

COMPREHENSIVE JAIL DIVERSION PROGRAM-MENTAL HEALTH COURTS STUDY

Iowa Department of Human Rights
Division of Criminal and Juvenile Justice Planning
Statistical Analysis Center
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Contents

Background.....	2
Section 18. Comprehensive Jail Diversion Program-Mental Health Courts –Study.....	2
Duties, Scope, and Membership of the Study Commission.....	2
Study Commission Members.....	2
Scope of the Report.....	3
Recommendations.....	4
Defining the Problem.....	7
Prevalence of Mentally Ill Offenders in the Criminal Justice System.....	7
Criminal Justice System Response.....	7
Diversion Programs and Interception Points.....	9
Types of Jail Diversion.....	9
<i>Pre-booking Diversion</i>	9
<i>Post-booking Diversion</i>	10
Sequential Intercept Model: Intervention points for Criminally-Involved Mentally Ill Persons.....	12
Participant Outcomes.....	19
Costs.....	20
Mental Health Court Considerations.....	21
Adapting the Philosophy of Drug Courts to Mental Health Courts.....	21
Disproportionality.....	23
Voluntary Participation.....	24
Status of Jail Diversion Programs and Mental Health Courts in Iowa.....	25
Site Visits.....	26
Black Hawk County Diversion Program.....	26
Woodbury County Diversion Program.....	29
References.....	32
Appendix A.....	39
Appendix B.....	48

Background

On April 12, 2012 Governor Branstad signed Senate File 2312, an Act Relating to Persons with Mental Health Illnesses and Substance Related Disorders.

Section 18. Comprehensive Jail Diversion Program-Mental Health Courts – Study. The Division of Criminal and Juvenile Justice Planning of the Department of Human Rights shall conduct a study regarding the possible establishment of a comprehensive statewide jail diversion program including:

- The establishment of mental health courts, for nonviolent criminal offenders who suffer from mental illness.
- The division shall solicit input from the Department of Human Services, the Department of Corrections, and other members of the criminal justice system including but not limited to judges, prosecutors, and defense counsel, and mental health treatment providers and consumers.
- The division shall establish the duties, scope, and membership of the study commission and shall also consider the feasibility of establishing a demonstration mental health court.
- The division shall submit a report on the study and make recommendations to the Governor and the General Assembly by December 1, 2012.

Duties, Scope, and Membership of the Study Commission

As directed in Section 18, study commission members were solicited from the departments of human services and corrections and the criminal justice and mental health systems. The study commission met three times to provide input and direction on the structure and content of the report.

Study Commission Members

Paul Stageberg	Criminal and Juvenile Justice Planning
Rick Shults	Department of Human Services
Kathy Stone	Department of Public Health
Lettie Prell	Department of Corrections
John Goerdt	Judicial Branch State Court Administration
Sam Langholz	Office of the State Public Defender
Linda Brundies	Iowa Citizens Aide/Ombudsman Prisoner Rights
Jim Goodrich	National Alliance on Mental Illness, Greater Des Moines
Randall Wilson	American Civil Liberties Union of Iowa
Craig Matzke	Iowa Law Enforcement Academy
Tom Ferguson	Iowa County Attorneys Association

Scope of the Report

This study draws primarily from existing reports and research findings of other programs. Included here are a review of the prevalence of mentally ill offenders in the criminal justice (CJ) system, the system's response to the problem, findings of participant outcomes, reported costs, special considerations regarding mental health courts, the status of jail diversion programs and mental health courts in Iowa, and recommendations.

One of the requirements of the legislation was to consider the feasibility of establishing a demonstration mental health court in Iowa. This directive was not examined because Iowa currently has two mental health courts in operation and one under consideration. Woodbury County has operated a mental health court since 2001 and Black Hawk County since 2009. Polk County has recently received funds from the Council of State Governments, Justice Center to review a mental health court curriculum for developing mental health courts.

Recommendations for the establishment of a comprehensive statewide jail diversion program, including the establishment of mental health courts for nonviolent criminal offenders who suffer from mental illness, are limited to operational issues gleaned from existing reports and interviews. Due to limited staff resources and a lack of funding, no assessment of cost or delineation of funding responsibilities (state, local), or estimation of potential implementation timelines was undertaken.

Recommendations

The committee acknowledges a broader need for discussion and programming to address how to assist not only the mentally ill, but also the developmentally disabled and the co-occurring populations of offenders. However, for the purposes, scope, and tasks outlined by SF2312 Section 18, this specific report will be more narrowly focused on the issues, programs, and needs surrounding the mentally ill.

I. Current and Future Research

Mental illness, treatment alternatives, and diversion programs have been extensively researched in recent years by academicians and various federal and local agencies and associations.

- a. In developing alternatives to current procedures, Iowa should make use of existing research to ensure that programs are consistent with “best practices”.
- b. The state should dedicate resources to inventory and conduct evaluations on jail diversion and mental health court programs in Iowa, including cost-benefit analyses. Information gathered could shed light on the feasibility of operating a statewide program, including:
 - i. the resources needed to operate successful programs,
 - ii. the availability of treatment resources across the state,
 - iii. identifying effective programs and those in need of improvement,
 - iv. establishing indicators to measure the success of programs.

II. Statewide Collaboration and Partnerships

The State should bring together representatives from key state and advocacy agencies to assist in developing the expansion of services, prevention, and diversion programs.

- a. Representation should include: county supervisors, law enforcement, human services, public health, corrections, courts, prosecuting and defense attorneys, citizen aide/ombudsman, National Alliance on Mental Illness, legislators, DHS Regional Administrators, and the American Civil Liberties Union of Iowa.

- b. Improve awareness, access, communication, collaboration, and linkages to existing treatment services between and among the public, social service agencies, general/mental health care providers, law enforcement, and other criminal justice professionals.

III. Prevention Beginning with Community

In order to reduce and/or minimize contact with the criminal justice system, prevention should begin in the community.

- a. Promote early intervention and community-level support.
- b. Recovery support should include housing, transportation, and employment services.

IV. Criminal Justice Diversion

Mentally ill individuals who come into contact with the criminal justice system should receive services and/or be placed in programs that match their needs, including the extent to which they pose a risk to public safety.

- a. Law enforcement and jail staff should be trained to recognize and respond to mentally ill offenders.
- b. Pre-adjudication interventions are recommended for offenders with minor offenses, including crisis intervention and de-escalation techniques by law enforcement and/or other professionals.
- c. Screening and treatment should be culturally and gender informed.
- d. Post adjudication diversion, such as mental health courts, prison mental health services, and reentry programs, should be offered to offenders charged with or convicted of more serious crimes.
- e. Technology should be utilized to make treatment more accessible to clients across the state, including tele-psychiatry.

- f. Justice-involved services should be core services. This includes:
 - i. Implementation of mental health courts, including both diversion and conditions of sentencing models; and
 - ii. Implementation of jail diversion programs.

V. Mental Health Court Considerations

Research suggests that the treatment approach and goals of mental health court programs should be adapted to the unique needs of mentally ill offenders.

- a. Recognize the differences of this population from other problem solving courts.
- b. Disproportionality among program participants should be closely monitored.
- c. Ensure voluntary participation.

