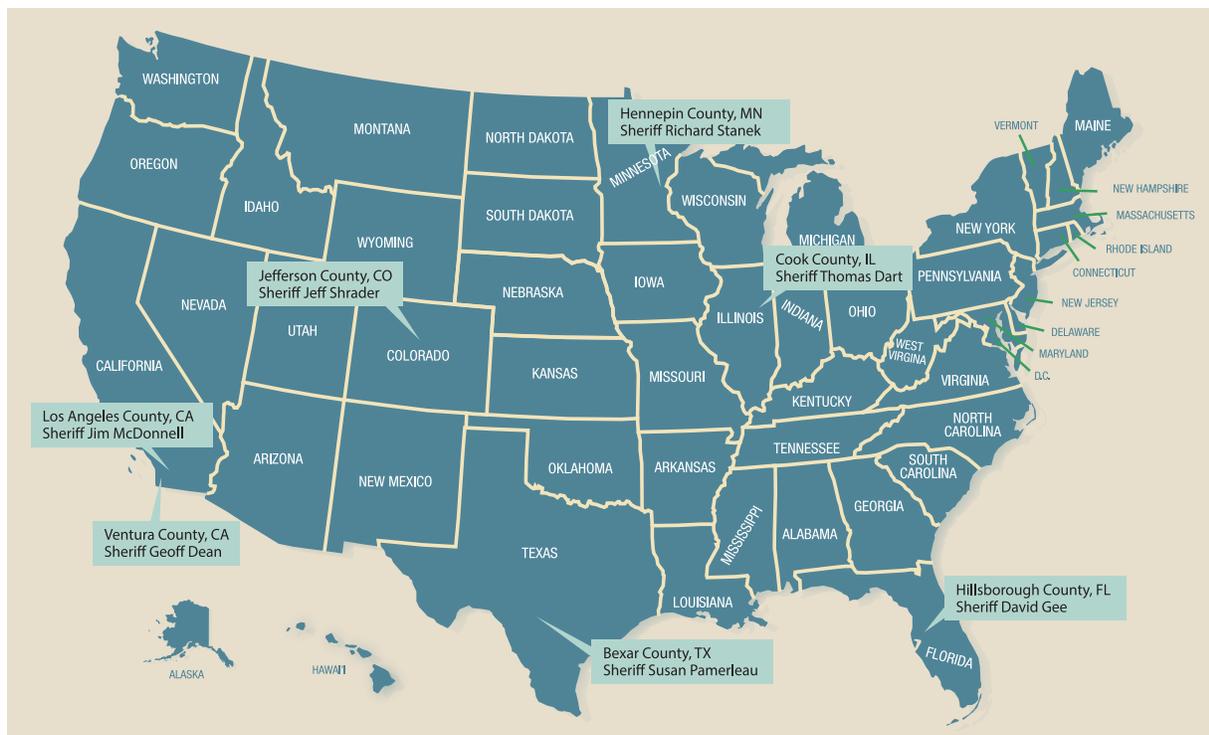
- There has been an increase over the last two years and rising expectations of what is considered quality treatment for mental illness needs. We are short providers and counselors.
- There is such a large volume of inmates identified as having mental health issues. The resources we have are just limited and are being spread so thin.
- Our psychiatric staff has seen a workload increase of 16.5% (mental health worker) and 21.5% (psych doctor contacts) in the last four years. There is always a need for increased services in custody for this population.
- While we are fortunate to have mental health staff on 24/7, the needs of this population far exceed our capabilities. We do not have any designated special needs space of any type and are often forced to rely on restrictive housing to ensure the safety and security of all.

With regard to discharge planning for individuals with mental health needs, approximately 90% of responding agencies stated that they participate in discharge planning for individuals with mental health needs. Four agencies (10%) stated that they do not.

It was found that a majority of the respondents do not track information or could not provide data about how long inmates with mental health issues stay in their facilities. Three reporting agencies stated their average length of stay (ALOS) was between 12 and 54 days.

The ALOS for a person with a mental illness is an area that needs to receive greater attention on the part of all jurisdictions, and that is a finding of the study. In some respects, jurisdictions are reducing the days of incarceration for those with mental illness through diversion efforts, stabilization of the mental illness while individuals are incarcerated, and effective discharge and re-entry planning. That is not to say that jails should not focus on specifically reducing ALOS for inmates with mental illnesses but rather that other indirect efforts are having a positive impact on this important issue.

Site Visits to Examine Programs and Initiatives that Work and Have Promise



Jefferson County Sheriff's Office, Golden, Colorado

Jefferson County is the fourth-most populous county in Colorado with a population of more than 550,000. The county seat is Golden, and the most populous city is Lakewood. Jefferson County is included in the Denver-Aurora-Lakewood, Colorado, Metropolitan Statistical Area. Located along the Front Range of the Rocky Mountains, Jefferson County is adjacent to the state capital of Denver (JCSO 2018a).

Jefferson County has reported that 79.9 percent of the population is White, less than 1 percent Black, 0.5 percent American Indian and Alaska Native, and 2.63 percent Asian or Pacific Islander. As of 2010, 14.3 percent of Jefferson County's total population was of Hispanic or Latino origin, which is considerably lower than the 20.66 percent reported Hispanic origin for Colorado (JCSO 2018b).

The Jefferson County Sheriff's Office (JCSO) was founded in November 1859 and today serves the residents of Jefferson County with a patrolling responsibility to 189,720 residents in the unincorporated areas of the 773 square miles of the county. As chief law enforcement officer of the county, Sheriff Jeff Shrader oversees the largest full-service sheriff's office in Colorado with 542 state certified deputies and 283 professional staff. In addition, about 300 volunteers support sheriff's operations. The daily average population of the Jefferson County Jail is approximately 1,250 inmates. Approximately 26 percent of JCSO inmates have been identified with some degree of mental illness.

In the wake of the Columbine High School shootings in 1999; the Aurora, Colorado, movie theater shooting in 2012; and the mass casualty event at Sandy Hook Elementary School in Newtown, Connecticut, in 2012; Colorado Governor Hickenlooper focused attention

and funding to develop mental health crisis programs throughout the state of Colorado. Much of the money for these programs has come from marijuana sales tax revenue, which went into effect in January 2014. There have been other sources of funding as well. In 2013 Jefferson County received a Justice Assistance Grant (JAG) that enabled it, in conjunction with the Jefferson Center for Mental Health (JCMH), to create a robust, multiagency crisis management and diversion team. What follows is a summary of their comprehensive and balanced system.

From the information gathered during the site visit by members of the MCSA study team, Jefferson County's approach to mental health issues is best described from its own JAG grant application summary:

"In the spirit of community policing problem solving, we initiated a dialogue with other criminal justice entities, as well as mental health treatment organizations such as the Jefferson Center for Mental Health, in an effort to create collaborative partnerships to address the issue. The response we received was outstanding and resulted in the creation of a monthly multi-discipline round table meeting, where we discussed specific problematic cases, and began to create a response protocol."

In addition, the county recognized early in the process that one of the biggest breakdowns in treatment is a result of the program's structure. They went on to explain:

"Mentally ill people are not always good at following through with commitments or with taking their prescribed medications and they don't easily trust in many cases. This 'gap' in follow-through is precisely what our mental health collaboration team is attempting to address in promoting the funding of CIT Case Managers. . . . This partnership will go a long way in proactively addressing and managing a

national phenomenon. It is our hope that we will ultimately be able to create an effective overall mental health response strategy and model that others will be able to replicate."

Between 2014 and 2018, JCSO reported an increase in mental health related calls and mental health consumers' use of resources and stakeholders' time. Unfortunately, Colorado has had several high-profile and active shooter incidents that were mental health related. This prompted statewide funding for mental health resources and crisis drop-off centers using tax revenues from marijuana sales.

JCSO, like many other law enforcement agencies across the country, recognized the need for collaboration and crisis intervention teams (CIT). The sheriff's office has also been involved in alternatives to arrest those with special mental health needs for many years. This included supporting CIT as a regional training program to ensure consistency in the community. In addition to field officers, JCSO also provides CIT training for dispatchers.

There has been a cultural change in the agency relating to the importance of dealing with individuals with mental illness as JCSO executives, as well as all layers of the command and supervisory team, frequently discuss this important topic. There is a clear message from the sheriff, and he has made a concerted effort to get all stakeholders involved. The JCSO's motto is not "How can we afford this (proactive approach to mental illness)" but "How can we afford not to do this?"

The program within the JCSO began with courts and branched out to additional stakeholders. The program uses CIT as the base or standard for training, but it maintains the flexibility to modify this tool to meet the needs of the agency. The CIT is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT model was first developed in

Memphis, Tennessee, after local police shot and killed a man with mental illness who had charged at them with a knife.

The Memphis model provides law enforcement and emergency responder-based crisis intervention training for assisting those individuals with a mental illness. The goal is to improve the safety of emergency responders, consumers,² family members, and community members. The Memphis model provides the foundation necessary to promote community and statewide solutions to assist individuals with mental illnesses. It reduced both stigma and the need for further involvement with the criminal justice system. The Memphis model (CIT 40-hour) course is the foundation for the countywide CIT program in Jefferson County. Like many current CIT programs, Jefferson County's participants (sheriff's office and police departments) have modified the program and added additional content to fit the needs of Jefferson County's specific population. Nationwide examples include adding veteran service PTSD modules near military bases and adding Alzheimer's and dementia training in areas with large retiree populations.

The JCSO believes role playing is vital to achieving successful program results rather than the traditional instructor-focused lectures frequently used in many training courses. Statistical data provided by the JCSO support the assertion that CIT training reduces the incidents of use of force when compared with deputies who have not attended the training program. While it would be helpful to track the use of force events involving individuals perceived to be impacted by mental illness, this information was

not collected by JCSO. Given the complex nature of having laymen assess the mental state of the individuals they confront, any assertions about the use of force involving individuals with mental disorders should be considered a gross estimate.

Numerous stakeholders who were dealing with individuals with special mental health needs were included by JCSO at the outset of the collaboration effort. Stakeholders included the offices of the county attorney and public defender, probation, courts, county police departments, jail medical and mental health staff, NAMI, and Colorado Crisis Services. Additional stakeholders were brought in to fill gaps as they were identified or when they became aware of the initiative and believed they had something to contribute.

Once the collaborative group became established and relationships were built, gaps in the initial programs were more easily filled as associations, groups, and individuals recognized the value of the programs and the synergy achieved through team work. The successes were due in no small part to the relationships and overall direction of the stakeholders acting with the same goal and mindset. NAMI was instrumental in the effort to build a countywide mental health database to better identify the needs of the individuals and coordinate intervention services. The database is primarily designed as a resource for better mental health care information on individuals who come in contact with law enforcement. This helped deputies to view those with mental illness as individuals in need rather than just criminals to process.

2. The term *consumer* is used by many advocates, treatment providers, and others as an alternative to *patient*, *SMI*, or *individual with mental health issue* because the term conveys empowerment of the person over their illness. In addition, using *consumer* means the individual is proactively engaged in their treatment and is not defined by their mental health diagnosis. (Kersting 2005).

The resources within the JCSO include

- a crisis hotline;
- walk-in and drop-off centers;
- hospitals;
- juvenile assessment center;
- detox center;
- mobile crisis unit;
- CIT-trained deputies.

In the JCSO program, CIT case managers (CM) are more than just discharge planners. They are co-located in the main patrol station near the deputies' work locations and are a readily available resource for the field patrol staff. In addition, they work with the jail staff so that they have relationships with both field operations and corrections staff. In the jail operations, counselors interview and screen arrestees at intake as part of the booking process so they can refer inmates to appropriate programs or resources while they are in custody.

In situations where taking someone with special mental health needs into custody is the best course of action, the JCSO uses an approach that begins to lay the foundation for the development of a discharge plan. The co-location of CIT CMs allows for better collaboration, as relationships have been built that may not have evolved if the deputies and CMs were not able to see one another on a daily basis. Rather than waiting for a situation or call for service to force a business-related phone call between the deputies and CMs, the deputies walk by CMs on the way to briefings, which facilitates open, impromptu meetings and dialogue. Seemingly trivial questions that deputies and CMs may never ask one another are commonly asked, answered, and discussed because of the co-location, and gaps are filled often without convening a committee or working group. Because

of this strong and credible relationship, along with immediate access and response, patrol deputies often call the CMs for advice rather than wait for mobile crisis teams to respond. This has become an unforeseen added benefit for Jefferson County sheriff's deputies in their patrol operations.

The Jefferson County Detention Policy Manual supports this approach to planning for release at the earliest opportunity. The JCSO policy manuals are well written and revised on a regular and as-needed basis. The electronic manuals consistently have links to supporting documentation or additional information. They have well-written, comprehensive policies for all aspects of inmates' mental health needs including suicide prevention, mental health, counseling, and medical support. They are written in accordance with the guidelines and accreditation of the American Corrections Association (ACA), National Commission on Correctional Health Care (NCCCHC), or Commission for Accreditation of Law Enforcement Agencies (CALEA) and are so noted in the manual. JCSO's policies and procedures manual is available to its employees electronically or on a DVD. The DVD's label denotes JCSO is ACA-, NCCCHC-, and CALEA-accredited.

The inmate's booking, triage, and classification processes all consider the issues presented with those with special mental health needs. The JCSO has deputies assigned to work in special mental health housing units who receive additional training for dealing with those individuals with special mental health needs. Deputies who work in these areas are screened based on special qualities that fit best in this environment. MH housing unit deputies (Special Housing Unit [SHU] deputies) first have a desire to work in the MH housing unit. They have demonstrated excellent communication skills with staff (sworn, professional, medical, mental health), community members, and mental health consumers. They work well in a team environment, showing good de-escalation techniques and patience. These posts are

typically highly sought-after positions by the sworn staff as evidenced by having more highly qualified candidates than position vacancies.

In addition, the JCSO has a discharge planner who coordinates outside resources for an inmate's reintegration into the community. A single CIT CM (discharge planner) position was grant-funded for the first year through Jefferson County MH. Because of its success, Jefferson County MH picked up the cost when the one-year grant expired and supplied a second CIT discharge planner to be co-located in the sheriff's office. Since the positions began, the JCSO has seen a reduction in call-backs and calls for service regarding the behavior of the same individuals. Some of the resources the discharge planners help inmates access prior to release are housing, identification cards, Medicaid benefits, veterans programs (including acting as a liaison to Veteran's Court), and working with the non-discharge planner CIT CMs to assist the families with the re-entry process.

During discharge planning, CMs assist inmates in getting IDs or replacement driver's licenses, for which the fees are waived. Personal information, photos, incarceration dates, criminal history, and important mental health information is collected in a computer-aided dispatch (CAD) accessible electronic database. Inmates are also provided with a 30-day supply of prescription medications upon release. Suicide assessments are conducted on all inmates with special mental health needs who are being released to determine if they need additional follow-up evaluations at local hospitals. These assessments and other elements of the re-entry program have contributed to a positive outcome for an estimated 54 percent of inmates who have remained in successful programs one year after their discharge with a 0 percent recidivism rate.

The initial JAG grant was used in part to fund two full-time mental health case managers who provided liaison functions between the Jefferson Center for

Mental Health and the JCSO. The case managers are certified mental health professionals who provide nontraditional clinical case management services. Essentially, they receive referrals from deputies who have identified individuals and situations in the field that would benefit from their expertise.

While the case manager positions were created with JAG grant money, they were later funded full-time by the county mental health office when the grant expired. The decision to fund these positions was based on what the JCSO and Jefferson Center for Mental Health noted as a significant increase in referrals to the CIT CMs with a corresponding reduction in time deputies spent handling mental health related calls. Overall, the program was deemed to be successful and an efficient and effective use of limited county resources.

The JCSO and its collaborating partners have a shared philosophy with an emphasis on finding the best, most efficient way to handle a mental health client. Currently, case managers are only housed in one precinct with a significant distance between all three precincts. All of the precincts would benefit from the presence of CMs because of the ease of interaction their presence creates between the deputies and clinicians. Whether serendipitously or by design, the JCSO has created a program that naturally crosses over between the jail system and patrol operations. By being attached to the jails through their mission of discharge planning and "walking" the jail housing units, the CIT CMs interact with and receive referrals from the jail, medical, and mental health staff. This interaction has built relationships inside of the jails. By doing their desk work near the patrol briefing room, they have a relationship with the deputies there as well. If their work location(s) were in the jail, (possibly) their only relationship with or resource to patrol would take place during an occasional ride-along or patrol briefing.

The mobile crisis unit used by the JCSO has about a 30-minute estimated time of arrival in the field. The unit comprises a CIT deputy and a mental health professional. CIT deputies are selectively recruited for an intense 40-hour training course, which involves expert lecturers, role-playing scenarios with actors, and visits to local mental health facilities. Once certified in crisis intervention, all CIT deputies wear a CIT pin on their uniforms that denotes their certification.

One of the most important aspects of a successful program was the ability of the patrol officer, regardless of jurisdiction, to have a centralized crisis center to assist with people who fall into a grey area where their violations of the law are petty crimes such as vagrancy, trespassing, etc., and the individuals are not exhibiting moderate or severe mental illness behaviors. This includes a broad spectrum of people the patrol officer recognizes in need of assistance rather than incarceration or involuntary hospitalization.