VI. Funding and Responsibilities

In order to have a comprehensive statewide program in Iowa, significant state funding and resources should be distributed to local jurisdictions and Mental Health Disability Services (MHDS) regions.

- a. Resources should be “front loaded” in order to focus on early intervention. Treatment options and recovery supports should be available in the community.
- b. Approve the Department of Human Services’ 2015 budget request for increased funding for crisis programs and pre-commitment assessments.
- c. Some funding should be allocated to research and assessment. Although diversion programs have generally shown promising results nationally, success may vary depending on program type, client characteristics, and the context in which the program operates.
- d. Decisions regarding the responsibilities and boundaries of the regions and the courts should be made as the regional system develops. Establish MHDS regions as the entities responsible for ensuring implementation of local programs.

Defining the Problem

Prevalence of Mentally Ill Offenders in the Criminal Justice System

Although various national estimates of the prevalence of mentally ill offenders in the criminal justice system have been calculated and presented in the literature, the numbers all point to one troubling conclusion – the mentally ill are overrepresented in the justice system. Several reliable sources offer recent estimates of prevalence rates in jails and prisons. In 2005, using the Survey of Inmates in State and Federal Correctional Facilities, the Bureau of Justice Statistics estimated that 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates had mental health (MH) problems that had occurred within the 12 months before survey interviews. Only a small percentage had been told they had a MH disorder by a professional: 9% (State), 5% (Federal), and 11% (Jail). Prevalence of mental illness was greatest for women, Caucasians, and young adults (age 24 or younger) (James & Glaze, 2006). A 2009 study utilizing data from five jails across two different time periods in two different states (Maryland and New York) estimated that 14.5% of male jail inmates and 31% of female inmates had serious mental illness (Steadman, Osher, Robbins, Case, & Samuels, 2009). In a recent report by the Council of State Governments, the authors estimated the rates of serious mental illness using a variety of sources, finding that 5.4% of the general public, 16% of state prisoners, 17% of jail inmates, and 7-9% on parole/probation have a serious mental illness (Osher, D’Amora, Plotkin, Jarrett, & Eggleston, 2012).

In Iowa, the rate of mental illness among the prison population is considerably higher than is true in the general population. Mid-year 2005, the Iowa Department of Corrections (DOC) estimated that 32.5% of the Iowa prison population had a chronic mental illness, with women exhibiting a particularly high rate compared to men (57.9% vs. 30.0%) (IDOC, 2006). However, state data from 2008-2009 indicated that only about 5% of the general Iowa population suffers from a serious mental illness and 19% has any mental illness (NSDUH, 2012). The Iowa DOC also estimates a great need for treatment options in Iowa’s criminal justice system. Forty percent of the prison inmate population was identified as needing mental health treatment. Among the community-based corrections population, 26.9% of offenders under field supervision and 42.6% in residential facilities were assessed as being in need of mental health treatment (IDOC, 2008).

Criminal Justice System Response

Over the past decade, the emergence and growth of “therapeutic jurisprudence,” (e.g., mental health courts and diversion programs) have been the result of increased

recognition of the overrepresentation of the mentally ill and the revolving door that keeps the mentally ill returning to the justice system (Erickson, Campbell, and Lamberti, 2006). The mentally ill are burdening a prison system that is not traditionally equipped to provide the care they need. However, these are just symptoms of a problem that is much more complex. The mere fact that the criminal justice system has become one of the largest mental health treatment providers (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010) has deeper roots in the failure and absence of a strong and functional community mental health system. This has been caused by multiple forces, including

- deinstitutionalization of state mental health systems;
- lack of funding, resources, and trained psychiatric staff; and
- negative sentiment and misperceptions of mental illness that exist among the public (Seltzer, 2005).

Police officers, who often serve as the first point of contact for many mentally ill persons, have traditionally lacked the training and the time to identify symptoms of mental illness and respond properly; thus, many contacts between the police and the mentally ill result in the “easiest” response, an arrest. Another problem is that access to the small number of existing community treatment options varies widely from place to place and tends to be especially limited in rural areas. Mentally ill persons, who simply do not have any other place to go, are likely to end up in jails and prisons, places that are likely to exacerbate their symptoms. The problem is compounded in the community by the absence of strong community social organizations that are willing and able to aid mentally ill ex-offenders in other aspects of life, such as housing, food assistance, and employment. Some organizations may not serve ex-criminals or may simply shy away from taking these more difficult clients (Seltzer, 2005). “In the end, the principal victims of mentally ill offenders are the mentally ill offenders themselves.” (Lovell, Gagliardi, & Peterson, 2002, p.1296).

The three main justifications for developing community-based alternatives for mentally ill offenders are:

- Much of the cost of prison health care stems from treatment of inmates with mental illness;
- It is more appropriate to treat the narrower population of MH offenders in the community, as the goal of the prison system is to provide security to a heterogeneous population with broad rehabilitation opportunities;
- Mentally ill offenders may become involved in the justice system due to an actively symptomatic condition or need to obtain food or shelter when their

illness interferes with capacity to obtain basic necessities (Heilbrun, DeMatteo, Yasuhara, Brooks-Holliday, Shah, King, Dicarolo, Hamilton, & Laduke, 2012, p.352).

Diversion Programs and Interception Points

The following sections of the report discuss different types of jail diversion programs for mentally ill persons who have been failed by the community and ultimately end up in the criminal justice system.

Types of Jail Diversion

Information presented in this section is directly taken from “Practical Advice on Jail Diversion: Ten Years of Learnings on Jail Diversion” from the Center for Mental Health Services, National GAINS Center (2007), pp. 15-19.

Diversion programs can be divided into pre-booking and post-booking models, and post-booking programs can be either jail-based or court-based. Court-based programs can be further separated into specialty (e.g., mental health and drug courts) and regular dispositional courts.

Pre-booking Diversion

Pre-booking diversion occurs at the point of contact with law enforcement officers and relies heavily on effective interactions between police and community mental health and substance abuse services. Specially trained officers who encounter a person exhibiting symptoms of a mental disorder are allowed to use their discretion to determine the necessity of arrest (Lattimore et al., 2003). The most recognized pre-booking program is the Crisis Intervention Team (CIT).

The Memphis CIT is considered a *police-based specialized police response*. A second type of pre-booking diversion is called a *police-based specialized mental health response*, in which police departments hire mental health consultants to provide on-site and telephone consultation to officers. For example, in Birmingham, AL, a Community Services Officer program—civilian police employees with professional training in social work or related fields—helps police officers in mental health emergencies by providing crisis intervention and some follow-up assistance.

A third pre-booking strategy is referred to as a *mental health-based specialized mental health response*, which often includes a mobile crisis team that responds when requested by police. All three types of programs reduce arrest rates for people with mental illness, and each has its benefits and drawbacks. CIT is marked by a rapid

response time and the lowest arrest rate, while mental health professionals who respond with police are particularly adept at resolving mental health disturbance calls on the scene. The sometimes slow response time for a mental health crisis team makes this option less likely to be used by patrol officers (Steadman et al., 2000; Munetz & Griffin, 2006).