One collaborating partner in this effort is the Colorado Crisis Walk-in Center administered by the Jefferson Center for Mental Health. The walk-in center offers a variety of services to the general public. It is a 24/7 facility that allows law enforcement officers to bring individuals who may be experiencing a mental health crisis. The officers can release the individual to the Crisis Walk-in Center staff and be back in-service in the community within about 15 minutes. This is a remarkably efficient alternative to sitting in a hospital emergency room for several hours, and it is much more beneficial to the individual than arrest and incarceration for petty offenses. The crisis center can provide the services on a voluntary basis or perform involuntary holds if there are no other mitigating medical concerns.

During regular meetings of all stakeholders (including the sheriff's office, Jefferson Center for Mental Health, probation, county attorneys, fire and rescue services, Adult Protective Services, and several local police agencies), members of the group discuss how

they can better incorporate a community caretaker philosophy into their current training and training in the community.

The JCSO and the sheriff's executive team support the need for good mental health programs both in the community and in the jails. They are also very supportive of an efficient crisis center drop-off facility. A detailed flow chart describes exactly how to handle mental health field contacts. This flow chart appears in appendix B of this report. The chart includes

- a comprehensive and current list of available resources;
- detailed policies regarding referrals to the CIT CMs;
- detailed policies regarding referrals to the jail-based behavioral health services;
- effective and frequently used deputy referral forms (used as the basis for much of their statistical records).

Their detailed record keeping of relevant statistics include

- number of referrals from law enforcement to county mental health services;
- number of referrals from caseworkers to law enforcement;
- number of referrals by caseworkers to outside treatment programs or resources;
- number of follow-ups with law enforcement and caseworkers;
- number of repeat calls or call-backs for "frequent fliers."

The JCSO conducted more than 20,000 initial screenings at all bookings and approximately 4,900 follow-up MH screenings during 2014 (documented

in their annual report). The follow-up MH screenings have been increasing at a rate of 10 to 15 percent each year. The JCSO also tracks inmate reclassifications, follow-ups, crisis calls, collateral consultations, MH referrals, suicides (as well as attempts, flags, and watches), and MH status exams. In addition, the sheriff's office keeps statistics on inmate program participation, including programs related to MH issues (addiction, coping skills, stress management, self-esteem). Referrals to CIT CMs, CIT CMs' referrals, and placements and resources are also tracked, along with success rates.

The JCSO is constantly looking for additional fiscal resources to support its work with individuals with mental illness who come in contact with law enforcement and the criminal justice system. With additional funding, the JCSO would

- increase its effort to assist with offender re-integration and re-entry services;
- provide better medication support, when warranted, upon release from jail;
- work with other stakeholder groups to secure more mental health beds in the community and add to additional specialized lodging units in the jail.

Jefferson County in general and the JCSO specifically has a flexible, fluid, and organic approach to dealing with mental health clients throughout their justice system. From the deputy on the street to the clinician in the jail to the judge at the diversion court, everyone had the same goal in mind. The goal was to reduce the number of MH-related calls for service and jail bookings, which branched into the comprehensive, inclusive program that exists today.

The JCSO initially began to address the MH concerns because field operations personnel saw an increase in MH-related calls and bookings. As they began reaching out to stakeholders, starting with the courts, they discovered all of the stakeholders were also experiencing increased numbers of MH consumers, were attempting to get their arms around the issue, and were looking for solutions and partnerships. The JCSO discovered they were not alone and other stakeholders were ready for a change (first driven by the courts and Sheriff Shrader). Their specific programs may not work for everyone, but the amount of support and dedication from all their stakeholders has certainly provided a level of success that would not exist otherwise.

In and beyond Jefferson County today, families are relied upon to provide stability and resources for those in need. The sheriff's office, as well as other county stakeholders, provides education, referrals, and resources to support family members, who in turn can provide resources to their loved ones. Families may have one or more members with specific needs, including seniors with limited mobility, those with physical illnesses, and those with mental health issues. The JCSO currently maintains the mobile crisis unit in the county as well as short-term, crisis management, and de-escalation techniques within the agency. Families play a significant role in treatment and are heavily relied on to help law enforcement and social services respond effectively. But families with even the best intentions may sever contact with a family member suffering from mental illness if resources and supports are not made available. With the appropriate support and resources from all stakeholders, families do not have to go it alone and communities are ultimately safer and more harmonious.

Contributions to case study by Lt. Shawn Allen.

Hillsborough County Sheriff's Office, Tampa, Florida

Hillsborough County is the fourth-most populous county in the state of Florida with a population of more than 1,279,000. Tampa, Florida, is the county seat and the most populous city in Hillsborough County. Hillsborough County Sheriff's Office is the primary law enforcement agency and is responsible for 980 square miles of patrol response as well as operating two jails and a work release center and staffing courthouses (Hillsborough County Sheriff's Office 2018).

Statistics show that 71 percent of Hillsborough County is White (total White population is 876,137), while the Black or African-American population is 17 percent (total Black population is 205,073). The Asian population is 3 percent with a total Asian population of 42,076. Native Americans, Pacific Islanders, and individuals reporting more than one race make up the remaining 9 percent. (The total Hispanic population is 306,635, for 25 percent of the population; this is considered an ethnicity rather than a race.) There are three incorporated cities within Hillsborough County: Tampa, Plant, and Temple Terrace, each of which has an independent police department (United States Census Bureau 2018a).

Florida is ranked last in the United States when it comes to its financing of the mental health crisis. Although there appears to be no single event as the catalyst for change, the Pre-Arrest Intercept Program (PIP) Jail Diversion Central Receiving Center (CRC) Model Program (PIP-CRC) was developed as a result of a several years-long planning process carried out by a group of diverse and dedicated stakeholders in Hillsborough County.

The Hillsborough County Sheriff's Office (HCSO) was founded in 1845. The HCSO employs 2,485 sworn personnel under the leadership of Sheriff David Gee. Out of the sworn personnel, 1,061 are in corrections

and 1,424 personnel are in the patrol division. The HCSO has 13 divisions: four jail divisions, one training division, one homeland security division, one investigation division, one child protective division, four patrol divisions, and a community outreach program (CIT-trained deputies). The main booking site is located on Orient Road and services 26 local, state, and federal agencies; the second detention center is Falkenburg Road Jail and is located on 142 acres. HCSO most recently reports a daily population of 2,882 inmates with approximately 18.4% identified as having a mental health illness (Florida Department of Corrections 2018).

The Orient Road location is the primary receiving facility that services more than 27 local law enforcement agencies. It offers offender re-entry programs and is the primary juvenile facility for the county. It is also the central breath test location for driving under the influence (DUI) and for individuals who voluntarily self-arrest. It is one of the largest facilities in the United States. The HCSO is able to house 4,947 persons, which includes 3,300 beds at the Falkenburg Jail. Both HCSO jails offer educational and vocational education such as cooking, general educational development (GED), and sewing.

Any arrested individual can be booked into HCSO at either jail location, and each location is staffed with a mental health professional who can assist during the screening, which is completed immediately after the individual is searched. However, the main county jail (Orient Road location) also offers pre-booking interventions that can be engaged by patrol officers and deputies. This is a pilot program designed to address unmet needs of individuals with mental health and CODs, with a single point of entry into the behavioral health system. A behavioral health provider, jail medical staff, and the booking sergeant are part of the process. They determine if these individuals qualify for Agency for Community Treatment Services (ACTS), who respond to the

jail within a two-hour window and transport the individuals to mental health facilities rather than arrest and booking into the jail facility.

The jail also works with consumers who act as peers in the booking area. In order to participate in the ACTS program from booking, individuals must volunteer for this service. Consumers can provide peer support and answer questions that individuals have prior to arrest and booking. Also, if no treatment beds are available in a timely manner, ACTS can refer diversion individuals to available hospitals for care until a treatment bed is located. The Jail Diversion Program is a collaboration between Hillsborough County Board of County Commission, HCSO, Tampa Police Department, court administration, the Office of the Public Defender, the State Attorney's Office, Hillsborough County Jail's medical provider, and several behavior health providers.

Hillsborough County holds the 40-hour crisis intervention team (CIT) training one week after its full academy training. New recruits are not chosen to become CIT deputies until two years later when they have gained either the road experience or correctional experience needed to appreciate the CIT program. If they decide that they wish to become part of the CIT program, they take the 40-hour CIT program a second time and become certified in CIT. Hillsborough holds up to 50 students both from patrol and corrections. When they come to the role-playing exercises required by the Memphis model, they break into their respective career assignments to obtain the maximum training specific to their career path. HSCO first launched its CIT program in 2003 and has trained more than 1,000 deputies from both corrections and patrol.

It is apparent that having the correct champion to lead the CIT program is imperative to the success of this program. Patrol Services Colonel Greg Brown's recommendation is to have the CIT coordinator report directly to the sheriff or at least to the Colonel of Patrol Operations. With the support of the sheriff or the colonel, the CIT coordinator is able to work

without restrictions that would normally need a chain of command consent. This works in Hillsborough without a doubt. Sheriff Gee is a long-time champion of the program.

Hillsborough has both a crisis response team and a robust CIT program. Five CIT deputies are part of a homeless community outreach program in which they keep track of this special population and are there to get individuals into treatment or make sure they have access to other resources. Gracepoint Mobile Crisis Unit is available 24 hours, seven days a week, for acute mental illness for adults. The Gracepoint Foundation was formally established in 2002 as the Mental Health Foundation, a 501 (c)(3) nonprofit organization. As the fundraising charity for Mental Health Care (MHC) Inc., they changed their name to the Gracepoint Foundation when MHC became Gracepoint in 2013. The foundation's mission is to educate, advocate for, and give hope to all people touched by behavioral health and developmental challenges. Since its beginning in 2002, the Gracepoint Foundation has focused on developing a solid base of support. The foundation solicits and receives gifts from Gracepoint's operating and foundation boards, medical staff, employees, vendors, corporations, foundations, and private donors. They respond to the individual's home, school, or other safe environment.

Contributions to case study by Maj. Paul Adee.

Ventura County Sheriff's Office, Ventura, California

Ventura County covers 1,882 square miles, stretching from beaches to rugged mountains. Three-quarters of a million people call Ventura County home. Five of the county's 10 incorporated cities (Thousand Oaks, Camarillo, Moorpark, Fillmore, and Ojai) contract with the sheriff's office to provide police services. These cities, plus the unincorporated areas of the county, make up nearly half of the county's population and 95 percent of its land area (Ventura County Sheriff's Office 2018).

Ventura County is the 13th-most populous county in California with an estimated population of more than 850,000. The county seat is San Buenaventura (also known as Ventura). Ventura County is a semiurban, semirural county. The largest Ventura County racial group is White, non-Hispanic (45%) followed by Asian (8%). The county is 43 percent Hispanic. In 2014, the median household income of Ventura County residents was \$77,335. Approximately 11.1 percent of Ventura County residents live in poverty. The median age for Ventura County residents is 36.9 years (United States Census Bureau 2018b).

The Ventura County Sheriff's Office (VCSO) was founded in February 1873 and today serves the residents of Ventura County and provides law enforcement for the unincorporated areas of Ventura County as well as several cities within the county. Geoff Dean is the 19th sheriff of Ventura County and a 35-year veteran of the VCSO. The VCSO is staffed by approximately 1,200 personnel, including allocations for more than 700 sworn positions.

Five to seven percent of all law enforcement calls for service can be directly linked to a mental illness. In addition, fatal shootings of individuals with mental illnesses doubled between 1997 and 2002, with six fatal incidents in 2001 alone. In 1999, the VCSO and Ventura County Behavioral Health Agency formed a strategy committee with various community health organizations including NAMI, the Mental Health Board, and mental health consumers.

The committee designed a two-phase action plan to provide a comprehensive range of services to the population of offenders with mental illnesses. Phase one began assisting the offender with mental illness post-arrest in 2000. Phase two started the implementation of a crisis intervention team (CIT) program based on the Memphis model. As a result of this effort, 72 percent of all law enforcement officers in the county are currently trained in CIT. This has led to a significant reduction in use of force incidents since 2001 and increased integration of law enforcement

and medical services for mental health clients. What follows is a summary of Ventura County's mental health diversion options and CIT training program.

Ventura County's CIT program has four main goals with regard to mental health concerns:

1. De-escalate crisis situations.
2. Reduce the use of force.
3. Reduce jail incarcerations.
4. Decrease recidivism.

With this in mind they use the classic Memphis model CIT training program that has been updated with modern scenarios and relevant local and state laws. In addition to the training, a component of the CIT program is the collection of information via a CIT card (essentially a mental health field interview card) when law enforcement comes in contact with an individual who needs mental health services. Each documented contact is included in a database at Ventura Sheriff's Central Station where it is reviewed and recorded by CIT staff and then distributed to patrol briefings, courts, and county behavioral mental health.

All five of the municipal police departments in the county provide funding for the CIT program. Along with financial support, each agency fills out the CIT cards and provides additional staff members including an officer of the day, evaluators and actors at the CIT training, and a CIT coordinator. In addition, California State University Police, Ventura County Community College District, the California Highway Patrol, and Naval Base Ventura County Police all participate in the CIT Academy and filling out the CIT cards.

Staff members from at least six area hospitals attend regular meetings to work toward a better relationship with their law enforcement partners. Mobile crisis teams can respond in the field to perform mental health holds and assist with transportation. They also provide a child-specific crisis response team (CIRT,

the Children's Intensive Response Team). Additional stakeholders, members of all of which attend regular meetings together, include Adult Protective Services, NAMI, Autism Society, Brain Injury Center, and various veterans' services.

Nonviolent de-escalation of crisis situations in the field and a reduced recidivism rate in the county is well documented since the inception the CIT program. A decrease in use of force by officers and an increase in contacts that result in "contact only-resources offered" is evidence that the CIT philosophy is producing positive results. Injuries to officers and mental health consumers have also drastically declined. The rate of use of force during contacts with a consumer in crisis by a CIT-trained officer is low, with "verbalization only" techniques used 95 percent of the time. Unanticipated benefits have been an increase in public and consumer support and a building of confidence in Ventura County law enforcement from consumer advocates.

A new program in the Ventura County Behavioral Health System (VCBH), Rapid Integrated Support and Engagement (RISE), is funded by a large grant from the state of California and is up and running in Ventura County.

RISE teams are resources for the population of homeless people and those with mental illnesses who do not meet the requirements of California's Welfare and Institutions Code § 5150 (the state mental health hold statute) but are frequently incarcerated in jails; disruptive; and in need of care, resources, and outreach. These repeat-call consumers are reported to VCBH for follow-up. Teams frequently include families in the recovery and resource process and Homeless Liaison Officers (HLO). Each agency and sheriff's station has a CIT coordinator. The sheriff has a headquarters program manager for all outlying coordinators.

RISE is intended to help hard to reach and difficult to serve clients in the county. Staff from the RISE program visit Hillmont Psychiatric Unit every day

to identify people who may not yet be enrolled in services. They do whatever they can to help get the unserved or underserved patient enrolled and involved in services. The RISE program will make appointments and then provide rides for the person to attend the appointment. They will also assess for other needs besides appointments, such as food and tokens for public transportation.

Included in the grant proposal was a psychiatric emergency room inside Hillmont Psychiatric Unit, which is currently under development. The Psychiatric Emergency Service (PES) will provide psychiatric evaluations, intervention, and referrals for voluntary and involuntary patients 24 hours a day, seven days a week. It will provide crisis intervention and medication assessments. An individual will be able to stay up to 24 hours. Some will be discharged to home, others to the acute inpatient unit, and others will be referred to community mental health resources. This seems to be a good model and something that is fairly easy to replicate in other jurisdictions.

Ventura County uses funding from the Mental Health Services Act of 2004 to fund a VCBH staff person assigned to work in the jail as a screener of mental health services for those being released from custody. These intensive services employ an Assertive Community Treatment (ACT) model directed at 30 voluntary clients with a goal of engaging them in long-term treatment to reduce recidivism. Results from the program have been encouraging. Jail staff referred 218 individuals to long-term treatment through outreach and engagement efforts between 2007 and 2012. The reduction in jail days for those engaged in services and treatment was found to be statistically significant.

Ventura County has a history of specialty mental health courts reaching back to the late 1990s. Early mental health court efforts were prompted and partially funded by Mentally Ill Offender Crime Reduction (MIOCR) grants from the State of California. Ventura County has maintained mental health courts

An innovative way the VCSO is sharing information on consumers is the creation of I Cop, an application for smart phones for all patrol and many critical assignments.

since 2009 without MIOCR grant funding. A mental health court is a post-plea, interagency endeavor where both misdemeanor and felony defendants may be referred. Successful completion of the program takes an average of 18 to 24 months and usually results in the elimination of the suspended jail sentence, termination of formal probation, and forgiveness of fines and fees. The courts currently analyzing 565 referrals made between 2009 and 2013. Results that will examine both incarcerations and hospitalizations are pending.

A dramatic rise in misdemeanor defendants found not competent while facing trial has focused Ventura County on outpatient efforts ranging from augmented board and care to independent living with competency training. Felony defendants may ultimately be placed in locked psychiatric settings on civil commitments to receive long-term psychiatric care under conservatorship.