Successful pre-booking programs are characterized by specialized training for police officers and a 24-hour crisis drop-off center with a no-refusal policy that is available to receive people brought in by the police. A central drop-off site provides police with a single point of entry into the mental health system, though some larger or more rural communities adapt this model to work with multiple facilities. Regardless of the configuration, without some type of triage facility that is prepared to accept police referrals, Reno police officer Patrick O'Bryan noted, "CIT will be a service to nowhere." It's important to point out that not all encounters with police that result in a referral to treatment can be considered pre-booking diversion. **Diversion is what happens when charges could have been filed.** In many cases police intervene with people in a mental health crisis (e.g., a suicide attempt) that does not involve commission of an offense. In other cases, the specialized police response is believed to have prevented the commission of an offense. These are important roles for police in contact with people who have mental disorders, but they do not constitute jail diversion (Reuland & Cheney, 2005).

Post-booking Diversion

Post-booking programs identify and divert people with mental illness after they have been arrested and at or after booking. Nearly all post-booking diversion programs include some type of monitoring of compliance with treatment, though the level of supervision and the active involvement of the court vary from jurisdiction to jurisdiction. A post-booking program at either the arraignment court or the jail is one that:

- ***Screens*** people potentially eligible for diversion for the presence of mental illness;
- ***Evaluates*** their eligibility for diversion;
- ***Negotiates*** with prosecutors, defense attorneys, community-based mental health providers, and the courts to produce a disposition outside the jail in lieu of prosecution or as a condition of a reduction in charges; and
- ***Links*** people to an individualized array of community-based services.

Court-based programs can occur at any stage in the criminal justice process prior to sentencing and may be decentralized—with diversion staff working in multiple courts

with multiple judges—or centralized in a specialty court such as a mental health or co-occurring disorders court. Specialty courts are marked by the use of one primary judge, a courtroom team approach, separate court calendar, court supervision, and interaction with the mental health treatment system (Lattimore et al., 2003; Broner et al., 2004; Steadman, Davidson, & Brown, 2001).

Specialty courts such as mental health courts are based on the concept of “therapeutic jurisprudence.” To produce a beneficial outcome, many of the courts offer dismissal of charges after successful completion of the mental health court program as an incentive to participate in community treatment and avoid re-offenses. Though based on the drug court model, mental health courts operate somewhat idiosyncratically; currently there is no one definitive mental health court model (Steadman, Davidson, & Brown, 2001).

Some mental health courts only accept people who have committed low-level offenses, though increasingly, many mental health courts are accepting felony cases. Courts that accept offenders with more serious charges often require defendants to enter a plea and to be supervised by criminal justice personnel, and they are more likely than mental health courts that do not accept felonies to use jail as a sanction for noncompliance with court-approved diversion plans (Griffin, Steadman, & Petrila, 2002; Redlich et al., 2005).

Non-specialty court models address a number of barriers to the development of mental health courts. In particular (Clark, 2004):

- In some communities, the size or configuration of the court system may not make such dockets feasible or practical, particularly because of the need to dedicate substantial judicial resources to actively supervising cases.
- Many mental health advocates are cautious about these courts, believing that they create additional stigma for people with mental illness or abridge defendants’ rights.
- Some observers fear that mental health courts may have the unintended consequence of making a limited set of mental health services available on a priority basis to those who have been arrested rather than expanding community-based treatment to serve all people with mental illness and co-occurring substance use disorders. This argument has been made against jail diversion programs in general.
- Even where mental health courts exist, not all defendants with mental illness are appropriate candidates for these courts.

While similar in purpose to many mental health court models, non-specialty court approaches that rely on deferred prosecution or conditional release strategies do not require dedicated court resources and can apply to a broader group of offenders with mental illness, including those with extensive criminal histories or violence associated with their charges (Bush, 2002).

Jail-based programs are operated by pretrial service personnel or by specialized jail personnel, often for defendants who have more serious charges or more severe mental health problems, or who have not been identified earlier in the process. For example, in Hawaii, staff of Oahu Intake Services screened new detainees in jail and referred those with symptoms of mental illness to the diversion team. The team negotiated with the judge, prosecutor, and public defender to arrange for diversion into community-based mental health treatment (Lattimore et al., 2003).

Sequential Intercept Model: Intervention points for Criminally-Involved Mentally Ill Persons

The Sequential Intercept Model, developed by Munetz & Griffin (2006) presents points of “interception” where intervention can be made prior to entering or penetrating deeper into the CJ system. Each point is a “filter.” Earlier intervention along the continuum is better.

Information presented in this section was taken from the guide *Therapeutic Alternatives to Incarceration in Iowa: A Summary and Road Map for Iowa Communities* by Carter, Higdon, Lamb, and Peckover (2011, pp.11-17). It provides details on each point of intercept.

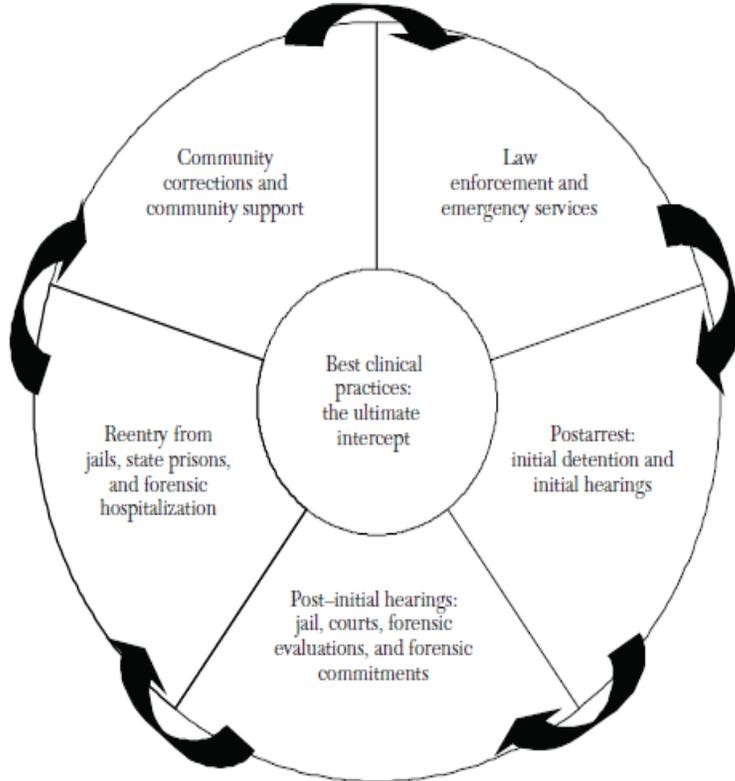
The Sequential Intercept Model (Munetz & Griffin, 2006) is a tool that provides a framework for understanding interactions between the criminal justice and treatment systems and illustrates key points at which to intercept individuals with mental illness and substance-related disorders to promote access to treatment, opportunities for diversion, timely movement through the criminal justice system, and linkages to community resources. It is also a useful means to do systems mapping of community resources to assess what is currently available, identify areas of need or gaps in services, and to prioritize program development. When doing systems mapping it is essential to have a team of key stakeholders that represents multiple systems, including mental health, substance abuse, law enforcement, pre-trial services, courts, jail, community corrections, housing, health, social services, etc.