County and sheriff executive-level support, specifically CIT, exists for good mental health programs both in the community and in the jails. Ventura County effectively and frequently uses CIT contact cards. Detailed quarterly reports, including numerous statistics derived from the CIT cards, help to track critical information. These reports include

- number of referrals from each local jurisdiction;
- corresponding use of force incidents;
- disposition of contact.

Ventura County has a shared philosophy among multiple stakeholders with an emphasis on finding the best, most efficient way to handle a mental health client. They maintain shared medical records (within Health Insurance Portability and Accountability Act of 1996 [HIPAA] rules) between the sheriff and Behavioral Health, and access to data via improved

technology is a great resource to officers (80 percent have department-issued iPhones with a County app to check on consumer status).

Ventura County recognizes that there is a need for additional discharge planning from the jails and would like to form a regional task force dedicated to dealing with mental health crisis situations.

There is a national movement to deal with community mental health needs in a safe and professional manner. Ventura County needs to maintain its current level of professionalism and diligence by continuing with its CIT program. Relevant, accurate statistical record keeping will continue to validate the county's current successes and make it easier to maintain long-term support of the program.

Ventura County identified the need for additional funding for a sobering center and a dedicated crisis drop-off program. Further, county officials mentioned they did not have enough mental health housing beds either in the community or the jail system to address demands and fear that longer inmate sentences will result in the need for a higher level of care for those with mental health issues without the appropriate resources to meet those needs in custody. The jail will need to expend more resources to treat those with mental illnesses if they are given longer jail sentences. In addition, the State of California now diverts a percentage of inmates away from the state prison system back to county facilities. This results in longer sentences and older inmates without supporting funds at the county level. The county jail is now responsible not only for older inmates with medical issues but also for longer periods of care for individuals with mental illness, and the corresponding medical standard of care must rise to meet all of the needs of this population—including additional staff, housing needs, and medication costs—without any additional funding.

Those interviewed referred to the VCSO as having a “small town attitude” and a “nonantagonistic relationship” with other County agencies. They unanimously stated they had a “holistic” (rather than “militaristic”) approach to dealing with people with mental illnesses from a law enforcement perspective. This stems from the philosophy instilled in their officers and deputies during 15 years of CIT training. They feel they have an organic approach that is flexible and not overly bureaucratic. Combined with top-down support and effective use of grants and local resources, Ventura County has much to offer in terms of diverting mental health offenders away from custody. Recent efforts in dealing with those with mental health needs and the CIT process have contributed to a lowering of officer involved shootings, use of force, repeat bookings, and repeat calls. There are no direct statistics regarding these events. However, the referral rate to the CIT program resources has steadily increased since 2012. These efforts help divert cases away from custodial arrests.

In 2014, there were several shootings in the county that involved individuals with mental health issues, and the increased public awareness led to a new cooperative effort of the sheriff’s office and the county’s five municipal police agencies to commit to CIT training for every officer in the county. Chiefs of police and the sheriff had a positive, long-standing relationship that benefited the process. CIT has been used since the mid-2000s but was initially taught to only a small percentage of deputies. CIT has now expanded to all VCSO and law enforcement personnel. The County has modified the CIT program to include jail deputies who are about to be transferred to patrol. Currently 100 percent of patrol is CIT trained; the VCSO offers CIT training for 100 percent of dispatchers.

Another way that VCSO has increased response effectiveness to service calls involving people with mental illness is the use of CIT field interview cards; the responding officer notes pertinent information that is then entered in a countywide database for future reference. Field interview cards provide important information such as family, friends, and contact information; de-escalation techniques used; and prior calls for service, to be shared with other responding officers. In addition to the field interview cards, dispatchers also have access to a list of CIT deputies available and best prepared to respond.

An innovative way the VCSO is confidentially sharing information to help in response with individuals who suffer from mental health issues is the creation of I Cop, an application for smart phones for all patrol and specialized assignments such as CIT. The application gives law enforcement officers access to a field interview database, probation, parole, photos, tattoos, booking records, and CIT contact cards. Forms are also available through a CIT icon or app along with resources and policies.

The VCSO has a newly created medical and mental health liaison sergeant position in the jail. This supervisor works with the Legal unit (DNA collection, jail records and Public Records Act requests, mailroom, public defender, district attorney, courts, and persons who are remanded into custody by the court while making an appearance before the judge) and the VCBH discharge planner. The discharge planner works with voluntary pre-releases to be released and transported to facilities by the contract discharge program coordinator. The philosophy for discharge is “housing first.” The medical administrator advised that the positive relationship between the sheriff’s office and medical staff leads to better outcomes, less liability, less death, and less public and media scrutiny and believes it is crucial for the medical liaison sergeant to have credibility with “the troops.” Despite the strides VCSO has made, the sheriff’s office would like to see additional psychiatric staff and a detox drop-off center.

Contributions to case study by Capt. Robert Davidson.

Bexar County Sheriff's Office, San Antonio, Texas

Bexar County is the fourth-largest in Texas and the 16th-largest in the United States. It has a population of 1.8 million, covering 1,257 square miles. San Antonio is the largest city (the seventh-largest city in the nation), representing 1.4 million of the county population, with its own large police department. More than half the population claims at least some part Hispanic or Latino (of any race); 42 percent speak a language at home other than English. The median household income for the county is \$51,900 (United States Census Bureau 2018c).

Texas did not agree to Medical Assistance expansion under the Affordable Care Act, so the State and County must provide for a much larger percentage of health care costs for the indigent than in some other states. There are several military installations in the area, including Fort Sam Houston, the home of the Army Medical Training and Education Campus; Lackland Air Force Base; and Randolph Airforce Base, collectively known as Joint Base San Antonio. There are also a number of police departments in the county, such as San Antonio Police Department and smaller Hill County Police Department. Beyond those agencies, Texas Highway Patrol also has a station in the county.

The team met with Sheriff Susan Pamerleau, critical partners, and participants from the sheriff's office, San Antonio Police Department, courts, public Defender, regional mental health coordinator, and representatives who operate and facilitate the public-private partnerships that have been indispensable to the county's many achievements in four areas:

1. Pre-arrest diversion
2. Conditional release and other jail diversions
3. Jail mental health
4. Post-conviction and release services

The visiting project team traveled to the county's restoration center and Haven for Hope (described in the sections that follow) and the county jail's mental health unit. In addition, the team observed the last day of the sheriff's office's crisis intervention team (CIT) training program. All sheriff's detention and sworn personnel are trained through the intensive week long CIT program. While at the Haven for Hope, the team also had an opportunity to meet with the mental health patrol officers who are part of the sheriff's office mental health unit.

One of the primary goals of the visit was to examine the aspects of their policies, practices, and strategies that would be of interest to other sheriffs and law enforcement agencies in general. It was important to consider whether the work being done in Bexar County was both scalable and transportable to other organizations. Another significant goal was to learn of the leadership and development involved to achieve their level of successful services.

The sheriff's office has approximately 1,500 personnel; roughly half work in detention positions. The jail houses about 4,100 inmates per day (preadjudication and those sentenced up to 365 days). In August 2015, the *San Antonio Express-News* reported that Bexar County Jail had one of the highest rates of suicide (15 suicides since 2009) (Zavala 2015). Inmate suicides were a significant concern during the 2012 sheriff election, won by Sheriff Pamerleau, and they continue to be an important challenge for the sheriff today.

The programs developed in Bexar County come as a result of 10 years of work and a strong catalyst: a court order in 2002 that would require the addition of up to 1,000 beds in the county to address overcrowding. One of the district judges convened a working group to determine how to divert inmates from jail who were not "appropriately housed in the jail." This is a critical part of the project study relative to how significant programs were initiated



Source: Haven for Hope

through the process of getting the decision-makers to the table and empowered to make timely, meaningful, and system-wide changes.

The original group of criminal justice stakeholders included private and public hospital representatives and has evolved into the current medical directors group that meets once per month. Gilbert R. Gonzales, the Director of the Mental Health Department and representing the Office of the County Manager, was a founding member of the group and seems to be the lynchpin (he refers to himself as the “bridge-spanner”) in maintaining positive communication and affirmations among members and their respective organizations. The success of this group appears to be due to its agility and resourcefulness, developing innovative programs and making adjustments and even course corrections in a very constructive process that depends upon trusting partnerships. The medical and mental health advocacy communities and private partners, through their membership in this working group, have been pivotal to the success of their efforts.

The Haven for Hope is a 117-acre campus two blocks from the sheriff’s jail in downtown San Antonio. The facility site is reclaimed industrial property located between two railroad tracks. A private philanthropist purchased the land and built the facilities despite the objections of local property owners. Sixty-one percent of the funding for the \$100 million project came from the private sector, 22 percent from the City, 11 percent from Bexar County, and 6 percent from the State of Texas. The operating budget for facilities is approximately \$15 million from a variety of government, private sector, and charitable sources.

A fundamental reason for the apparent success of this initiative is the layout. All residential and service resources are located on one campus and are set up to encourage a sequential progress in eliminating criminal justice barriers, obtaining housing and employment, addressing chemical dependency and physical and mental health issues, etc. Proximity was key. There were representatives from courts on site to deal with new court dates and probation and parole resources on site to assist in keeping

Children of residents are picked up first by the school buses and dropped off last so they will not be stigmatized for being at the facility. Further, with the support of the school district, the children are bussed to the schools they attended before their parents brought them to Haven for Hope.

people in compliance. The barriers exist elsewhere as these systems are not located in close proximity to the clients. Placing all services in close proximity to one another eliminates barriers that can exist in other jurisdictions that have all of the same resources but whose resources are spread throughout the community. Spreading resources across a large geographical area creates insurmountable obstacles for those the services are intended for.

Multiple buildings provide every critical service needed for this vulnerable population living with medical illnesses, drug dependency, and homelessness. Services are provided to voluntary participants and those diverted from the jail either pre-booking or post-booking on conditional release. Some of the services and requirements at Haven for Hope include the following:

- Short-term residential dormitories for men, women, and families are available, with longer-term subsidized apartments available on adjacent properties. There is some storage available for possessions, but residents are required to leave the dorms each day at 8:30 a.m. to engage in work, services, treatment, etc.
- Located on the property are a pharmacy, primary care, dental care, childcare and school buses, banking, post office, gym and recreation areas, a reading and learning environment for parents and children, a barber, and a kennel; all meals are provided. It should be noted that the Haven for Hope administration not only provides these services but also considers carefully issues of dignity of the clients they serve. For example, the children of residents are picked up first by
 - the school buses and dropped off last so they will not be stigmatized for being at the facility. Further, with the support of the school district, the children are bussed to the schools they attended before their parents brought them to Haven for Hope. This attention to detail was evident throughout the entire operation.
 - Thirty nonprofit service providers run offices in the transformation services building (and 40 more are accessible off campus) where residents can make appointments to seek assistance or services (among others, social services, help in clearing warrants, getting a government identification, language classes, general educational development [GED], family counseling, parenting, programming, housing, and employment assistance).
 - Mental health treatment and chemical dependency treatment are provided.
 - Security is extensive, with about 40 cameras, and locked and restricted access points to separate families from the general population. Further, there is a specially trained security staff on site 24/7 that patrols the entire campus.
 - The external community participates through volunteers, and faith groups pick up and drop off residents to attend services. In addition, these volunteers and faith groups assist the residents to transition back to the community.
 - Residents generally stay an average of 12 months but can stay for up to two years.
 - The dormitories are running between 92 and 98 percent occupancy.

The Courtyard is an outdoor, partially covered area designed to allow up to 400 homeless persons to voluntarily stay without being required (or allowed) to access services. There are peer counselors trained to work with these individuals to encourage them to enter the facility with an agreement to seek the services necessary for the transformation to a better way of life. These residents receive primary medical care, three hot meals per day, and lockers to store their personal belongings. While designed to serve 400, the area regularly reports a daytime count of 776 and a high of 870. The shelter area where the meals are served is a certified Federal Emergency Management Agency (FEMA) shelter and therefore can receive funding from additional sources for emergency preparations. The necessary funds are used to operate the area and support general facility maintenance.

The Haven for Hope operates as a private-public partnership. The facility is owned and operated by a nonprofit, essentially leasing space to nonprofit service providers who seek reimbursement for services through the County and State. It could be argued the fact that this is not a government-owned and -operated facility is critical to its success. It would be impossible to get the kind of political support necessary to provide and maintain access to all of these services without privately funded enterprises that can accept charitable donations, work with religious and for-profit organizations to conduct business, and provide the types of services for the residents that would be subject to annual budget review and authorization for taxpayer funding.

The Haven for Hope was intended to eliminate or at least significantly reduce homelessness. While the homeless no longer gather on the business district streets (which was part of the motivation of the business community), the Vice President of Operations acknowledged that homelessness has not declined in the county. In fact, he believes the programming has brought more people to the county to seek the service provided. The Haven for Hope draws funds from the City's Community Development Fund and new markets

tax credits, as well as \$22.5 million contributed by the City, \$11 million from the County, and \$9.5 million from the State of Texas at the start. As a result, a qualifying residence police force was recently implemented to reduce the number of homeless individuals who migrate from other locations around the country.

Haven for Hope is celebrating its fifth anniversary in 2018 and reports great success since it was established:

- 2,367 people have left the transformation center and moved to permanent housing.
- 1,553 have attained employment.
- In one year, 90 percent of the people that exited did not return to homelessness.
- The in-house wellness program providing treatment for mental illness has served 691 individuals with a success rate (engaging in treatment and finding long-term housing) of 51 percent.
- The in-house recovery program provides designated housing for people with addiction; 1,119 individuals have successfully completed the program with a 58 percent success rate, meaning that they successfully complete a rigorous 90-day treatment program and move to a stable living situation. This is significantly higher than the national average of 30 percent (American Addiction Centers 2018).
- Jail recidivism for those who have accepted services at Hope is 24 percent since opening, while the County average is 80 percent.
- Approximately 5,000 fewer jail bookings occurred in Haven's first year of operation than in the prior year.
- 40,000 medical, dental, and vision care services are provided annually.

There are other County-run facilities providing similar services in more traditional and expected formats. This program is innovative and shows why so much time was spent learning about the model.

The Restoration Center was the first diversion site at this location. Built in 2008 and located on adjacent property, it provides sobering and detoxification services to people who walk in or are dropped off by law enforcement officers in lieu of arrest and incarceration. While remaining at the drop-off center is voluntary, the individuals are informed that if they leave the facility while still under the influence of drugs or alcohol or exhibiting disruptive behavior, the police department will be notified. Families or peer counsellors dismissed from Haven for Hope because of drinking or intoxication also are sent here. An unlicensed, very informal section is staffed by emergency medical technicians (EMT). Across the hall is a licensed, locked facility for those individuals who volunteer to participate in a substance abuse rehabilitation program.

The center also has designated housing and support services for those in immediate need of psychiatric care (72-hour holds and others diverted by law enforcement are brought to a separate entrance). From the Restoration Center, residents can be evaluated, treated, and released or transitioned to other services as appropriate.

The Restoration Center has also documented great success:

- It has provided services to 35,000 people.
- It claims \$50 million in five years of documented cost avoidance for operating city and county jails, emergency rooms, and courtrooms.

Law enforcement has a very wide leeway in diverting people from jail to the Haven for Hope, the Restoration Center, or other County services facilities. The fact that so many (including dispatchers) have been trained to identify mental illness, addiction, and homelessness issues and de-escalate each contact is critical to the success of these diversions.

The sheriff's office and the San Antonio Police Department both operate patrol mental health teams with officers in nontraditional uniform attire and with customized equipment to assist in response to mental health and public order calls. The sheriff's office teams (14 people in teams of two patrols in two shifts between 7:00 a.m. and 2:00 a.m.) have been operating since 2005 and are regularly called upon by their City partners for calls relating to their expertise. Officers assigned to this patrol team said this assignment allows regular patrol units to move on to other duties and calls, as the mental health calls take so much longer.

One of the key metrics for Bexar County—and of high importance to the Medical Director partners from private and public hospitals in the area—was the number of and wait time for law enforcement at drop-offs. They all claim this has been markedly reduced through the operation of these teams and the availability of facilities like the Restoration Center.

Bexar County operates 24-hour magistrates' courts that see arrestees immediately. This is a striking and critical fact instrumental in diverting people from the criminal justice system either through release on their own recognizance or on conditional release to facilities like the Haven for Hope. The conditional releases work as a result of a Texas Criminal Code, which authorizes, and some suggest mandates, the

release of any inmate with a treatment plan approved and presented by a public defender and mental health clinician.

Addressing mental illness issues and conditional release options prior to and at the individual's first encounter with law enforcement provides for a more reasoned approach to the problem of criminalization of individuals with mental illness. Far too often, in too many jurisdictions, the court process does not allow for such intervention until after a person has been charged, made a first appearance, been assigned a public defender, and been evaluated for competency. Also of note is the fact that the mental health clinician must guarantee immediate access to the treatment outlined in the plan. This immediate access has given the judges the assurance that public safety needs have been met in a non-jail setting.

A probate judge hears competency and commitment motions at a mental health court for diverting people with mental illnesses charged with misdemeanors. The court monitors a docket of approximately 80 defendants closely to ensure proper services are provided, and the defendants are given every chance to succeed. This specialty court is similar to others in operation across the country. While the monitoring of 80 cases may be significant for the resources available to the court, it seems to fall short of addressing the needs of the mental health population associated with 4,100 inmates housed in the Bexar County jail.