The next page contains two pictures that provide a visual representation of the conceptual framework of the Sequential Intercept Model. One of the pictures portrays the model as an inverted funnel. The concept is to “catch” as many people at each intercept point before people penetrate further in the criminal justice system. The other picture is a visual of the model from more of a revolving door perspective, i.e., people move through the criminal justice process. Conceptually, one would hope to identify and divert people before they go to the next door. Each intercept point is described in detail following the pictures.

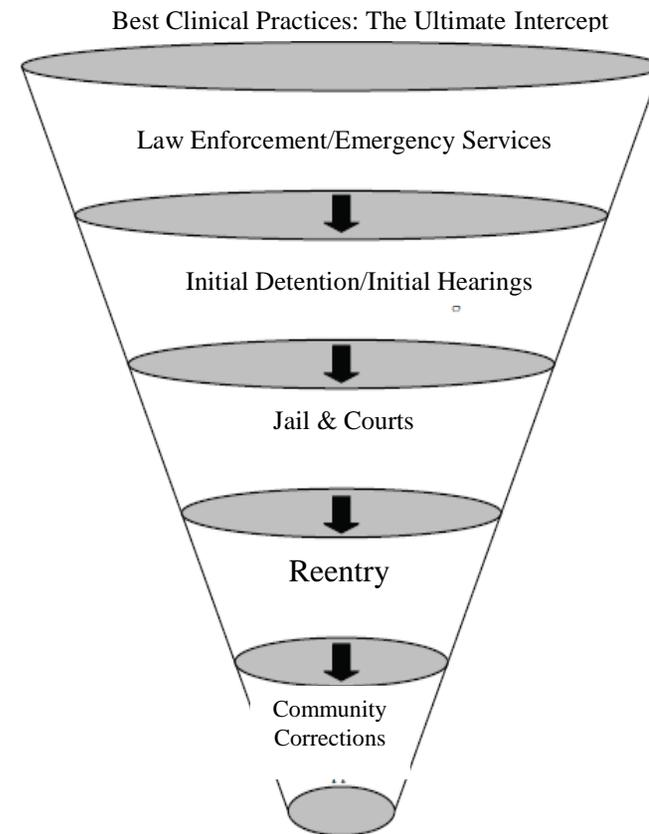
Five Key Points of Interception

1. Law Enforcement/Emergency Services
2. Initial Detention/Initial Hearings
3. Jails & Courts
4. Re-entry
5. Community Corrections

The Sequential Intercept Model from a revolving-door perspective with best practices at the core



The Sequential Intercept Model viewed as a series of filters



Ultimate Intercept: An Accessible Treatment System

The key to successful Therapeutic Alternatives to Incarceration is access to appropriate, adequate, comprehensive, and integrated community-based treatment services (Munetz & Griffin, 2006). An ideal system of care would include competent, supportive clinicians, community support services such as case management, medications, vocational supports (Anthony, 2006), safe and affordable housing (Roman, 2009), and crisis stabilization services. Additionally, the accessible and comprehensive system of care would utilize evidence-based treatments including appropriate medications, psycho-education programs (Mueser & MacKain, 2008), assertive community treatment teams (Morrisey & Meyer, 2008), trauma specific interventions (GAINS Center, 2011), and integrated mental health and substance abuse treatment (Osher, 2006; Mueser et al, 2003). Integrated treatment is essential given that three-quarters of incarcerated individuals with a mental health disorder also have a co-occurring substance use disorder (James & Glaze, 2006).

To navigate the comprehensive system of care and the criminal justice system, GAINS (2007) suggests utilizing a boundary spanner to promote Therapeutic Alternatives to Incarceration. This role requires staff to bridge the multiple systems (e.g. mental health, criminal justice, substance abuse, etc.) and promote cross-system staff interactions. This position assists in the overall development of communication at the systems level. The boundary spanner is given the task of collecting all the relevant information to assist in developing a transition plan for the individuals re-entering the community from various intercept points. Given the complicated needs of individuals with mental illness and substance-related disorders, “transitional planning can only work if justice, mental health, and substance abuse systems have a capacity and the commitment to work together” (Steadman et al, 2002, p.4).

Intercept 1: Law Enforcement/Emergency Services

Successful pre-booking or pre-arrest Therapeutic Alternatives to Incarceration efforts require partnership and collaboration between law enforcement and treatment providers. Pre-booking diversion includes two primary response types:

1. Police-based specialized police response;
2. Police-based specialized mental health response.

The GAINS Center (2009) suggests the following action steps for change at Intercept 1.

- **911:** Train dispatchers to identify calls involving individuals with mental illness and substance-related disorders and refer to designated, trained respondents;
- **Police:** Train officers to respond to calls where mental illness and substance-related disorders may be a factor;

- **Documentation:** Document police contacts with persons with mental illness and substance-related disorders;
- **Emergency/Crisis Response:** Provide police-friendly drop off at local hospital, crisis unit, or triage center.

Intercept 2: Initial Detention/Initial Hearings

Post-arrest diversion programs are the next point of interception. Jail diversion efforts at this point include the following:

1. Early screening for the presence of mental illness and substance-related disorders and linkage to appropriate treatment;
2. Use of information management systems to identify individuals currently using community-based treatment services and re-link them to those services;
3. Pre-trial release with treatment as a condition of release;
4. Use of deferred prosecution;
5. Use of pre-trial interview to assess for mental illness and substance-related disorders and refer to jail diversion programming.

Intercept 3: Jails & Courts

Ideally, individuals who are appropriate for Therapeutic Alternatives to Incarceration will have been filtered out of the criminal justice system in Intercepts 1 and 2 and will avoid incarceration (Munetz & Griffin, 2006). Since that is not current reality, prompt access to appropriate treatment is critical to stabilization and successful return to the community. At this intercept, Therapeutic Alternatives to Incarceration efforts include:

1. Post-booking jail diversion programs that screen, assess, coordinate care, and link to community-based services. Jail diversion staff establishes a treatment plan and coordinates with attorneys and judges to arrange for release from custody. Diversion staff then provides case management follow up services upon release from custody.
2. Specialty Courts or Problem-Solving Courts
 - These courts are typically very structured and designed to provide a balance of accountability as well as supports and resources.
 - This includes mental health courts, drug courts, specialty dockets, and community courts.
 - Specialty courts with multiple tracks (e.g. mental health, substance abuse, co-occurring, veterans, etc.).