Bexar County Jail maintains two mental health units (MHU) of 15 cells each. Around-the-clock nursing staff is available, medications are given, and a psychiatrist or other clinician meets with inmates regularly. Mental illness is managed—not treated—in the jail. Inmates leave here to go to competency restoration or to commitment facilities as appropriate.

This MHU did not seem to be much different than MHUs operated by other counties studied. One interesting element is an automated system requiring

15-minute to 30-minute cell checks. It was noted during the site visit that several of the inmates were severely disturbed and could be housed here for as many as 365 days for a variety of reasons. Upon inquiry, the Director of Mental Health acknowledged that so much more could and should be done to provide better a facility and care and treatment for these inmates, but no other options were available.

One of the most interesting aspects of Bexar County's operations relating to mental illness and drug abuse are the facilities and resources now under construction. The County is building a video visitation center for families of inmates, situated at a location separate from the jail. Visitors connecting with inmates will be treated like Bexar County residents seeking sheriff's services. The center features very little waiting for access to the inmate (families simply schedule an appointment and arrive 10 minutes early). There is room for two people in each of 60 booths, and there are to be three to five family visiting areas to allow multiple family members to visit at the same time. There is no concern for contraband at this separate facility, and all of the calls are monitored for safety and for intelligence gathering. For inmates, each pod will have its own monitor screen so inmates can have visits all day long; no transports or escorts are necessary. This is exceptional in that the plan allows for mobile screens to allow visitors to connect with inmates even in isolation. Further, the commercial company that provides the equipment and services offers a plan that permits the families to visit from their own homes for a monthly fee.

Across the street from the visitation center, the county plan includes a work release and re-entry services facility for inmates leaving the jail. Only limited information regarding these new services was available during the site visit. In an informal conversation, it was mentioned that this facility may allow for medications and even a short (voluntary) stay for inmates leaving the jail in immediate need of

services (housing, mental health treatment, addiction treatment or counseling, employment assistance, etc.). For additional information about Haven for Hope, visit www.havenforhope.org.

Bexar County Court also has a felony mental illness docket for post-conviction offenders, again serving approximately 80 offenders with mental illnesses and a propensity for violence. Individuals on this docket are closely monitored.

Bexar County has been addressing justice involved mental illness since the mid-2000s. Several aspects of their efforts are worth emulating, and are all arguably scalable and transportable, at least in principle:

- Focus on a cost-benefit analysis of jail diversion. The financial information is persuasive in all political and operational efforts to address jail overcrowding, emergency room overcrowding, and homelessness.
- Focus on ensuring committees formed to address these issues are attended by those with decision-making capability, who are committed to working collaboratively with a sense of common mission. It is imperative such committees include not only public officials but private sector partners as well.
- The Bexar County court system has developed its policies and practices so mental illness issues can be detected, addressed, and diverted when appropriate: at the very front end of the process rather than after a case is well under way. This requires 24/7 resources and commitment from all justice involved entities—courts, prosecutors, defense, probation, medical, law enforcement, etc.
- Homeless, chemical dependency, mental illness, and jail diversion resources are located in close proximity to one another and have developed in a coordinated manner to ensure sequential progress and success. Again, the success of these programs is due to the private-public partnership and the overwhelming common mission of all entities involved.
- Bexar County has created a stand-alone mental health department with a director whose mandate is to coordinate all efforts in the county to address mental illness, including and especially justice-involved cases.
- Bexar County law enforcement has recognized the value of and has committed to ensuring all law enforcement and dispatchers received CIT training to more properly deal with people in mental health crisis. This is a huge undertaking and a significant time commitment but the benefits are obvious and documentable.
- Finally, the Bexar County Jail has established a dedicated mental health unit with mental health professionals and clinicians who manage the population of those with mental illnesses. Like most correctional facilities, however, they struggle with the problem of management versus treatment of this subset of inmates.

Contributions to case study by Capt. Martin Molina, Lt. Brian Barrick, and Sgt. Alice Lopez.

Cook County Sheriff's Office, Chicago, Illinois

Cook County, Illinois, is the second-largest county in the nation (Los Angeles County is the largest) with a population of 5.2 million, representing 40 percent of the state's population in an area of 1,635 square miles. Chicago, the third-largest city in the nation, serves as the county seat. The county has 135 municipalities (54 percent of the population) and 30 townships (36 percent of the population) (Cook County Government 2018).

More than 20 percent of the population in Cook County is foreign born; 24 percent are Black or African American and 26 percent Hispanic; 35 percent speak a language at home other than English. Median household income for the county is \$54,548, but for the city of Chicago the median income drops to \$38,625 (United States Census Bureau 2018d).

For several years, the State of Illinois has struggled with severe budget deficits, credit downgrades, dysfunction, and the most severely underfunded pensions in the nation. Illinois passed a temporary tax increase of 67 percent in 2011, but that temporary tax expired in 2016 and the state faces a current deficit of \$5.8 billion. The State has been unable to provide funding resources for the County and has shifted the expense of housing inmates to the counties (one reason for the overcrowding and lack of resources leading to a U.S. Department of Justice investigation into substandard facilities and services of constitutional proportion). The FY 2018 budget does not account for the earlier \$6.6 billion deficit, and the proposed FY 2019 budget cuts prison funding further (Geiger, Garcia, and Lukitsch 2018).

The Cook County Sheriff's Office employs 6,900 under the leadership of Sheriff Tom Dart. The Cook County Department of Corrections (generally referred to simply as the jail) has 14 divisions (at least 12 buildings on one single site), and houses approximately 9,000 preadjudication inmates and those sentenced to jail for less than 365 days. Prior to the agreed order (*United States v. Cook County et al.*), also called a consent decree, the Cook County Jail reached a high of 10,000 inmates. Bringing down the high numbers of inmate incarceration was one of the sheriff's goals. Currently the county jail has 8,750 inmates, 2,000 of whom are on the mental health caseload, and county staffers also supervise 2,100 people sentenced to home monitoring.

Cook County operates three hospitals and 30 clinics and provides all of the prescribed medical and mental health services to inmates in the jail. Cermak Health Services is a stand-alone facility on the jail campus that provides those services for inmates not in need of a hospital level of care.

In February 2007, the Civil Rights Division of the U.S. Department of Justice notified the County of its intention to investigate constitutional violations in the jail relating to use of force, jail security, medical

treatment, mental health care, fire safety, and environmental health. As a result of the investigation, the County, Sheriff Dart, the Cook County Board of Commissioners, and Board President all stipulated to an Agreed Order filed with the U.S. District Court in May 2010 that they all still operate under, requiring remediation regarding the following:

- Proper staffing levels and supervision
- Use of force reporting
- Inmate discipline and classification
- Internal investigations
- Medical and mental health services
- Facilities
- Suicide prevention
- Fire and life safety
- Sanitation and environmental conditions

The consent decree was very detailed, especially regarding the development of an interagency written agreement delineating the respective mandates, roles, and responsibilities of Cermak, the County, and the sheriff operating as the Cook County Department of Corrections (CCDOC).

Mandates for Cermak range from timely responses to clinician orders to processing sick calls to daily rounds and a 24-hour screening process; detailed requirements for emergency, chronic, and acute care and disabilities; record keeping, mortality reviews, cleaning, lighting, maintaining medical exam rooms, providing hand washing stations, and the removal of medical waste; and stable leadership and staffing plans, ensuring qualified personnel with adequate licensing and certification.

Additional requirements for the County and CCDOC included building a new clinical space within three months of the order, providing additional and

sufficient clinical space (building, remodeling, or renovating space as required to meet the demands for services), completion of a staffing study with requirements to hire as reported, provide training to correctional officers for recognizing and responding to medical and mental health emergencies and drug and alcohol withdrawal, and proper and timely transport for all inmates with medical or mental health emergencies.

In June, 2017, the U.S. District judge ruled that the sheriff's office and the Cook County Jail were in compliance with all standards and ended the Agreed Order successfully. Cook County Jail had been under federal oversight for more than 40 years—since 1974 (Cook County Sheriff's Office 2017).

Both before and since the end of the Agreed Order, Cook County has adopted an innovative approach to serving people with mental illness in jail. Following assessments and diagnoses, inmates are classified and housed according to their P-Levels:

P-1: An inmate with no known behavioral health issues is housed in general population.

P-2: An inmate with mental illness that can be managed through outpatient levels of care (regular medication, weekly group meetings, a psychiatrist visit every three months). These inmates also are housed in general population.

P-3: An inmate with mental illness that needs a heightened level of care (medication, regular group meetings, and weekly psychiatrist visits).

These inmates are housed in division 8 Residential Treatment Unit (RTU), men on one level and women on another.

P-4: An inmate with acute care needs (medication, daily meetings, and a daily care plan with psychiatrist visit); these inmates are housed on the second floor of the Cermak Health Services facility described on page 45.

CCSO and Cermak staff coordinate all of their work at the superintendent level weekly and at least monthly at the operations level (the CCDOC Director, and Chief Operating Officer for Cermak Sheriff Dart implemented a jail management system that has a direct interface with the Cermak electronic medical record. Cermak also has authorization for "Jail Data Link" that tracks mental health records for state forensic hospitals, allowing for early identification of individuals with histories of mental illness. Housing assignments for inmates are made based on these records and the assessments completed at booking.

The order noted earlier reads like a checklist (or early warning system) for any sheriff operating a jail. In addition, MCSA may want to create some reformatted version of many of the items included in the list as areas warranting special consideration in jail management.

Between 1,200 and 1,300 of the inmates on the mental health caseload are housed in general population; between 700 and 800 have specialized housing assignments.

Each correctional building on the jail campus is named a division. Division 1 is the oldest building on the campus, which opened in the 1920s. The basement of this building was where the County formerly housed the most dangerous or infamous inmates (Al Capone was housed in division 1). The sheriff was able to close the division as the jail population decreased.

Division 8 RTU is a new building that includes a state-of-the-art booking and medical and mental health assessment facility. Visiting the pre-bond area (a drop-off site for inmates where they wait to be moved to booking) makes it clear just how necessary this

new facility was. At the pre-bond area, arrestees are housed in large empty stalls that look like cages. The staff writes numbers on the inmate's hands in black indelible ink as they are checked in for hearings. Those with behavioral issues are moved to separate fenced areas.

Following arraignment, inmates are moved to the new booking facility in the basement of division 8 RTU. This space has walk-through metal and object digital screening systems; a space for changing into jail attire (Cook County uses a shrink-wrap bag for inmate possessions, which are sent to storage in a sub-basement); and clinic-level spaces for medical assessments, mental health and psychiatric screening and assessment, and documentation. Each inmate is given a separate color wristband for staging through regular and specialized assessment.

It was apparent this facility was built as part of compliance with the order, and pursuant to the Order each inmate is required to be assigned to a bed within eight hours of the assessment.

Division 8 RTU housing for P-3 inmates

The upper levels of division 8 RTU provide housing for P-3 level inmates, with women and men on separate floors. Again, these facilities are state-of-the-art, with rooms for group therapy, therapeutic programming, outdoor activity space, and a barber and salon. The inmates are housed in large numbers in bright, clean, and open wings for easy supervision (from behind one-sided glass). Each floor has a nursing and staff station for charting and care decisions. But each wing also has a separate booth for medical staff to access and distribute medication one inmate at a time without actually going into the wing. In this housing unit, inmates distribute their own meals as well as clean. As P-Levels are continually assessed, inmates in general population may be moved here as the need arises.

Cermak second floor for P-4 inmates

This floor of Cermak was reserved for the P-4s, the more seriously ill inmates. It looked nothing like a jail but was far more similar to a hospital ward, managed mostly by medical staff with a nursing station for directions, charting, and supervision. The correctional staff also participates in inmate supervision. During the site visit, one officer was providing one-on-one observation of an inmate on suicide watch. The rooms were clean and well cared for, all with windows, and there was also space designated for out-of-cell activities. The site visit team observed a meeting for one inmate where the doctor, nurse, and correctional staff were all in the room developing a daily psychiatric care plan for that inmate. It was clear that Cook County has worked to fully implement the court's goal of focusing their efforts and the necessary resources on inmates with the most critical need.

Cook County is unique in many ways, principally because the sheriff appointed a licensed clinical psychologist as Executive Director of the Cook County Department of Corrections. He has also brought on doctors as the Chief of Programs and Director of Behavioral Health within the sheriff's office.

The sheriff has implemented several of his own initiatives to address jail mental health issues. These initiatives operate separately from Cermak, offering biopsychosocial programming to detainees identified by Cermak as higher functioning or P-2.

The sheriff's office website home page is dedicated to messaging about jail mental illness and includes 18 separate inmate profiles as unjust incarceration case studies.

Mental health assessment at jail intake for diversion

Sheriff's personnel have made a great effort to assess the incidence of jail mental illness. Not relying on the Cermak screening process, the sheriff has appointed a social worker to assess the self-reported incidence of jail mental illness. She and nearly a dozen social workers separately assess inmates as they are brought in to pre-booking and prepare an assessment. They work to identify special cases that they bring to the public defender, the prosecutor, and the courts for possible diversion. This initiative has drawn attention to those with mental health issues who may benefit from community-based services rather than incarceration.

Cook County was selected as one of the recipients of the MacArthur Foundation grant working to identify alternatives to incarceration.

Mental Health Transition Center intensive re-entry program

The sheriff has invited dozens of chronic low-level offenders to participate in a targeted and very intensive program assisting inmates with reintegration and re-entry: jobs, housing, mental health treatment, and adult basic education. This is a cognitive and behavioral restructuring program operated out of the former boot camp facility on the jail campus. Qualified inmates (mostly in the P-2 level) are bussed to the facility for programming that the inmates discussed with the site visit team personally. More than 200 graduated in the first year of the program, which includes an alumni program and family support group.

Several inmates stated they were very grateful for the program, all reporting a new awareness of self-respect and responsibility and positive encouragement for making a fresh start with family and potential employers (even from within the jail).

Key correctional staff members run the program, and a number of the participants claim the program to be highly successful. Currently the program is a day program but the hope is to expand it to include residential participants. The County follows up with these inmates with post-release programming and services. More than 10 former detainees return to the jail twice monthly to receive ongoing mental health services and support from the mental health and correctional staff.

Mental health treatment and programming

The sheriff has made a deep investment in programming for inmates, with the philosophy that even a very short-term inmate can benefit from therapeutic programming, learning coping or living skills that may help them address mental health challenges they face while incarcerated or stresses and challenges faced when released. The goal is to provide therapy and programming for all spectrums of mental illness in particular keeping the population busy and active in an effort to reduce incidents and improve the quality of life for staff and detainees, even those not on the Cermak mental health caseload. Accordingly, the sheriff has implemented the following innovative programs in addition to individual and group therapy:

- Yoga and meditation
- Mindfulness and emotional intelligence
- Culinary and barber schools
- Urban farming
- Creative arts and expressive therapies
- Literacy
- Health education
- Discharge planning services
- Photography and advertising skills

- The Sheriff's Anti-Violence Effort (SAVE) program

Perhaps the most interesting aspect of these programs is the fact that the sheriff has linked these efforts to a reduction in inmate incidents and grievances. The sheriff's office has also trained its own correctional and clerical employees (who are given time away from their regular duties) to run these Working for Change programs. The employees report back that they find this to be a rewarding aspect of their employment.

The sheriff's office has promoted a crisis hotline specifically to address the risk of inmate suicide and to identify detainees in need of treatment and support services. Top managers and directors in the Cook County Jail take turns answering the 24-hour hotline. They want families to make them aware when there is bad news to share with an inmate or to report an inmate that may need urgent mental health attention. Only top-level personnel are assigned to this duty, because they are knowledgeable of the entire system and services and have the authority to access and secure an immediate response. They receive roughly 15 to 20 calls per month from families.

Sheriff Dart partnered with the Cook County Health and Hospitals System and a community treatment provider to assist inmates in signing up for CountyCare (under the Affordable Care Act) and securing other benefits, accessing community providers, and developing a plan for ongoing medication and treatment. The County also has a contract with a residential community treatment provider for homeless detainees who are court-ordered to submit to electronic monitoring (up to 200 at one time).

The Sheriff's Training Academy provides all sworn employees with more than 100 hours of training on mental health topics and an additional 40 hours of crisis intervention team (CIT) training. In addition, sworn staff receive training on effective engagement with the public, interpersonal skills, and cultural diversity. The academy is located at the local Cook

County Community College, and participants get college credit toward an associate's degree.

The following summary lists the aspects of the Cook County program that are scalable and transportable and would be worth replication:

- Above all else, the Cook County Sheriff's initiatives benefit from an obvious and deliberate mandate from Sheriff Dart and senior leadership. The program is infused with a sense of "can do" and is void of common concerns and shortcuts due to a lack of support or funding. This atmosphere is the foundation for the Cook County program.
- Cook County is deliberate in deploying resources towards intercepting individuals with mental illness throughout the criminal justice process (sequential intercept model). This was most apparent in the following areas:
 - Sheriff's Pre-Bond Initiative, in which all new arrests are screened by sheriff's office personnel even prior to being remanded to the sheriff's office's custody. Information from this screening is shared with the court prior to arraignment in an attempt to divert those who would be better served by not criminalizing the behavior that led to the arrest.
 - Sheriff's Transition Center, in which inmates who have traditionally "churned" through the criminal justice system are engaged in cognitive and behavioral programming designed to assist them with reintegration into the community with the goal of reducing recidivism. A by-product of this program has been a reduction in behavior issues for enrolled inmates while they remain in custody.

- Mental health screening for all inmates upon initial booking by medical staff. Various colored wristbands are used to ensure inmates are not inadvertently passed through the system without the proper follow-up. Cook County has established criteria for programming and treatment based on P-Level. This ensures that each inmate in each P-Level receives the designated amount of programming and treatment each month. Designated inmates participate in a more thorough mental health assessment and are then assigned a “P” (Psych) level—P 2, 3, or 4. The P-Levels are used to appropriately house inmates and ensure they receive a designated level of programming and treatment. This P-Level system also allows the sheriff’s office to maintain a clear picture of their mental health population and devote resources appropriately.
- Cook County has established a designated mental health hotline to better facilitate critical information from family members specific to the mental health needs of an incarcerated individual. The hotline is also innovative in encouraging family members to pass potentially upsetting (to an inmate) news on to the sheriff’s office rather than directly to the inmate so jail staff can prepare the best way to deliver potentially upsetting news to the inmate and provide support. Finally, the hotline serves as a resource for former Cook County inmates needing assistance after release.
- Cook County Sheriff’s CIT training is designed specifically for correctional officers to deal with individuals with mental illnesses in a correctional environment. As a result of the program design, Cook County has made physical changes to their mental health housing areas to include lighting and baffling to reduce noise.
- The 2010 consent decree from the U.S. Department of Justice was the result of a federal investigation dating back to 2004 and details the interagency

agreements between key stakeholders in Cook County. This document may be very useful for those sheriffs in the process of or interested in reviewing their interagency agreements for the provision of facilities and medical and mental health services. It is exhaustive in delineating the respective roles and responsibilities for key stakeholders in providing housing and services for inmates with mental illnesses. As a result of these efforts, Cook County and the Cook County Sheriff’s Office now are recognized nationally for their innovations and for their leadership in improving the services provided to people with mental illness.

For those interested in reviewing this order, it can be found online at https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/CookCountyJailAgreedOrder_05-13-2010.pdf.

Contributions to case study by Dr. Nneka Jones Tapia.

Los Angeles County Sheriff’s Department, Los Angeles, California

The County of Los Angeles is the most populous county in the United States with a population of more than 10 million people. The county seat is Los Angeles, which is the second-most populous city in the nation and the most populous that lies entirely in a single county. The County of Los Angeles has 88 incorporated cities and many unincorporated areas. It is one of the original counties of California, created at the time of statehood in 1850. As the population increased, sections were split off to organize San Bernardino, Riverside, Kern, and Orange counties. Most of the population of Los Angeles County is located in the south and southwest, with major population centers in Los Angeles Basin, San Fernando Valley, and San Gabriel Valley. Other population centers are found in the Santa Clara Valley, Pomona Valley, Crescenta Valley, and Antelope Valley (Los Angeles County Sheriff’s Department 2018).

MHAT is an LA County Department of Mental Health resource. MHAT provides mental health response to local and federal law enforcement agencies in facilitating a negotiated solution to barricade and hostage situations.

The racial makeup of Los Angeles County is 26 percent White, 15 percent Asian, 9 percent African American, 1 percent Native American, and less than 1 percent Pacific Islander. Hispanic or Latino residents of any race made up 49 percent of Los Angeles County's population. The median income for a household in the county was \$42,189, and the median income for a family was \$46,452 (United States Census Bureau 2018e).

The Los Angeles County Sheriff's Department (LASD) was founded in 1850 and today serves the residents of Los Angeles County. The LASD provides general law enforcement services to 40 contract cities; 90 unincorporated communities; 216 facilities, hospitals, and clinics located throughout the county; nine community colleges; the Metropolitan Transit Authority; and 47 Superior Courts. The LASD also provides services such as laboratories and academy training to smaller law enforcement agencies within the county. In addition, the LASD is responsible in securing approximately 18,000 inmates daily in seven custody facilities, which includes providing food and medical treatment.

The LASD supports mental health programs in a variety of important ways. The LASD and LA County Mental Health provide deputy and clinician mental evaluation teams (MET) in the field from 10:00 a.m. to 1:00 a.m. These teams are specially trained and will respond to calls where mental health issues may be involved, which include domestic violence, violent or bizarre behavior, and suicide threats. The team's involvement supports better outcomes for those with mental illness or mental health problems who come into contact with LASD field officers while also helping area deputies focus on other duties.

In addition, mental health alert teams (MHAT) are available to tactical and SWAT (special weapons and tactics) teams as a resource during call-outs. MHAT is a Los Angeles County Department of Mental Health resource. MHATs provide mental health response to local and federal law enforcement agencies in facilitating a negotiated solution to barricade and hostage situations. These are separate from METs and are used more for barricaded, violent, stand-off situations.

The LASD was the first agency in the nation to have METs. Like other teams across the United States by the same or similar names, METs pair a deputy with a Department of Mental Health clinician. Each deputy receives additional pay, and selectees include both deputies and clinicians vetted for these positions. Patrol personnel receive the baseline mental health (MH) training of three hours (Peace Officers Standards and Training Commission [POST]-certified). Others move on to the eight-hour intermediate class (POST-certified) and others continue through the 40-hour crisis intervention team (CIT) course. METs and JMETs (jail mental health team) receive at least the 40-hour course. These professionals operate in nonuniform assignments. There are currently eight teams with an expectation of expansion to 23 teams (one MET team for each station).

In addition to METs, a 25-person JMET walks the housing areas to identify those who may need MH resources but were not identified during booking. As part of providing better mental health call outcomes and resources, a mental health committee with representation of all available stakeholders was convened. A call may be a call for service from central dispatch or a secondary field activity report. JMETs were provided training by national authorities such as the

National Alliance for Mental Illness (NAMI) and the National Institute of Corrections (NIC). NIC provides 40 hours of training similar to the Memphis model CIT training.

In the law enforcement community, mental health “flags” are placed in a CAD system for mental health related calls, locations, and availability of responding deputies who have been trained in how to deal with individuals with special mental health needs. Sergeants in the field direct when use of force incidents are necessary and a watch commander monitors all use of force anticipated calls. When possible, they look for disengagement opportunities on possible use of force calls. If possible, viable alternatives are reviewed and discussed between the field sergeant and watch commander. Each shift has CIT-trained personnel on duty and ready to respond.

LASD provides a variety of training in the form of various mental health learning blocks, which are provided according to assignment and rank. Each CIT trained personnel receive the following:

- Six hours in the academy
- 32 hours while working custody (de-escalation and verbal resolution training or DeVRT)
- Three hours for lieutenants and below
- Eight hours intermediate
- 32 hours of advanced techniques (Memphis model)
- Eight hours recertification for all every three years
- Patrol School resource officers have a two-hour MH block covering
 - policies and procedures;
 - field ops directives;
 - department newsletter information.

An additional layer of support is provided by jail compliance teams (JCT). These were created in response to litigation and subsequent federal oversight. JCTs and all other stakeholders (including mental health staff) were present in the U.S. Department of Justice negotiations from the outset. Two attorneys are embedded with the JCT to make sure the department is in compliance with U.S. Department of Justice agreements, including those pertaining to mental health.

The LASD has made a number of positive changes in how it treats people with mental illness who have not been diverted into community treatment and are incarcerated in the jail. It is currently conducting a pilot program in which inmates have access to electronic tablets that are used for contacting mental health clinicians in the jail and for requesting mental health services. Although this initiative remains in the pilot stage, the feedback the team received from inmates indicated that it is improving the response time on the part of clinicians and helping inmates stay better connected to the clinicians in the facility.

All inmates at the main men’s facility in downtown Los Angeles who are currently experiencing suicidal ideation or intentions or are identified as being at risk of self-harm are being housed in direct observation and supervision units. This means they are continuously monitored by staff members and have no opportunity to secretly engage in self-injurious or suicidal behavior. It was reported that there have been no successful suicides in the two years since the sheriff’s department began managing suicide and self-injury risk in this manner, and there have been only two incidents of self-injurious behavior. Many smaller jails may not have the physical space that is needed to maintain a suicide prevention housing unit such as this one, but the model and practice appears to be one that is worthy of replication.

The jail provides access to a variety of services at the time of discharge from the facility. One hallway consists of a number of offices, each one providing a

distinct discharge planning or re-entry service such as planning for housing, medications, vocational needs, etc. This design is similar to the “treatment mall” concept that has been developed at a number of state mental hospitals and is effective in that it provides access to all services in a single location, which is in the same area where inmates must go to be processed out of the facility.

The LASD is under a consent decree or settlement agreement related to its provision of services for people with mental illnesses in its jail facilities. The facility administration has developed a strategic approach to ensuring that all staff members are receiving the training they need to effectively manage the inmate population with specific focus on those inmates with mental illness and that the processes in the jail not only meet the requirements of the consent decree but also provide appropriate care for those incarcerated. In addition to addressing the needs of inmates and the requirements of the consent decree, the LASD administrators’ approach has been to proactively engage with the monitors of the consent decree to ensure there is clear communication between them and a consistent approach to monitoring compliance.

In addition to all of these efforts, as a part of overall jail planning and to stay in front of future issues, the LASD is working with the University of California Irvine (UCI) to forecast the jail population and demographics, thus identifying future staffing and resource needs. A Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) risk management tool is used for jail population management. COMPAS is a standard assessment tool in the criminal justice system, and is used primarily for detecting criminogenic needs, including substance use disorders. It has been presented in professional journals and is used by both jails and prison systems.

The LASD continues to address the problem of people with mental illness within its jurisdiction to include care of those with special mental health needs. Housing and jobs for individuals with mental health needs are an important part of discharge planning, and the LASD uses a specific outprocessing system with discharge and resource windows available to staff and inmates as they are discharged from jail as noted earlier.

At a systemic level, the LASD is trying to find a balance in the mindset that directs the way deputies operate. This includes making a cultural change from warrior to guardian. Specific activities include creating videos for internal and external use. The sheriff’s department has brought on a senior media figure to serve as a strategic communications manager and provide a link on their website called guardian-lasd.org. Although LASD has several videos available, the one that was highlighted and related to community relations was the Guardian Project, which can be viewed at <http://lasd.co/the-guardian-project-what-is-it/>. In addition, the department has created tri-fold fliers of resources for the field for families of individuals with special mental health needs.

The paring down occurred when the communications manager saw an early draft of the tri-fold, which contained numerous phone numbers and resources. Being new to LASD and the project, she inquired as to the reason or purpose for the tri-fold and the intended audience. She was told it was meant for those in need and their families, who required resources (24/7). It also serves as a quick reference for the deputies. She felt the tri-fold was too busy and did not communicate a clear message (to the deputies or public). Many of the numbers in the earlier version of the tri-fold were not staffed 24/7 or only led to recorded messages or unanswered phones. The paring allowed for an easy-to-navigate guide with a few simple numbers and resources that were the most user-friendly and effective (the ones that were already

being used the most). As mentioned elsewhere, even the most willing families at their wits' end may give up without effective, 24/7 resources.

Contributions to case study by Chief Stephen Johnson.

Hennepin County Sheriff's Office, Minneapolis, Minnesota

Hennepin County has a population of 1,212,064 with the overall population for Minnesota at 5,457,173. The county has a total area of 607 square miles, of which 554 square miles is land and 53 square miles is water (Hennepin County, Minnesota 2018). The White population of Hennepin County is 69 percent; the Black or African-American population is 13 percent. The American Indian population of Hennepin County is 1 percent, and the Asian population is 8 percent (United States Census Bureau 2018f).

The Hennepin County Sheriff's Office (HCSO) employs 800 sworn and civilian members of the agency under the leadership of Sheriff Richard Stanek. The Hennepin County Department of Corrections (generally referred to simply as the jail) has six divisions and houses approximately 839 preadjudication inmates and those sentenced to jail for less than 60 days. The divisions are broken down into Patrol, Special Operations, Water Patrol, Transportation, and K-9. The Patrol division covers Greenfield, Hanover Medicine, and Rockford Counties. The primary law enforcement response for Minneapolis is the Minneapolis Police Department. The jail capacity is approximately 839, of whom 539 are held at City Hall and 300 are in the public safety facility.

Average daily bookings are almost 100 per day, with a similar number of inmates being released daily. The average length of stay is 13.07 days for felonies while for gross misdemeanors the average is 1.87 days. Approximately 75 percent of persons booked are detained for less than 72 hours. It should be noted that Hennepin Jail is a pretrial detention facility,

and once the inmate is convicted they are transferred to local or state correctional facilities. The average morning count is 707.

Minnesota uses rule 6 of the Minnesota courts' Rules of Criminal Procedure, which sets forth the decision-making criteria on arrest, detention, and release on citation for warrantless arrests for individuals with mental illness.

The Minneapolis Police Department and the HCSO adopted a crisis intervention initiative as a result of a confrontation with an individual with a mental illness who confronted them with a deadly weapon. During that event, on June 12, 2000, Minneapolis police interacted with Barbara Schneider. Schneider opened the door with a large knife and confronted the police. The police ended up shooting and killing her. Much like the Memphis case from 1987, citizens became upset with how this was handled and the Barbara Schneider Foundation was established to ensure law enforcement is trained on crisis intervention.

Another significant historical event occurred in January 2011, when the jail command staff attended an order to show cause hearing compelling the Minnesota State Department of Human Services (DHS) to explain why it was taking so long to move civilly committed individuals with mental illnesses from the jails to state-operated treatment locations. The HCSO began a working relationship and partnership with the civil court judge to collaborate on how to improve or streamline aspects of the court system as it relates to the population of those with mental illnesses in the jail.

In February 2013, a comprehensive review of the civil commitment became an issue, so in May 2013 Judge Kerry Meyer was named as the presiding judge of the Criminal Mental Health Court. Her job was to determine the competency on all rule 20s. Rule 20 relates to the issue of a defendant's competency to stand trial. If the defendant lacks the ability to understand their rights when communicating with their attorney or cannot understand the degree or

the nature of charges, the possible punishment for their actions, or the nature of the proceedings, they may not meet the standard for competency. As a result, the prosecutor or defense must make a motion challenging competency, or in the alternative the court may raise the issue. At the time, a committee was created that included the public defender's office, the state attorney's office, the probation office, and social services who were given the responsibility to review all case dockets.

In December 2013, the Hennepin County Department of Human Services and Public Health created a social service team within the jail. Because there is a large number of individuals with mental health disorders returning to the jail as repeat offenders, the HCSO along with the Department of Social Services established the integrated access team (IAT). This team, comprising social workers and correctional deputies, works in the jail specifically tasked to focus on low-level offenders with mental illness who have a risk of recidivism. They make a recommendation to the inmate and if they agree to accept the social services, they begin an intensive 90-day case management plan.

The HCSO also provides two mental health nurses, and a psychiatrist is in the jail two to three times a week but is also available for consult with inmates 24/7. They have an inmate classification system that is operated by selected jail deputies. They have CIT-trained deputies that work in the special management housing units, which houses inmates with mental disorders and drug dependency issues. This specialized unit within the jail was developed to address inmates with mental illness whose interaction requires greater management to ensure the safety, security, or orderly operation of the jail.

One of the initiatives, led by Sheriff Stanek, involved a change to state legislation to compel the Department of Human Services and Public Health to accept civil commitments from the jail settings within 48 hours of incarceration.

Hennepin County has an excellent judicial process designed to address offenders dealing with mental disorders. The Hennepin County Criminal Mental Health Court was established in 2008 and is a working collaboration between courts, corrections, human services, and public health and medical professionals. This court is focused on a problem-solving model designed to serve the defendants with mental illness or co-occurring disorders. The individuals processed by this court go through an intense 12-to-18-month voluntary program that works toward sobriety and stability. It is closely monitored by the courts and by mental health and corrections professionals. This program allows immediate access to services such as mental health professionals, individual housing specialists, chemical health counselors, and the U.S. Department of Veterans Affairs. The individual's progress is closely monitored by probation and the judicial system. All parties (i.e., state prosecutor, defense attorney, and the client) must consent to have the matter handled by the mental health court.

While Hennepin County is moving in the right direction, it recognizes there is more to be done to effectively address this vulnerable population. For example, there is a lack of community-based housing options available to those who need community-based housing—a common problem in most communities across the country. They are also looking at repurposing the vacant juvenile detention center to use as a treatment facility for those in the justice system who are suffering from mental illness. Hennepin County has demonstrated a willingness to address the needs of individuals struggling with mental disorders both in the community and in the jails and will continue to seek innovative ways to improve the outcomes for individuals who come in contact with the law enforcement and the criminal justice system.

Contributions to case study by Julianne Ortman.