Intercept 4: Reentry

The goal at Intercept 4 is to increase communication between correctional institutions (jail and prisons) and community treatment providers to promote a successful transition back into the community. National attention has been given to reentry services subsequent to class action litigation for failure to provide aftercare linkages (Munetz & Griffin, 2006). Efforts at this intercept include:

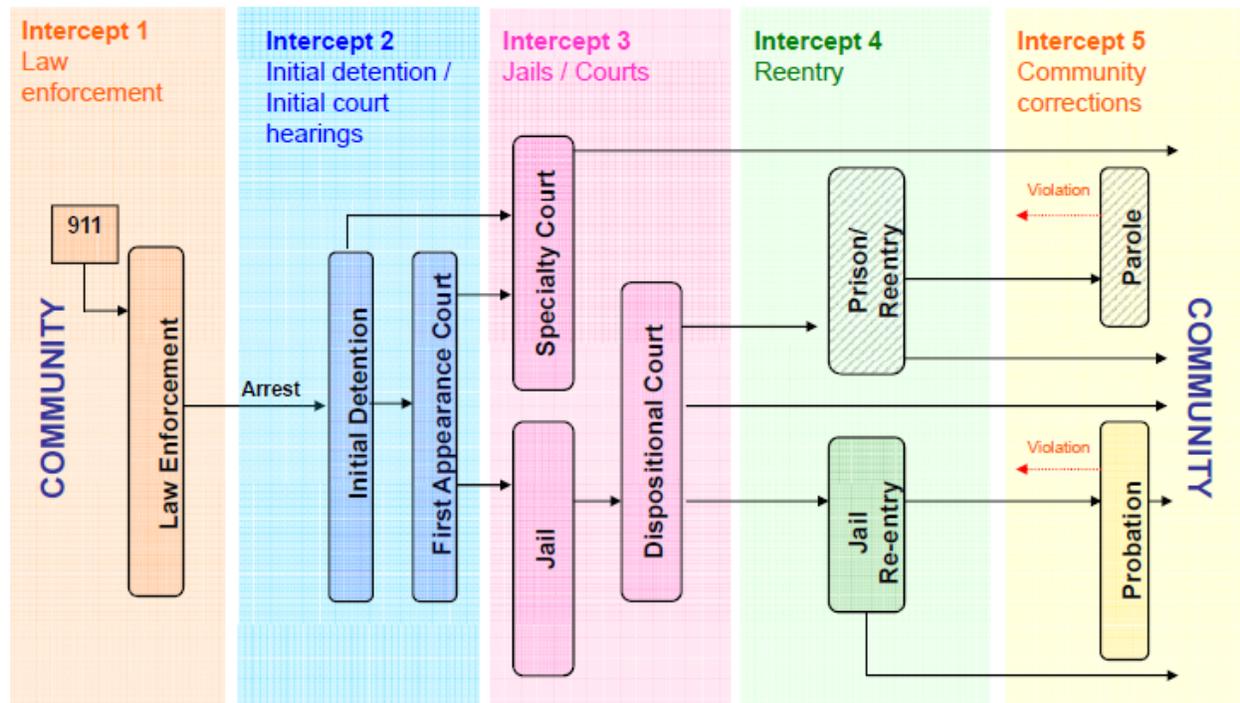
1. Creating corrections/community linkages at points of release;
2. In reach/outreach;
3. Expedited access to entitlements at release;
4. Using a team approach to promote successful reentry;
5. Promising practices in transition planning (NACo , 2008)
 - Collaboration between criminal justice system and treatment agencies;
 - Access to benefits such as healthcare, housing, food, employment;
 - Sustainability/consistent funding;
 - Cultural/gender components;
 - Community linkages (family reunification, access to housing, employment, transportation, general aftercare).

Intercept 5: Community Corrections

The goal of Intercept 5 is to effectively address mental illness and substance-related disorders to prevent reoffending and/or return to incarceration due to technical violations or failure to adhere to the conditions or supervision. Therapeutic Alternatives to Incarceration efforts at this point include:

1. Specialized supervision caseloads;
2. Integrating probation and parole activities into treatment and community supports (e.g. use of Community Accountability Boards);
3. Using services and supports to help individuals live successfully in the community;
4. Linkages to treatment, case management, housing, and employment;
5. Making use of sanctions and incentives.

Using the Sequential Intercept Model



The Sequential Intercept Model is an effective tool for communities to use in developing jail diversions strategies. Steadman (2010) outlines the following steps in the process:

- List/map what currently exists in your system of care
 - This is a group process
 - Important to include multiple stakeholders and key players
 - Create a picture using figure above
- Identify Biggest Gaps and highest needs
 - What is already in place?
 - Focus on individuals who utilize the system frequently
 - What is politically viable?
 - What will have the biggest community impact?
- Prioritize programming
 - What will produce the most effective results with the fewest resources?
 - Build political capital by promoting strategies and interventions that make early successes most probable
 - What will leverage existing programs and services?
- Plan, implement, and operate
 - Designate a lead person
 - Identify the key agencies
 - Meet regularly
 - Identify key positions

- Specify the pathways of diversion process
- Designate specific responsibilities
- Develop a basic management information system
- Plan for collection of basic data
- Communicate regularly.

Participant Outcomes

Program evaluators and academicians have evaluated numerous diversion programs with varying models across the country. Some of these studies have tracked post-program participant outcomes, typically utilizing measures such as rearrest, rehospitalization, violence, and use of community support organizations. In particular, outcome research on mental health courts has been plentiful (Heilbrun, DeMatteo, Yasuhara, Brooks-Holliday, Shah, King, Dicarlo, Hamilton, & Laduke, 2012). Many of these studies were conducted on newly developing mental health court programs in the early 2000's as part of the booming "drug court" movement.

Research findings have shown overall promising results for diversion programs. Empirical studies generally have shown reductions in rearrest, the most commonly used measure of recidivism. In general, the programs do not appear to do harm to participants, but research has not yet been able to clearly establish the elements of successful programs (wide variety exists in community context and program design), the types of clients for whom the programs are most likely to work, the mechanisms by which the programs create positive outcomes, and whether or not the programs are more beneficial than other alternatives (Almquist & Dodd, 2009).

Extant outcome studies have typically used pre-program arrests as a baseline to compare with post-program arrests, while fewer used a comparable comparison group and none of the studies located used experimental designs. Another shortcoming of many existing studies is their failure to include a variety of recidivism measures with long follow-up tracking periods, instead only tracking rearrest over short periods of time, typically only up to one year. Establishing external validity has also proven difficult, as many studies ignore a discussion of the community context of the program in the analysis, which can affect the quality of the program, its resources, and the availability of treatment options (Wolff & Pogorzelski, 2005; Almquist & Dodd, 2009). Summaries of eleven relevant studies on the effectiveness of various diversion programs are provided in Appendix B.

Costs

Preliminary cost analyses indicate that diversion and post-incarceration programs may be more costly than traditional community programs, but less costly than residential placement in prison, jails, and hospitals (Heilbrun, et. al, 2012). It is also possible that MH courts simply shift costs to other levels of government (e.g. Medicaid pays for treatment rather than the CJ system; reduced corrections staff costs shift to increased case manager costs) (Almquist & Dodd, 2009). The cost savings associated with mental health courts appear to occur over the long-term (Ridgely, Engberg, Greenberg, Turner, DeMartini, & Dembosky, 2007).

The first and most comprehensive cost evaluation to date was an analysis of the fiscal impact of diversion programs conducted by Ridgely et al. (2007) on the Allegheny County (Pennsylvania) Mental Health Court. The mental health court began in 2001 to divert nonviolent offenders, both misdemeanants and felons, who had a diagnosable mental illness or co-occurring conditions. Defendants who were accepted into the program and voluntarily agreed to participate were required to plead guilty before enrolling in the program.

The study population included all 365 participants in the MH court tracked over the course of two years from the time of MH court entry. The study compared the costs over the tracking period accrued for participants in the program vs. the costs that would have been expected in a different scenario if the participants had been routinely adjudicated and processed in a traditional court. A “hypothetical comparison” group was created from the expected outcomes and associated estimated costs for MH participants if they hadn’t participated in the program. A separate “pre/post sample” allowed a comparison of participants’ costs of previous arrests vs. costs of the arrest that lead them into MH court.

The study suggests that the MH court is associated with greater cost savings the longer the participant is in the program. In the first year of study tracking, the MH court led to an increased use of treatment (a condition of program participation) and decreased jail time (program participants are released on probation), but no net savings occurred, as the decreased jail expenditures offset the increased cost of treatment. The fiscal impact of the MH court improved by the two year mark, as the savings in incarceration costs began to outweigh the cost of treatment. There was a dramatic decrease in jail costs in the second year of MH court participation due to lower recidivism that more than offset the treatment cost. The treatment costs leveled off in the second year due to reduced participation in the costliest types of treatment. The difference in costs became statistically significant in the last two quarters of the tracking period. The study also found greater cost savings for the more seriously distressed subgroups who participated in the program, including felons, participants with psychotic disorders, and those with high psychiatric severity and low functioning. The study did

not distinguish among the costs paid by various levels and entities of government through cost sharing agreements, such as Medicaid.

Mental Health Court Considerations

Adapting the Philosophy of Drug Courts to Mental Health Courts

Specialty courts differ from traditional courts and have in common the principles of 1) enhanced information about issues and participants, 2) community engagement, 3) a team approach with collaboration among justice officials and community organizations, 4) individualized justice 5) accountability, and 6) analysis of outcomes (Wolf, 2007). They typically use a separate docket for defendants, monitor participants, link offenders to treatment, and offer dismissed charges or deferred sentences as rewards for program participation and completion (see Moore & Hiday, 2006).

Mental health courts have roots in the drug court movement and have been modeled on drug courts as a prototype. MH courts are based on the same underlying therapeutic principles as drug courts in that the goal of participation is to encourage treatment under court supervision in lieu of prosecution (Erickson et. al, 2006). There may also be overlap in the clients served by drug and mental health courts in treating those with co-occurring disorders (Souweine, Tomasini, Almquist, Plotkin, and Osher, 2008).

Despite the similarities, important differences exist between mental health courts and drug courts, and it is necessary to tailor mental health courts to meet the needs of the special population they serve. “Mental health courts are not merely drug courts for people with mental illnesses” (Souweine et. al, 2008). Mental health courts may not reach their potential if they fail to recognize the needs of their target population and modify the drug court model accordingly; however, it is often difficult to define the needs of those served and the program goals due to the nature of mental illness.

A report by the Council of State Government’s Justice Center (Souweine et al., 2008) outlines the differences between drug courts and mental health courts, noting that most differences stem from the wider variability among mental health court participants. Mental health courts admit participants with a wide range of charges, while drug courts concentrate on drug-related offenses. In mental health court, there is also more variability among treatment plans and monitoring requirements because mental illnesses come in different shapes and sizes. The comparison chart from the Council’s report is provided below:

Key Differences between Drug Courts & Mental Health Courts

Program Component	Drug Courts...	Mental Health Courts...
Charges accepted	Focus on offenders charged with drug-related crimes	Include a wide array of charges
Monitoring	Rely on urinalysis or other types of drug testing to monitor compliance	Do not have equivalent test available to determine whether a person with a mental illness is adhering to treatment conditions
Treatment Plan	Make treatment plans structured and routinized; apply sanctioning grid in response to noncompliance, culminating with brief jail sentence	Ensure that treatment plans are individualized and flexible; adjust treatment plans in response to non-adherence along with applying sanctions; rely more on incentives; use jail less frequently
Role of advocates	Feature only minimal involvement from advocacy community	Have been promoted heavily by some mental health advocates, who are often involved in the operation of specific programs; other mental health advocates have raised concerns about mental health courts, either in general or in terms of their design
Service delivery	Often establish independent treatment programs, within the court's jurisdiction, for their participants	Usually contract with community agencies; require more resources to coordinate services for participants
Expectations of Participants	Require sobriety, education, employment, self-sufficiency, payment of court fees; some charge participation fees	Recognize that even in recovery, participants are often unable to work or take classes and require ongoing case management and multiple supports; few charge a fee for participation

Source: Souweine, D., Tomasini, D., Almquist, L., Plotkin, M., and Osher, F. (2008). "Mental health courts: A primer for policymakers and practitioners." State Council of Governments, Justice Center. Report prepared for the US Department of Justice, Bureau of Justice Assistance, p.1-25. Retrieved August 28, 2012 from Bureau of Justice Assistance <https://www.bja.gov/publications/mhc_primer.pdf>

Goldkamp & Irons-Guynn (2000) further note that fundamental differences in the nature and progression of drug addiction vs. mental illness may contribute to issues in mental health court implementation. Progression and milestones are difficult to define for those who suffer from mental illness, and the drug court's phase system may not apply. The mentally ill may have different illnesses, symptoms, and starting points. Mental illness is life-long, often not following a defined path with many peaks, dips, and curves along the way. Whereas the treatment goal of the drug court is directly measurable and applicable to all participants – abstinence – the goals for mental health court participants are sometimes difficult to define and highly

individualized – whether it be to increase participation in treatment, to continue medication, to reduce noncompliance, to increase access to community services, etc. Also, the drug court approach is based on the philosophy of addiction and uses the recognized methods to best engage and treat addicts. A structured environment and the use of rewards/sanctions has been effective for addicts, but may not work well for mentally ill clients, who may need more support and encouragement and are less responsive to sanctions (Goldkamp & Irons-Guynn, 2000).

Nevertheless, researchers may be able to use earlier drug court studies to design more useful and informative research on mental health courts. Drug court studies may help researchers to work around methodological shortcomings and to divert their attention to important key questions that have so far been unanswered – how the courts shape outcomes, whether they are effective compared to alternatives, and whether variables other than the court itself, specifically the selection of clients, may be associated with outcomes (Wolff & Pogorzelski, 2005).

Disproportionality

Mental health disparities exist at multiple levels. The American Psychiatry Association (2010) reports most racial and ethnic minority groups have similar or fewer mental disorders than whites, but these groups are much less likely than whites to receive mental health treatment. Factors influencing access to treatment include:

- Lack of insurance, underinsurance
- Mental illness stigma, often greater among minority populations
- Lack of diversity among mental health care providers
- Lack of culturally competent providers
- Distrust in the health care system
- Inadequate support for mental health service in safety net settings

In the justice system, studies have found that individuals referred for diversion and mental health court are disproportionately older, female, and white compared to arrestees nationwide (e.g., Steadman, Redlich, Griffin, Petrila, & Monahan, 2005; Naples, Morris, & Steadman, 2007). The reasons for disproportionality are not entirely clear. Naples, Morris, and Steadman (2007) found that disproportionality occurred early in the decision-making process and both legal and non-legal factors influenced the process. They suggest an overrepresentation of these subpopulations occurs because; 1) they tend to pose a reduced risk 2) they may be more likely to be identified with a serious mental illness.

A recent study by Prins, Osher, Steadman, Robbins and Case (2012) highlights the issue of identification. They found blacks and Latinos had lower odds than whites of screening positive on the Brief Jail Mental Health Screen (BJMHS). The BJMHS is an eight-item questionnaire. Six of the BJMHS questions ask about symptoms and two ask about past treatment for mental health problems. A positive screen is given to individuals who answer yes to either of the two treatment question or two out of the six symptoms questions. This screening tool may put racial and ethnic minority groups at a disadvantage because of the weight it gives to prior use of mental health services in predicting current mental health problems.