Summary and Conclusions

As the result of this assessment of the participating members of the Major County Sheriffs of America (MCSA), it is possible not only to identify a number of programs, processes, and systems that are effective in reducing the number of people with mental illnesses in the criminal justice system but also to present in-use programs and components that are central or foundational in achieving this goal. This review of participating sheriffs' departments and offices has revealed important descriptions and observations of successful programs and practices that may in turn serve as models, guides, or inputs for other jurisdictions confronted with similar challenges of caring for people with mental illnesses. This report represents a point-in-time examination in an ever-evolving challenge of dealing with mental disorders and co-occurring drug dependency. It should be noted the sheriffs' offices and departments identified in this report and others not highlighted continue to innovate and initiate programs to address contact with individuals in the field and in the jails.

As this report points out, there are a number of ways to achieve reductions in the number of people with mental illnesses who become involved or reinvolved with the criminal justice system. These interventions go beyond basic diversion efforts and include the day-to-day management, clinical treatment, and re-entry processes for people with mental illnesses who are involved in the system, up to and including periods of incarceration. For example, adequately identifying, assessing, and treating an individual's mental illness during a period of incarceration can prevent him or her from deeper systemic penetration into or

extended involvement with the criminal justice system because it can facilitate successful re-entry and prevent future incarcerations.

Perspectives concerning people with mental illness in the criminal justice system as identified by the MCSA members who participated in this study include the following:

- Jail is not the ideal clinical setting for managing mental illness.
- There has been a significant increase in the number of people with mental illness in the criminal justice system since the deinstitutionalization of people with mental illness that began in the 1960s and has continued to the present time.
- Sheriffs' offices are increasingly the primary point of contact for those with mental illness, whether this is by patrol officers or custody staff.
- Sheriffs' offices, largely out of necessity, have developed programs to more appropriately and effectively interact with those with mental illness both in the community and in the jail.
- All MCSA members who participated in the study have had programs for addressing mental illness in place for longer than one year at the time of the review.
- Sheriffs' offices are actively gathering and implementing ideas, policies, procedures and practices for effectively interacting with, housing, and treating those with mental illness with whom they come into contact.

The results of this study indicate that the following programs or practices are being implemented by a number of the MCSA members with great benefit to those with mental illness in terms of

- reducing the frequency with which they are arrested;
- diverting them from jail or minimizing the amount of time spent in jail;
- appropriately treating those who are incarcerated;
- helping them successfully re-enter the community, which includes reducing the frequency with which they recidivate.

In addition to the demonstrated effectiveness of these programs and practices as described earlier, the following practices can be viewed as a template for law enforcement officials specifically and the criminal justice system generally in how to best interact with and treat those with mental illness who encounter law enforcement officers, whether or not they have committed any criminal acts.

Practice 1. CIT-trained field officers

Every one of the seven jurisdictions selected for site visits had an active program for training field officers in crisis intervention teams (CIT), and a high percentage of their field officers had already received CIT training. In Los Angeles County and a number of other jurisdictions, there is an active effort to further mold the ethos of deputies from that of warrior to that of guardian of the public and their safety. CIT training dovetails with this mindset and is a critical component of a field officer effectively encountering those with mental illness. When a patrol deputy has a better understanding of the ways in which mental illness may affect an individual's attitude and behavior, they are able to distinguish criminal behavior from clinical illness and therefore more safely and effectively interact with that person.

Jefferson County, Colorado, and Hennepin County, Minnesota, took this practice a step further by providing CIT training for mental health professionals who are then assigned to the patrol station of the sheriff's department. This provided an additional level of mental health expertise to patrol deputies which, per the report staff, has contributed to better outcomes when interacting with people with mental illness. In addition, the Los Angeles County Sheriff's Department (LASD) has also established mental evaluation teams (MET) that accompany deputies on patrol and are available to immediately assess and clinically intervene for those who have mental illness and are encountered on the street.

The Bexar County Sheriff's Office has, for a number of years, required CIT training for all of their deputies, a practice that has spread to the San Antonio Police Department. They have also opened up their training program to the fire service, emergency medical services, and radio dispatchers. Further, they also permit first responders outside of Texas to attend the training as well. As a result, Bexar County has experienced a significant drop in use of force occurrences with people with mental illnesses since the mid-2000s.

Recommendation. CIT training for all deputies should be considered a necessary component for those jurisdictions that desire to reduce the number of people with mental illness who become involved in their criminal justice system.

Practice 2. Diversion

All sheriffs' offices selected for site visits have an active program for diverting from jail those with mental illness who have been arrested but can safely and appropriately be sent into another setting. The site visits revealed that the most effective early diversion effort is having a drop-off center or mobile crisis unit, where officers can take an arrested individual with mental illness for an assessment and

then treatment rather than booking into jail. The drop-off centers or mobile crisis units can process individuals relatively quickly. Field officers in Jefferson County, Colorado, report that processing an individual at the drop-off center often requires no more than 30 minutes, so officers are not required to invest large blocks of time in the diversion effort that would make them unavailable on the street. Bexar County also has an important drop-off center for individuals who have a mental illness, abuse drugs, or are under the influence of alcohol. The center is staffed with emergency medical services (EMS) personnel and other professional staff at their City of Hope facility. This drop-off process ties up deputies only for about 10 minutes and provides a gateway to other psychological, medical, and social services which are co-located at the center.

In addition to drop-off centers or mobile crisis units, Cook County, Illinois; Hillsborough County, Florida; and other jurisdictions screen individuals who are brought to the jail for mental illness and the possibility of diversion prior to being officially booked into the jail. Although this occurs later in the arrest process than dropping an individual off for an assessment, it still results in those with mental illness who are appropriate for diversion being diverted away from jail and into more appropriate treatment settings.

Recommendation. The ability to divert an individual with mental illness away from jail and into a more appropriate assessment or treatment setting is critical to reducing the penetration of people with mental illness into the criminal justice system.

Practice 3. Mental health and problem-solving courts

All sheriffs' offices that were visited for this study had active mental health or problem-solving courts. Bexar County, Texas; Hennepin County, Minnesota; and Ventura County, California; have longstanding

problem-solving courts (i.e., drug abuse courts and veterans' courts) that have demonstrated effectiveness in reducing incarceration and recidivism. Problem-solving courts should be considered within the diversion continuum and are strong contributors to the goal of reducing the inappropriate incarceration of those with mental illness. The establishment of these specialty courts focused on at-risk populations require a significant collaboration between the courts, prosecutor's office, defense attorneys, and related professional services organizations. While the effort to establish such an arrangement is significant, the beneficial impact was very apparent in each of the MCSA jurisdictions studied.

Recommendation. All jurisdictions should consider establishing specialty noncriminal courts (e.g., drug courts or mental health courts) The results of this review indicate that these specialty courts are effective in diverting those with mental illness away from incarceration and into more appropriate treatment settings.

Practice 4. Mental health screening in jail

Underscoring the importance of screening activities, the National Commission on Correctional Health Care (NCCCHC) Standards for Health Services in Jails require that all individuals who are booked into jail must have a screening of their mental health history and needs. All sites surveyed for this study conduct mental health screenings for those booked into the jail. Appropriate screening identifies current mental status and functioning, including the potential risk of suicide, along with the history of or current symptoms of mental illness. Being arrested and incarcerated is traumatic in and of itself and has the potential to reactivate latent or exacerbate active symptoms or experiences of mental illness. It is not possible to effectively address the risk of suicide and symptoms of mental illness without effective screening.

Cook County, Illinois, conducts initial screening of all those booked into the jail but has implemented a system that goes beyond appropriate initial screening. They have a mental health classification system that mirrors that of many state Departments of Correction. Based on the results of the screening, individuals are assigned a mental health level that helps determine the level and extent of treatment services needed and provided to that individual.

Recommendation. It is an accrediting body requirement and an operational necessity that all individuals who are booked into a jail are screened for the presence of suicide risk and need for mental health monitoring or services. Further, it is recommended that the screening be initiated at the earliest possible opportunity in the intake process.

Practice 5. Mental health treatment in jail

As is the case with mental health screening, the NCCHC standards require that mental health treatment be provided to all those in jail with a mental illness or those who have been identified as needing mental health treatment. All sheriffs' offices that were visited provide professional mental health treatment to those who require it in the jail. Stabilization should occur for all inmates who enter the facility, primarily meaning they are supported and their needs addressed so they are no longer in crisis. It is very common for inmates to experience symptoms of depression and anxiety at the time of booking into a facility. Stabilization helps the offender deal with those feelings and return to a relatively calm emotional state. Treatment refers to providing diagnoses, treatment planning, medication, psychotherapy, homework, and other interventions by a mental health professional to specifically address either disruption in mental health or the presence and symptoms of a mental illness.

Mental health and jail management professionals are beginning to recognize the need not only to provide treatment for those in jail who have a mental illness but also to actively work to maintain or support the mental health of all those who are incarcerated in the jail. Cook County, Illinois, has developed an array of services specifically designed to maintain—or at least prevent deterioration of—the mental health of those who are incarcerated. This is an innovative approach and one that should be adopted by all jurisdictions. To manage expense, sheriffs' offices should explore public and private community resources for bringing these services into the jail as well as the more traditional approach of directly providing mental health staff.

Recommendation. Providing some level of care for people with mental illness while in jail should be considered a requirement for increasing continuity of supervision and reducing mortality while a patient is in custody and supporting successful re-entry, which then reduces the risk for future arrest and re-incarceration of those with mental illness. In addition, it is highly recommended that jails review and monitor their policies, procedures, and practices to identify those that contribute to deterioration of mental health and work to remove or alter those that contribute to worsening mental health in the jail.

Practice 6. Discharge planning and re-entry

It is another NCCHC standard that those who are incarcerated be provided discharge or re-entry planning services. All jurisdictions visited provide discharge planning for those who have been incarcerated in the jail. The importance of adequate re-entry or discharge planning is widely recognized in the field and is an indispensable component of preventing future incarceration or re-incarceration of those who are in the jail.

Recommendation. Provide comprehensive re-entry planning that begins early in the incarceration process.

Additional observations

Some additional observations were made over the course of this study that did not rise to the level of a recommendation as their application may be limited by resources, practices, and philosophies relating to the role of law enforcement and jail operations. Two of the most significant observations relate to the development of a multidisciplinary residential campus versus geographically dispersed services and the development of a high-level treatment facility incorporated into the jail complex.

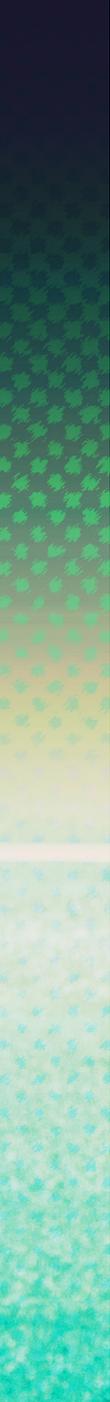
In the first instance, co-located versus geographically dispersed services require a significant commitment by the agencies that comprise the criminal justice system and the treatment and social communities. The commitment includes compromise and contributions that focus on the greater good for the individual rather than the accomplishment of individual organizational goals and objectives.

The second observation goes to the question of the role of the jail operation as it relates to treatment versus stabilization and maintenance. In facilities represented by Cook County, Illinois, a decision was made to create a high-quality treatment facility to make every effort to help the individual leave the jail far better than when they entered. Considering that individuals with mental illness stay longer and have

more frequent recidivism rates (Treatment Advocacy Center 2014), such an approach is realistic because these individuals will spend more time in jail than the average inmate. Further, community-based treatment may be interrupted by periods of incarceration that can impact medication regimes, counseling and other supports. This approach requires significant financial commitment, facilities, and staffing. The counter-argument to this approach is that jails should limit their efforts to stabilization and maintenance of the individual, with treatment the responsibility of others in the mental health community.

Sheriffs and other members of the criminal justice system should use their voices and political influence to support agencies and organizations that are better equipped, and have as their mission the treatment of those dealing with mental disorders and various forms of drug abuse. In other words, we need to return to a model that does not create jails as the largest mental illness and drug abuse centers in their states. Decisions as to how this should play out are by necessity left to the individual communities based on a wide range of considerations.

This report has identified a number of effective practices that go beyond the six listed in this summary, but these six in some form are used by all MCSA members as critical components of their programs to reduce and prevent the arrest and incarceration of those with mental illness. In one form or another, these practices should be carefully considered as potential essential components of sheriffs' office operations.



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Appendix A. Survey Instruments

This appendix contains the text of the survey that was sent to sheriffs in 2015. The formatting has been changed to conform to COPS Office publication standards.

The Major County Sheriffs' Association has made addressing individuals with mental health needs, both in our communities and in our jails, a priority issue for the past several years. As a result of our association's focus, we received a grant from the Office of Community Oriented Policing Services (COPS Office) to survey our membership and determine what our sheriffs are already doing to deal with individuals with mental health needs.

Our project begins with a survey instrument that is divided into three tracks of questions targeting the Office of the Sheriff, jails, and field operations and law enforcement personnel. By breaking this data collection effort into tracks, the questions can be answered by the most appropriate individual as determined by the sheriff.

This data collection survey, the first step in this project, will be used to identify several sheriffs' offices for site visits over the next year. We will use these visits to learn more about what is being done in your communities to respond effectively to individuals with suspected mental health needs in the community and to those who are arrested and confined in our jails. Your answers to this survey will be considered confidential and only shared with the COPS Office grant team.

The following questions pertain to the manner in which your agency deals with individuals with mental health needs in law enforcement. Please answer the following questions from the perspective of an administrator or elected official. Space has been provided to expand on answers when necessary. Your answers and your agency's specific information will be kept in strict confidence and will not be released to the public.

If you have any questions, please contact us.

Name and rank: _____

Agency: _____

Sheriff's name: _____

Address: _____

City/Town: _____

State: [select state]

ZIP: _____

Position: _____

Email address: _____

Phone number: _____

Please provide us the following information:

Total number of sworn employees: _____

Total number of employees assigned to the jail: _____

Total number of employees assigned to motor pool/operations: _____

Chief executive officer

1. Does your agency have a specialized program that identifies and addresses individuals with mental health needs? (If yes, please continue. If no, please indicate as such and you may stop. The remaining survey questions pertain to sheriffs' offices that have a program in place.)

- Yes No

2. Was there a significant event that caused you to implement a program that addresses individuals with mental health needs?

- Yes No

If yes, please describe: _____

3. What were your most important considerations when developing and implementing your program that addresses individuals with mental health needs?

- Legal issues
- Cost
- Training of corrections or road patrol deputies
- Obtaining support from the community
- Engaging important stakeholders (e.g., courts, prosecutors, community mental health professionals, others)
- Developing specialized facilities
- Other (please specify)

4. Using your selections from question 3, what were the two most important considerations? Please select only two:

Most important: _____

Second-most important: _____

5. How do you track the impact of your program or practice when addressing individuals with mental health needs? Please describe. _____

6. How long has your program that addresses individuals with mental health needs been in place?

- 10 years or more
- 5–10 years
- 1–5 years
- One year or less

7. Do you engage or coordinate with stakeholders to execute and guide your program?

- Yes
- No

8. If the answer to question 7 is "yes," identify with whom you engage and coordinate. (Select all that apply.)

- Community mental health professionals
- Hospitals and other medical or mental health facilities
- Community leaders or support groups
- Prosecutors
- Courts
- Other (please specify):

9. Have you encountered significant resistance to your mental health program?

- Yes
- No

If yes, please describe: _____

10. When talking about your agency's program with others, what are the three most important points you mention about the program?

Point 1: _____

Point 2: _____

Point 3: _____

11. What are three things that will increase your program's success?

First benefit: _____

Second benefit: _____

Third benefit: _____

12. If your agency had sufficient resources, how would you envision the best program to effectively deal with people with mental health needs, both in your jails and in encounters with deputies in the field? What stakeholders need to be part of this effort? Please describe.

13. What other partners would need to be part of the effort? Select all that apply.

- Community mental health professionals
- Hospitals and other medical or mental health facilities
- Community leaders or support groups
- Prosecutors
- Courts
- Other (please specify):

Field operations/law enforcement personnel

1. Does your agency have training that focuses on identifying, addressing, and intervening with individuals with mental health needs?

- Yes No

2. Does your jurisdiction have a mental health dropoff facility?

- Yes No

3. Does your agency have a deputy and mental health professional response team (psychiatric assessment team) in the field?

- Yes No

4. If your jurisdiction does have a mental health dropoff facility, does it operate 24 hours a day and 7 days a week?

- Yes No

5. Are mental health resources and alternatives to incarceration for persons with mental health needs available to your field operations/law enforcement personnel?

- Yes No

If yes, briefly explain what is available:

6. Are your field operations/law enforcement personnel given discretion to use alternatives to incarceration for persons with mental health needs, deferred prosecution of such individuals, or both?

- Yes No

7. If your field operations/law enforcement personnel are given discretion to use alternatives to incarceration for persons with mental health needs, deferred prosecution of such individuals, or both, are those cases tracked using statistical information? (Check all that apply.)

- Yes, by number of persons with mental health needs
- No, persons with mental health needs are not tracked
- Yes, including rates of recidivism
- No, recidivism is not tracked

8. Is there a central (countywide) database of past individuals with mental health needs that is available to field operations personnel at the time of contact?

- Yes
- No

9. Does your county have an existing mental health focus group made up of mental health stakeholders?

- Yes
- No

10. If your county has an existing mental health focus group made up of mental health stakeholders, identify which agencies are involved. (Check all that apply.)