Voluntary Participation

Concerns have been raised regarding the voluntary nature of mental health court participation. The Bazelon Center for Mental Health Law, Where We Stand: Mental Health Courts, website page cautions, "It is crucial from the outset that transfer to the mental health court be entirely voluntary. Otherwise, singling out defendants with mental illnesses for separate and different treatment by the courts would violate the equal protection guarantee of the 14th Amendment and would likely violate the 6th Amendment right to a trial by jury and the prohibition against discrimination by a state program found in the Americans with Disabilities Act."

The Center advises that a simple declaration by the defendant is simply not adequate, particularly since the individual may be under considerable stress, having been arrested, taken into custody and perhaps jailed. In order to secure voluntary consent, the defendant needs to understand all risks associated with participation as well as potential outcomes of a conventional criminal hearing.

Redlich, Hoover, Summers, & Steadman (2010) examined perceptions of voluntariness, and levels of knowingness and legal competence among 200 clients in two mental health courts and found more than half:

- 1) claimed not to have been told that the decision to enroll in the court was voluntary prior to enrolling;
- 2) claimed not to have been told of the requirements of the court prior to enrolling;
- 3) did not know that the final decision (after eligibility decisions) to enroll in the court was theirs to make;
- 4) did not know they could stop being in the court if they so chose and;
- 5) could not cite even one disadvantage to being in the court.

Status of Jail Diversion Programs and Mental Health Courts in Iowa

Crisis Intervention Team Training (From the University of Memphis CIT Center):

- Waterloo Police Department
- Council Bluffs Police Department
- Pottawattamie County Sheriff's Department
- Fremont County Sheriff's Department

Jail Diversion Programs

- Black Hawk County
- Dubuque County
- Johnson County
- Linn County
- Polk County
- Story County

Mental Health Courts

- 2001 Woodbury: Project Compass
- 2009 Black Hawk: Project Equinox
- 2012 Polk -Pilot project funded by the Council of State Governments, Justice Center. Mental Health Court Curriculum for developing mental health courts.

Other Efforts:

- Iowa Law Enforcement Academy
Mental Health First Aid Course 12 hour course
- Mobile Crisis Response Team, Polk County
Eyerly Ball Community Mental Health Services in conjunction with all police departments in Polk County
- Enhanced Drug Courts: Waterloo, Dubuque, Council Bluffs, Des Moines, Cedar Rapids, Coralville, Davenport, Burlington, and Ottumwa
In October of 2012, the Governor's Office of Drug Control Policy (ODCP) received three years of funding through the Bureau of Justice Assistance (BJA), Adult Drug Court Discretionary Grant Program to enhance nine drug courts through the addition of mental health services for offenders with a co-occurring substance abuse and mental illnesses.

Site Visits

On October 3, 2012, CJP staff traveled to Waterloo to observe the Black Hawk County Mental Health Court and informally interview the DCS Director and the jail diversion program coordinator. On October 23, 2012, CJP staff traveled to Sioux City to visit with the Woodbury County Mental Health Court Judge and program staff. Below is a summary of these two visits.

Black Hawk County Diversion Program

The jail assessment program began in 2004 and the mental health court started in July, 2009. The interviewed staff members indicated a great need for jail diversion to reduce the jail population, noting that mentally ill defendants would sit in jail for months before the program's development. They also believe the program has reduced hospital and emergency room visits.

The jail assessment program in Black Hawk County uses post-booking intervention. Although the county has discussed an earlier intervention program at the law enforcement level (CIT and mobile crisis) -- and the interviewees agreed that earlier intervention is ideal -- such a program has not developed due to lack of time and resources. The staff mentioned that regional training for law enforcement and corrections staff would not be sustainable without continued funding provided by the state.

One impediment to operating the Black Hawk County diversion program has been maintaining a steady and ongoing stream of funding to sustain the program. Initially, full funding was provided by the Central Point Coordination, but funding has gradually decreased, county funds have largely been lost, and the program currently relies on a mixture of funding sources, including Department of Correctional Services locally generated funds and funds from the sheriff's office. Mental health funds are discretionary across the state and depend on who is in charge. The staff indicated that those allocating funds want to see short-term results, but the cost savings of this program occur over the long term. The indicators of success in such programs are not always measureable; it is difficult to put a dollar amount on the savings that may have resulted from the program without having the resources for a full evaluation study.

One issue in many locations is that Corrections has not yet "bought into" such programming, as programs for the mentally ill have largely been concentrated in the behavioral health system. The Black Hawk program also initially faced this problem, having difficulty getting collaboration and "buy-in" at program start up. This has not been an on-going issue, however, because the jail diversion program has gained the continued support of the region's sheriffs, county attorneys, and judges. The staff believes that none of the diversion programs in Black Hawk

County would work without buy-in from corrections, courts, judges, and local mental health/substance abuse treatment centers. Collaboration among the systems is essential.

Locally, this is the only program for the mentally ill that runs out of corrections. There are programs elsewhere that use a therapeutic model based in the behavioral health system. For instance, a local crisis center has recently opened, but it is not tied to the criminal justice system. The Black Hawk/Grundy Mental Health Center works with clients in the jail diversion program by administering medications, offering psychiatrist visits, and working with the more difficult clients. Pathways Behavioral Services is another behavioral health organization that, in the past, had completed substance abuse screenings in the jail until funding was cut. Horizon Healthcare currently offers assistance, but only to clients with insurance.

The staff emphasized that the characteristics of diversion programs will differ depending on the community and “what makes sense” for it. The staff has been working with counties across the state and meets quarterly with a coalition of programs that come together to provide training to communities on diversion program development and making jail alternatives for the mentally ill available in every county. There is also an effort to establish a committee of local community providers to consider partnering to address the community’s needs.

Both the jail assessment program and the mental health court have tried to reduce the likelihood that offenders needing services will “fall through the cracks.” The process starts at intake, when the jail intake staff screens offenders. Jail staff monitors medication and handles the acute needs of patients. A local psychiatrist visits the jail once a week. Seventy percent of those screened in jail are released and referred to the community.

The mental health court program also has broad eligibility criteria. It accepts offenders charged with both misdemeanors and felonies, although the most serious offenders, such as murderers and some sex offenders, are generally ineligible. All types of mental illnesses are represented. Referrals to the program are made from a variety of sources, including jail intake screenings, family members, pre-trial interviews, community providers, and attorneys. The court’s attorney meets with defendants to explain the mental health court program and works with them to decide whether the program is a good fit. The typical incentive for participation in mental health court is reduced charges. Participants undergo intensive monitoring by the Probation/Parole Officer and meet regularly with the treatment counselor for medication. Sanctions for misbehavior may include community service, writing assignments, increased court appearance and, as a last resort, jail time. The length of stay in the program is usually around a year, although it depends on the offense; it is generally shorter for misdemeanants and longer for felons.