- County sheriff's office
- County or city attorney
- Police chief(s)
- County health department
- Jail mental or medical health staff
- County mental health department
- Social service program(s)
- Public defender's office
- Courts
- Volunteer groups or agencies
- Other (please specify):

11. If your agency tracks uses of force, does it track individuals with mental health needs separately?

- Yes
- No

12. Does your agency's mission or culture support field operations/law enforcement's activities related to investing time, problem-solving, and follow-up activities when dealing with individuals with mental health needs?

- Yes
- No

If so, how? _____

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13. Please provide data for the last three years on the number of individuals with mental illness identified by field operations/law enforcement personnel. (If no data exist, please signify by indicating N/A.)

2012: _____

2013: _____

2014: _____

14. Please provide data for the last three years on the number of individuals with mental illness contacted but not arrested by field operations/law enforcement personnel. (If no data exist, please signify by indicating N/A.)

2012: _____

2013: _____

2014: _____

15. Please provide data for the last three years on the number of individuals with mental illness diverted from jail to mental health services in the community. (If no data exist, please signify by indicating N/A.)

2012: _____

2013: _____

2014: _____

Jail personnel responders

1. Does your agency conduct mental health screenings on all arrestees/commitments/bookings?

Yes No

2. Does your agency conduct mental health screenings for co-occurring substance use disorders? (A co-occurring substance use disorder may include alcohol or drug use, alcohol or drug dependence, or both.)

Yes No

3. At what point in the processing of individuals in your facility are these screenings conducted?

Arrest

Booking

There are no mental health screenings done in our facility

Other (please specify):

4. If an individual's mental illness is recorded, is the information shared with pretrial services, prosecutors, defense counsel, and the courts, promoting safety for both arrestee and staff?

Yes No

We share with the following stakeholders:

5. How does your facility count how many people with mental health needs are housed there? (Check all that apply.)

- Individuals who receive medication for psychiatric illness
- Individuals who receive treatment
- Individuals who self-identify at admission to the facility
- Individuals who are identified during an assessment
- Other (please specify):

6. As a percentage of your average daily population, what is the current prevalence of individuals with mental health needs in your facility? If not tracked, please enter N/A.

7. What is your facility's average daily population?

8. Has the percentage of individuals with mental illness needs in your facility increased or decreased in the last two years?

- Increased by ___% in the last two years (2013–2014)
- Decreased by ___% in the last two years (2013–2014)
- Our facility cannot provide a percentage because we do not track increase or decrease

9. What percentage of individuals with mental illness needs in your facility increased or decreased?

10. Has your jail established partnerships with local mental health agencies or providers and other community partners related to incarceration, status, and discharge planning for people with mental illness?

- Yes
- No

If yes, whom have you partnered with? _____

11. Does your facility screen for health insurance or Medicaid status and eligibility upon admission?

- Yes
- No

If yes, does your facility suspend or terminate the individual's Medicaid benefits on admission?

- Yes
- No
- N/A

12. Does your agency place a priority on mental health treatment in the facility?

- Yes
- No

Please explain: _____

13. Does your agency have resources to adequately support the mental health needs of the inmate population in your facility?

- Yes
- No

Please describe: _____

14. Does your agency conduct or participate in discharge planning for individuals with mental health needs?

- Yes
- No

If yes, please describe: _____

15. If your agency provides mental health services, does the provider share pertinent mental health information with local community resources upon release?

- Yes
- No

16. As a result of any mental health interventions your agency has implemented, can you provide data to demonstrate any of the following? (Check all that apply.)

- Reduced recidivism
- Reduced bookings or return to the facility
- Reduced number of assaults on staff
- Reduced cost for mental health treatment
- Other (please specify):

17. Does your agency provide an assessment for suicide risk upon release?

- Yes
- No

18. What has been the average length of stay in jail for inmates with mental illness each year for the past three years? If you do not track, please enter N/A in the appropriate boxes.

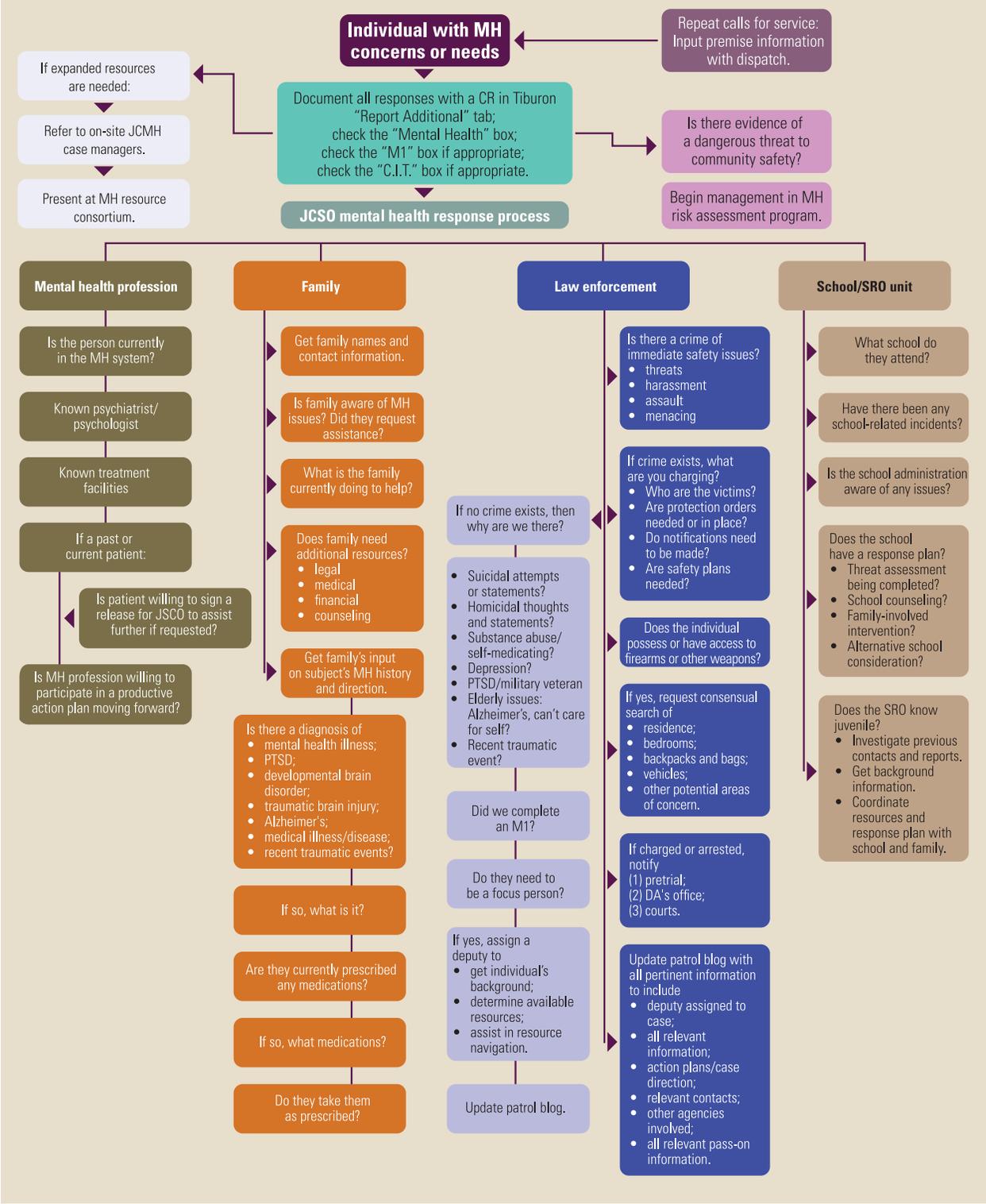
2012: _____
2013: _____
2014: _____

19. Do you have specific interventions or processes in place for reducing the length of stay for inmates with mental illness?

- Yes
- No

If yes, please describe: _____

Appendix B. Jefferson County Sheriff's Office





Appendix C. Local Law Enforcement and Mental Health Crisis MCSA Report: Cook County Sheriff's Office Additions

Mental health template for American jails

In 2015, the Cook County Sheriff's Office led the development of a Mental Health Template for American Jails: <http://www.cookcountysheriff.org/MentalHealthTemplate.html>.

The template serves as a step-by-step resource for sheriffs' offices looking to implement thoughtful approaches to the mental health crisis affecting their jails. With common sense reforms that save lives and money, including proof points from Cook County Jail, the template serves as a comprehensive "add-water" resource for other counties.

The template targets 10 areas of focus for reform: (1) public advocacy, (2) advanced mental health training, (3) pre-bond diversion, (4) insurance enrollment, (5) population knowledge, (6) advanced treatment, (7) discharge planning, (8) family support, (9) post-incarceration employment, and (10) legislation.

Rocket Docket legislation

In 2014, Sheriff Dart authored state legislation to launch a "Rocket Docket" in Cook County. The legislation decreed that defendants charged with either retail theft or criminal trespassing without a background of violence were to be discharged from jail—either on their own recognizance or on house arrest—if their cases were not disposed of within 30 days of assignment to a judge. The Rocket Docket bill passed the legislature overwhelmingly and was signed into law by the governor.

In 2016, Sheriff Dart introduced legislation that expanded the Rocket Docket to include minor traffic offenses and petty drug possession. This measure was signed and took effect January 1, 2017.

Since its introduction, 100 cases have been referred as Rocket Docket and 97 individuals have been released.

The Sheriff's Anti-Violence Effort

SAVE is designed to instill positive social norms and values in participants who are most likely to return to one of Chicago's most violent communities. Up to 48 participants are housed together and participate in an intensive, eight-hours-a-day, five-days-a-week program. The cohort-based programming is grounded in an effective form of psychotherapy known as cognitive-behavioral therapy (CBT), widely recognized as an evidence-based component of effective rehabilitative programming. This well-researched treatment has been shown to be successful in reducing crime and violent behaviors. For example, a review of 269 meta-analysis studies found that CBT resulted in better outcomes than six other treatment options, as well as control groups (Hofmann et al. 2012). It aims to provide a set of pro-social problem-solving techniques that work to alter negative patterns of thinking and behavior. To prepare for eventual release into the community, participants will engage with Chicago community leaders while they are still incarcerated in the jail. These leaders will work with participants on self-development and on increasing their understanding and appreciation of the impact of violence in their neighborhoods. Once the participants are released into the community, social workers from the sheriff's office provide intensive case management services to help them stay focused and connected to community supports.

Cook County Sheriff's Office Strength and Wellness Center

In 2012, Chicago made national news when the city closed six of its 12 mental health clinics (Corley 2012), and since then the sheriff has worked to provide support services for individuals with mental health issues. He encouraged the city to allow the Cook County Sheriff's Office to restaff one of the closed facilities with his own mental health staff when he recognized that many of the detainees with mental illness in his custody were returning to areas surrounding the closed clinic (Tafoya 2017). The Strength and Wellness Center, located on Chicago's west side, offers individual, family, and group therapy supports to individuals sentenced to the sheriff's electronic monitoring or others who have been released to the community.

Community support van

Through his frequent interactions with detainees, Sheriff Dart often encountered examples of how a lack of reliable transportation negatively impacted individuals' ability to obtain and maintain stable employment and compliance with treatment, thereby increasing their likelihood of engaging in criminal

behavior. To aid in the success of former detainees, Sheriff Dart used a donated passenger van to provide transportation services to those impacted by the criminal justice system who needed assistance with transportation to medical and mental health appointments, alumni support meetings offered at the Mental Health Transition Center, and court appointments.

Discharge Lounge

Detainees who are identified as having mental illness (identified by their P level) are targeted in the Cook County Jail's Discharge Lounge, where they are able to receive support services and case management before entering the community. The Cook County Sheriff's Office has worked with Cermak Health Services of Cook County to identify individuals who are returning to the community and in need of medications. The individual's prescriptions will then be coordinated to be picked up at an identified hospital location in the community. The sheriff's office has also collaborated with Treatment Alternatives for Safer Communities (TASC) to offer case management assistance. In addition, those who have been identified as homeless receive additional support at discharge by receiving care packages and assistance getting to community shelters.

Appendix D. Cook County Rocket Docket Expansion Poster

ARE YOU ROCKET DOCKET ELIGIBLE?

A Rocket Docket Expansion went into effect January 1st, 2017, that allows for the release of defendants charged with some low-level crimes whose cases are not resolved within 30 days of assignment to trial court judges. Authored by Sheriff Tom Dart, the Accelerated Resolution Court Act, also called the Rocket Docket, provides for your release if you meet the following criteria.

You qualify for Rocket Docket if...

1) Your only charge is:

- **A Traffic Offense** excluding any offense involving fleeing or attempting to elude a peace officer or driving under the influence
- **Class 4 Felony violation of the Controlled Substance Act**
- **Criminal Trespass** excluding criminal trespass to residence and criminal trespass to vehicle
- **Retail Theft under \$300**

2) **AND** you must meet all the following criteria:

- ✓ Your case is still pending after **30 days of being assigned to a trial judge**.
- ✓ You have **no convictions in the last 10 years for a violent crime** including murder, criminal sexual assault, armed robbery or any firearm offenses.
- ✓ You are **not being held on a Violation of Probation, or a Violation of Bail Bond** connected with your current charge.

The Cook County Sheriff's Office tracks inmates in custody who meet these qualifications and sends a list of those eligible for the Rocket Docket to the States Attorney, Public Defender, the Cook County Clerk and the Office of the Chief Judge.

The law requires that these inmates must be released on their own recognizance or electronic monitoring while their cases are resolved. If released you must follow certain conditions including not leaving the state without the court's permission and appearing for all court dates. Release via the Rocket Docket does not mean your charges are dropped.

PLEASE NOTE: State's Attorney Office may object any order permitting release by personal recognizance or electronic monitoring.

If you qualify, you should tell your defense attorney to ask the judge to release you in accordance with the law: **730 ILCS 169/Accelerated Resolution Court Act**.



Appendix E. COPS Office Grant Team Members

Sheriff Sandra Hutchens, Orange County Sheriff's Department, Santa Ana, California, is the 12th Orange County Sheriff and the first woman to serve as the county's top cop. She was named sheriff by the Board of Supervisors in 2008 after a nationwide search which included a field of 48 candidates. She was elected in 2010 to her first full term.

In her 10 years as sheriff of Orange County, Sheriff Hutchens has made numerous changes to the Orange County Sheriff's Department with the goal of restoring honor to the department. New leadership staff has been added, and policies have been revised all with a commitment to the department's core values: "Integrity without compromise; Service above self; Professionalism in the performance of duty; Vigilance in safeguarding our community."

Sheriff Richard Stanek, Hennepin County Sheriff's Office, Minneapolis, Minnesota, is the 27th Sheriff of Hennepin County. He was first sworn in on January 1, 2007, was re-elected in 2010 and 2014, and is currently serving his third term.

Throughout his career, Sheriff Stanek has been committed to connecting at-risk kids with positive role models. He founded the Hennepin County Sheriff Foundation to provide programs for disadvantaged youth and support sheriff's office volunteers. In addition, he serves in leadership roles for local nonprofit groups that help youth, including Treehouse and the Boys and Girls Clubs of the Twin Cities.

Sheriff Stanek also serves in leadership positions with several national organizations. The U.S. Secretary of Commerce appointed him to FirstNet, which is working to develop a wireless broadband network for public safety nationwide. He is on the board of directors for the National Sheriffs' Association and is also the immediate past president of the Major County Sheriffs of America.

Sheriff Stanek earned a bachelor's degree in criminal justice from the University of Minnesota and a Master's Degree in Public Administration from Hamline University. He and his family live in Maple Grove.

Sheriff Michael Chapman, Loudoun County Sheriff's Office, Leesburg, Virginia, was elected Sheriff of Loudoun County in 2011 and took office January 2012. He directs operations for the largest full-service office in the Commonwealth of Virginia, which handles countywide law enforcement, the jail, and the courts. The sheriff's office employs approximately 750 people: 600 sworn deputies and 150 civilian personnel. The Loudoun County Sheriff's Office serves a population of 350,000 and an area of 519 square miles.

During his five years in office, Sheriff Chapman expanded the Drug Abuse Resistance Education Program (D.A.R.E.) to include both elementary and middle schools; established a cold case squad; enhanced media outreach through integrated technology and a restructured website; introduced online reporting; professionalized the human resources and hiring processes; and improved training, accountability, and efficiency. He also initiated a countywide internet safety training program for parents (which has now been expanded to middle and high school students), added prescription and synthetic drug awareness with assistance from the Drug Enforcement Administration (DEA), partnered with county schools for a No Texting and Driving campaign, helped integrate mental health services, and initiated CIT training for deputies and dispatchers.

Sheriff Chapman formerly worked for the Howard County (Maryland) Police Department in the divisions of patrol, SWAT, and criminal investigations and for the DEA as assistant special agent in charge, Northern District of California; as Acting Regional Director of the Far East; as chief of public affairs; as the country

attaché for Seoul, Korea; as a supervisor in McAllen, Texas; and in field assignments in Florida (Miami and Tampa) and Pakistan. In the private sector, Chapman worked as a subject matter expert on the global security and law enforcement team with Booz Allen and Hamilton. He has a bachelor of science in business management from the University of Maryland and a master's degree in public administration from Troy State University in Alabama.

Michael Ferrence, Jr., Alexandria, Virginia, was the executive director (retired 2017) of the Major County Sheriffs of America, a professional law enforcement association of elected sheriffs representing counties or parishes with populations of 500,000 or more. Ferrence represents the MCSA membership and works to promote a greater understanding of strategies to address future problems and identify law enforcement and correction challenges facing members of the organization. Ferrence has more than 45 years of experience in high visibility leadership and educational roles specializing in examining complex organizational systems and determining underlying causality of human performance problems.

Complementing his experience with graduate degrees in public administration, adult learning, and human resource development, he is viewed as an academic practitioner able to successfully blend the best of both worlds. A frequent consultant to federal, state, and local law enforcement, Mr. Ferrence has extensive experience in the design and delivery of programs and courses for a myriad of domestic and international agencies. After retiring from the FBI as chief of the Leadership Development Institute and an assistant to the FBI Academy Director, he created the firm Academy Leadership Associates, LLC, with the specific focus of working with law enforcement executives and high level managers to help them reach their full leadership potential. In 2013 he was selected to serve as the executive director of the Major County Sheriffs of America, whose members operate the largest sheriffs' offices across the nation.

Lieutenant Andy Ferguson, Orange County Sheriff's Department, Santa Ana, California, began his law enforcement career as an officer with the San Clemente (California) Police Department in 1985. While with the department he worked patrol, including as a field training officer, and was a detective in both general and narcotics investigations. He was a member of the SWAT team and was the department's law enforcement driving instructor. He is also the past president of the San Clemente Peace Officers' Association.

In 1993, the San Clemente Police Department merged with the Orange County (California) Sheriff's Department, and Lieutenant Ferguson remained assigned to the narcotics investigations detail through the transition. He was promoted to sergeant in 2000 and was assigned to the custody operations and classification sergeant positions. He went on to work several years in patrol and administrative assignments. Upon being promoted to the rank of lieutenant in 2009, he was assigned to the department commander position, which oversees patrol operations, dispatch, and emergency communications.

In 2010, Lieutenant Ferguson successfully competed for the position of chief of police services in the contract city of Laguna Niguel. He held the position of chief for four years, acting as a department head for the city and a liaison to the sheriff's department.

Since 2014, Lieutenant Ferguson has been the executive aide for Orange County Sheriff Sandra Hutchens. In addition to the duties of the aide position, he has participated on many local, state, and national committees and projects. He is also the department's legislative advocate.

Lieutenant Rob Gardner, Orange County Sheriff's Department, Santa Ana, California, is currently the administrative lieutenant for the Central Jails Division, a 1,400-bed facility comprising the Central Men's and Central Women's Jails. He was hired as a

deputy sheriff in 1995 and has served the County in a variety of assignments as a deputy—including the Central Men’s Jail, City of San Juan Capistrano, and the City of Stanton (FTO)—and as a sergeant at the Theo Lacy Jail Facility, Central Justice Center, and North Patrol Operations.

Lieutenant Gardner graduated with a bachelor of science degree in physical education from California State University Fullerton and earned a master of science degree in emergency services administration from California State University Long Beach. He also recently completed the 36-week Law Enforcement Agency Leadership Certificate program through Brandman University and the 40-hour FEMA/Incident Command System operations section chief training.

Lieutenant Gardner has been an associate instructor through Santa Ana College for the Orange County Sheriff’s Regional Training Academy since 2006. He has taught a variety of subjects including report writing, lifetime fitness, scenario training, and the correctional officer core course.

Julianne Ortman, Hennepin County Sheriff’s Office, Minneapolis, Minnesota, is an attorney in the Hennepin County Sheriff’s Office and serves currently as director of the Office of Sheriff and Community Engagement. She joined the sheriff’s office in 2007 and previously served as the HCSO’s finance director. She practiced law in Virginia and Washington, D.C., before moving to Minnesota and managing Ortman & Associates, an active business-civil litigation and trial practice.

Ms. Ortman has been elected to public office in five elections and currently serves in the Minnesota State Senate. For many years, she has served on the Senate’s Judiciary Committee, and she was the first woman to chair the Senate Tax Committee; she served as the Senate’s Deputy Majority Leader in 2012 and Assistant Minority Leader in 2005–2006. Prior to her service in the State Senate, Ortman served as an elected County Commissioner for Carver County, Minnesota, from 2001 to 2002.

Captain David Zimmer, Hennepin County Sheriff’s Office, Minneapolis, Minnesota, is a captain with the HCSO. He was hired as a deputy in 1988 and has served as a deputy, supervisor, and manager in investigations, enforcement services, special operations, and most recently the jail. He has a bachelor of arts degree in criminal justice studies from St. Cloud State University and is a 2008 graduate of the Police Executive Research Forum’s Senior Management Institute for Policing.

Captain Zimmer is the current commander of the Hennepin County Jail and oversees the operation of this facility, which holds approximately 750 preadjudication inmates, an estimated 30 percent of whom are dealing with mental illness.

Major Michael Manning, Loudoun County Sheriff’s Office, Leesburg, Virginia, graduated from Wheeling Jesuit University in Wheeling, West Virginia, in 1992 with a Bachelor of Arts degree in political science. He has served with the Loudoun County Sheriff’s Office since 1993. All 23 years of his service have been in the corrections and court services division. During this time, he has served, supervised, and managed in every capacity within the division.

He has attended numerous supervisory and leadership schools throughout his career including attending the 235th session of the FBI National Academy in 2008. He currently serves on the Peumansend Creek Regional Jail Authority Board and the Metropolitan Washington Council of Government Corrections Chiefs Committee.

Sergeant Linda Cerniglia, Loudoun County Sheriff’s Office, Leesburg, Virginia, has been with Loudoun County Sheriff’s Office since March 1995. Prior to the sheriff’s office, she volunteered as an emergency medical technician/firefighter (EMT/FF) for seven years. She rose to the rank of sergeant and became vice president for two years.

She has been part of the critical incident stress management (CISM) team since 1987. From 2000 to 2006 she was the coordinator for the County of Loudoun's response team. She was one of three deputies to respond to work with the New York City Police Department after the September 11, 2011, terrorist attacks for CISM. She assisted in bringing CISM to the Loudoun County Sheriff's Office in the early 90s for law enforcement and corrections.

She has been a negotiator since 1996 and has been on more than 100 hostage and barricade incidents. She has also served as assistant commander to the crisis negotiation team. She has presented at the Council of Governments for the Washington, D.C., area on negotiations.

Starting out as a dispatcher, she moved into patrol where she became a field training officer for two years. In 2003 she was promoted as an investigator to the Loudoun County Gang Unit. She was assigned to the unit for five years and served on the Northern Virginia Gang Task Force for two of those years. After working gangs and narcotics, she was promoted to sergeant and was transferred to patrol.

In 2011, she initiated the CIT program for Loudoun County in collaboration with Loudoun's Mental Health Department. She continues to be the lead coordinator for CIT for Loudoun County and chairs the Northern Virginia CIT Coalition.

Dr. Brent Gibson, National Commission on Correctional Health Care, Chicago, Illinois, is a board-certified physician executive with extensive and broad experience serving in a variety of government and commercial positions. He is chief health officer for the National Commission on Correctional Health Care (NCCHC) and a trusted advisor and implementer to that group's president and CEO, providing clinical and strategic perspective for both technical programs and

corporate governance. He has broad responsibilities across the organization's many services lines with a special emphasis on policies and programs.

Dr. Gibson specifically supports sustainment and growth in the areas of accreditation, educational programs, certification, publications and resources, and technical assistance. He provides executive oversight and liaison services to numerous and diverse critical association activities such as standing and ad hoc committees, the accreditation program, and the cloud-based association management system (AMS). He is a Certified Correctional Health Care Professional and has earned the specialty certification for physicians (CCHP-P).

Dr. David Stephens, Colorado Springs, Colorado, is a licensed psychologist, a consultant, and an expert in correctional mental and behavioral health. He has consulted with jails on issues related to mental health services, accreditation, suicide prevention, quality assurance, and program development, as well as having been responsible for all aspects of the mental health program in jails in 11 states. He is on the editorial board of the *Journal of Correctional Health Care* and developed the only correctional mental health concentration in a clinical psychology doctoral program in the United States.

As a consultant for the NCCHC, he has written the curriculum for a National Institute of Corrections grant project, *Planning and Implementing Effective Mental Health Services in Jails*, and he is the subject matter expert for a COPS Office grant with the Major County Sheriffs of America, *Identification of Programs Designed to Reduce Arrest and/or Incarceration of the Mentally Ill*.

Lieutenant Jim Martin, Vanderburgh County Sheriff's Office, Evansville, Indiana, was sworn in as a deputy sheriff with the Vanderburgh County Sheriff's Office in January 1994 and served Vanderburgh County for nearly 23 years.

He graduated with a bachelor of science degree in communications with an emphasis on public relations in 2001 from the University of Southern Indiana. In 2012, Lieutenant Martin received a master's degree in public service administration from the University of Evansville. He currently serves as an adjunct professor at the University of Evansville in the organizational leadership and public service administration programs.

During his career with the sheriff's office, Lieutenant Martin has been a motor patrol deputy, K-9 handler, supervisor in the jail and the court security unit,

and an investigator in the professional standards unit. He is a certified instructor through the Indiana Law Enforcement Academy, and through the Indiana Department of Homeland Security he is a graduate of the Police Executive Leadership Academy (PELA) and served as the assistant jail commander. As the assistant jail commander, he has served as a liaison for the Vanderburgh County Jail and mental health community partners and as an accreditation specialist with the NCCHC.



About the Major County Sheriffs of America

The **Major County Sheriffs of America (MCSA)** is a professional law enforcement association of elected sheriffs representing counties or parishes with populations of 500,000 or more. We are dedicated to preserving the highest integrity in law enforcement, corrections, and the elected office of the sheriff. Our membership represents law enforcement officers serving more than 100 million Americans and works to promote a greater understanding of strategies to address future problems and identify law enforcement challenges facing the members of our organization.

The nation's largest sheriffs' offices are united to ensure public safety in the communities we are elected to serve. The MCSA is a united and powerful voice of community leaders on issues of public concern through the following:

- **Sense of urgency.** Serving with speed and accuracy for maximum positive outcomes because America's safety is always at stake
- **Communication.** Delivering real-time, relevant communications with stakeholders using all state-of-the-art systems
- **Education.** Developing and promoting innovative law enforcement and detention training
- **Advocacy.** Educating and fostering relationships with legislators, government agencies, and stakeholders while proactively identifying relevant issues
- **Research.** Establishing standards and processes based upon science, technology, and time-proven best practices with public and private partnerships

About the COPS Office

The **Office of Community Oriented Policing Services (COPS Office)** is the component of the U.S. Department of Justice responsible for advancing the practice of community policing by the nation's state, local, territorial, and tribal law enforcement agencies through information and grant resources.

Community policing begins with a commitment to building trust and mutual respect between police and communities. It supports public safety by encouraging all stakeholders to work together to address our nation's crime challenges. When police and communities collaborate, they more effectively address underlying issues, change negative behavioral patterns, and allocate resources.

Rather than simply responding to crime, community policing focuses on preventing it through strategic problem-solving approaches based on collaboration. The COPS Office awards grants to hire community policing officers and support the development and testing of innovative policing strategies. COPS Office funding also provides training and technical assistance to community members and local government leaders, as well as all levels of law enforcement.

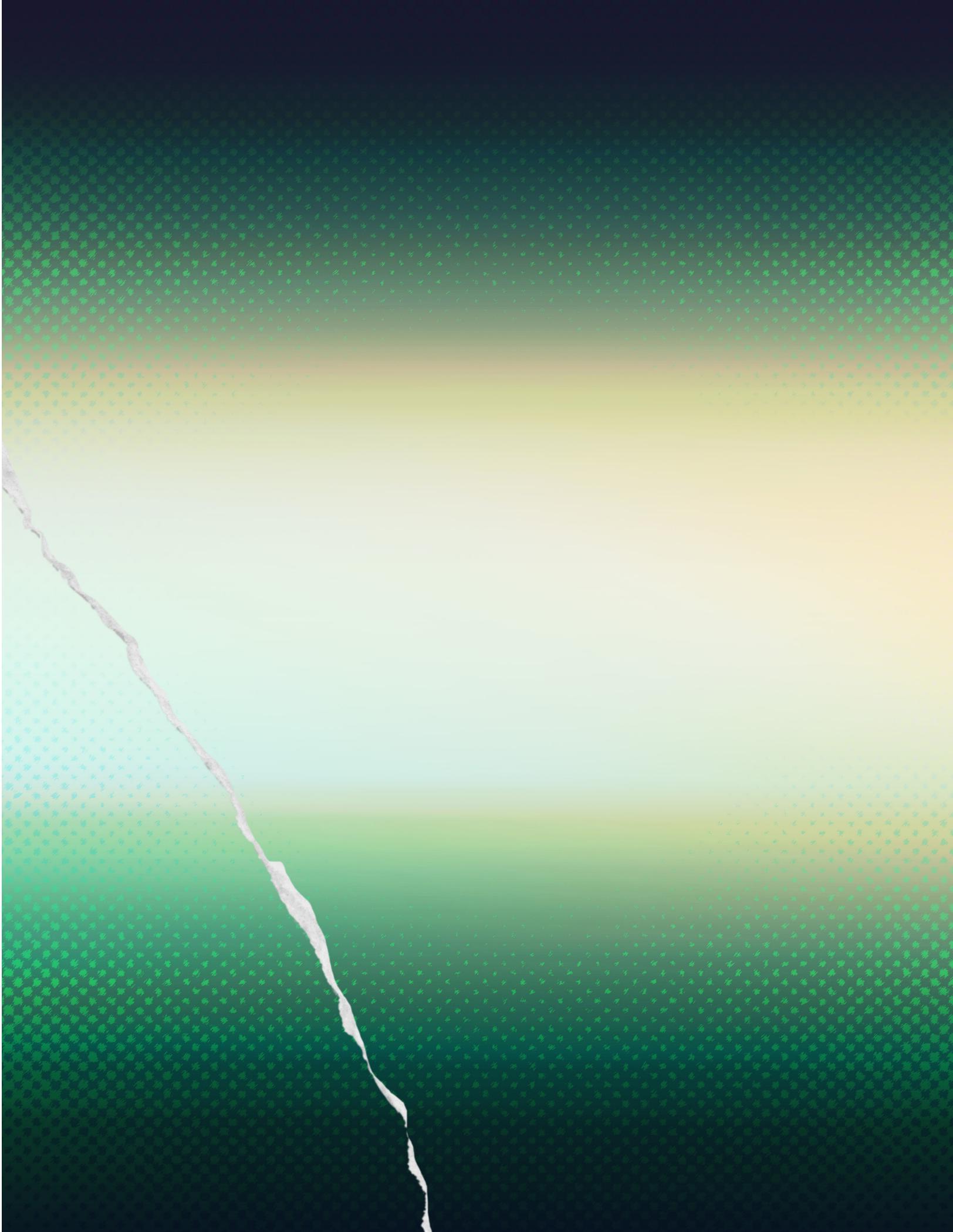
Since 1994, the COPS Office has invested more than \$14 billion to add community policing officers to the nation's streets, enhance crime fighting technology, support crime prevention initiatives, and provide training and technical assistance to help advance community policing. Other achievements include the following:

- To date, the COPS Office has funded the hiring of approximately 130,000 additional officers by more than 13,000 of the nation's 18,000 law enforcement agencies in both small and large jurisdictions.

- Nearly 700,000 law enforcement personnel, community members, and government leaders have been trained through COPS Office-funded training organizations.
- To date, the COPS Office has distributed more than eight million topic-specific publications, training curricula, white papers, and resource CDs and flash drives.
- The COPS Office also sponsors conferences, round tables, and other forums focused on issues critical to law enforcement.

COPS Office information resources, covering a wide range of community policing topics such as school and campus safety, violent crime, and officer safety and wellness, can be downloaded via the COPS Office's home page, www.cops.usdoj.gov. This website is also the grant application portal, providing access to online application forms.

Law enforcement has increasingly become the primary point of contact for individuals living with mental illness and the presence of these individuals in jail and prison populations have grown to crisis proportions. This report - developed by the Major County Sheriffs of America (MCSA) in partnership with the National Commission on Correctional Health Care (NCCHC) - identifies innovative practices which have proven successful in reducing the arrest and incarceration of individuals living with mental illness in jurisdictions across the country. The programs have shown promise in several areas: diverting those who live with mental illness away from the criminal justice system; supporting individuals in the court system; identifying and treating those who have been incarcerated; and helping individuals successfully re-enter their communities after discharge. The report includes case studies of seven jurisdictions and resources developed by law enforcement executives and experts in the field.



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Office of Community Oriented Policing Services
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To obtain details about COPS Office programs, call the COPS Office Response Center at 800-421-6770.

Visit the COPS Office online at www.cops.usdoj.gov.



Major County Sheriffs of America
1450 Duke Street
Alexandria, VA 22314

To obtain details about MCSA programs, call the Major County Sheriffs of America at 703-778-1381

Visit the MCSA online at www.mcsheriffs.com.