Client cases are reviewed about once per month, although the hearings may be reduced as clients move through the program. The program caseload is 25-30 clients. The treatment team – consisting of the mental health counselor, probation officer, defense counsel, and county attorney – meets with eight or nine clients every other week to discuss the cases and clients' progress. The mental health court hearing begins with a staff review of the cases. In these reviews, the judge meets with the team to discuss each client's recent activities, address any issues, decide on courses of action, and make decisions on how to handle clients who have broken the rules. The discussion between the judge and the team is informal, and the judge often asks for the team members' perspectives. Client updates are provided by the PPO and counselor on various topics, including living arrangements, employment, community service, recent offenses, keeping appointments, pregnancy, medication and treatment, attitudes, motives, and compliance.

Clients who have cases under review wait outside until the team has finished its discussion and then are invited individually into the courtroom by the counselor to see the judge. Communication between the judge and client was casual and almost friendly at times, with the judge starting the conversation by saying, "How's it been going?" When appropriate, the judge offered advice and encouraging words to clients, and the counselor and PPO pointed out clients' accomplishments. Even in a more difficult case of a client who broke the rules and lied, the judge listened to the client's story and calmly acknowledged his perspective before informing the client that he would be returned to jail. Everyone on the team seemed to be very cognizant of each client's individual situation and needs. Also, several mentions were made by the defense attorney and the judge, when deciding on a sanction for the difficult client, that the mentally ill are held to different norm than the typical defendant. They often have difficulty with structure and schedules. The judge also inquired of the counselor whether she thought the client was capable of meeting the program requirements.

Although there is an effort to overlap services to meet the needs of offenders with co-occurring mental illness and substance abuse issues (a new grant in Black Hawk County will allow adding a mental health component to the current drug court), the inherent differences between mentally ill clients and substance abusers were noted in both the interviews and in the observation of mental health court proceedings. Despite the nature of addiction, drug court clients are capable of functionally improving at a steady pace through the phases of recovery, whereas mental health court clients suffer from a lifelong condition with many ups and downs. Because of this, drug court clients are regarded by staff as easier to manage. One issue has been the lack of funding to train mental health court staff. It is difficult for staff to decide how to deal with mentally ill clients, as each client will respond differently. Appropriate responses must be individualized to meet individual clients' needs. Using jail to sanction mentally ill

offenders is often not appropriate and may exacerbate the symptoms and lead to a downward spiral.

Due to these differences, the drug court and the mental health court in Black Hawk County are structured somewhat differently. The drug court is more highly structured and dispenses sanctions more consistently. The judge addresses clients more formally and presents himself as the authority figure. Clients see the judge in a group, so they can observe and learn from failures and successes of other participants. The mental health court is more informal and individualized. The judge, rather than being seated at the judicial bench, sits in the court reporter's box, and is more informal in attire (i.e., no judicial robes). Clients see the judge individually and the judge engages clients in casual conversation.

Woodbury County Diversion Program

CJJP staff visited with Judge John Nelson and staff from Project Compass on October 23rd, 2012 in Sioux City, Iowa to discuss the Mental Health Court. Project Compass is operated through Siouxland Mental Health.

Project Compass was first implemented in Sioux City in 2001 to assist individuals with mental health concerns who found themselves in law enforcement custody. The mission of the project is to reduce the number of individuals with mental health concerns in the county jail and help those individuals stabilize and normalize their lives. The program targets individuals who have been arrested and come to the county jail, usually on less serious charges. The program is designed to identify these individuals prior to any adjudication and provide them with supervision to help maintain their lives in the community.

Project Compass has survived on year-to-year funding through the county, using county mental health funds. The program also utilizes in-kind time provided by the courts, county attorney, and public defender's office to offset the time of Judge Nelson, a prosecutor, and defense attorney. The Woodbury County Jail provides access to inmates and space to meet with inmates for interviews, identification, and assessments.

The mental health court meets monthly and reviews 18 to 25 clients each month; however, a particular client is typically reviewed only every other month. Occasionally, a client in crisis or requiring extra supervision is reviewed monthly. The program's client caseload is currently about 50 participants. A progress report is generated by the Project Compass team each time a client is seen by the Court, with this report shared with the judge, prosecutor, and defense attorney. During the Mental Health Court hearings, the client sits with the Project Compass team, judge, prosecutor, and defense attorney to review the client's progress in the program.

These review sessions generally last five to six minutes, and are informal sessions held around a conference table in the courtroom. The court room is not open to the general public; however, the client can invite appropriate friends and family to the review session.

Clients are accepted into the program based upon an evaluation and recommendation by Siouxland Mental Health, with approval by a judge. Potential clients are typically identified when they are incarcerated in the Woodbury County Jail. Additionally, an attorney can make a referral to the program; a few referrals have also come from the Woodbury County Drug Court. All clients are pre-adjudication and are typically identified within 24 hours of their arrest. Many clients are charged with offenses that would eventually result in release on recognizance. Clients with serious charges (e.g. serious felony, sexual assault, serious violent or domestic abuse charges) or who may be facing long jail terms or prison sentences are not eligible for the program. Most clients are facing minor property, drug, or person offenses or technical violations of probation. Entry to the program is voluntary. It is the firm belief of the judge and Project Compass staff that success requires a client to “buy-in” to the program, participating willingly.

It was noted that while there are efforts to overlap services for clients with co-occurring disorders, there may be some inherent differences in how mental health and drug abuse issues are managed, and the length of services that may be required. Drug court clients are capable of improving their functioning through the course of recovery; Mental Health court clients, however, may have a lifelong condition that requires constant monitoring and may result in many high and low points over the life of the client.

Prior to the inception of Project Compass, most of its prospective clients would have spent a longer time in the county jail awaiting decisions on how to process and manage their cases. While there has been no formal evaluation performed on the program, it is believed by the judge and Project Compass staff that the program has reduced the number of repeat offenders within the Sioux City community. As clients’ lives are stabilized and normalized, their likelihood of again coming in contact with law enforcement is reduced. In addition to the direct benefits from the Mental Health Court to the clients, there has been a reduction in the population of the county jail and a reduction in the stress placed upon the jail staff with the reduction of inmates with mental health issues.

Participation in the program requires that clients comply with the expectations by staying on any prescribed medications, attending treatment groups, working on treatment goals, and making doctor appointments. The typical client remains in the program for 12 months, with occasional clients needing 14 to 16 months to complete. The goal for each client is to stabilize

and normalize their lives and reduce or eliminate their contact with the justice system. Each client's treatment is individualized to meet his or her unique needs. It is estimated that in the Mental Health Court's 11 years of operation that about 380 clients have gone through the program. Of those, approximately 300 have successfully completed and 80 have been terminated from the program. Termination from the program has generally been the result of failure to comply with medication requirements, failure to make doctor or treatment group appointments, and/or substance abuse issues, with the latter being the leading cause of termination.

Clients terminated from the program are returned to the criminal docket. Upon graduation from the program, clients receive a certificate of completion at an informal graduation ceremony during a monthly review. Project Compass staff noted that graduates were most grateful for having stability in their lives.

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Appendix A



TERRY E. BRANSTAD
GOVERNOR

OFFICE OF THE GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

April 12, 2012

The Honorable Matt Schultz
Secretary of State of Iowa
State Capitol Building
LOCAL

Dear Mr. Secretary:

I hereby transmit:

Senate File 2312, an Act relating to persons with mental health illnesses and substance-related disorders.

The above Senate File is hereby approved this date.

Sincerely,

A handwritten signature in black ink that reads "Terry E. Branstad".

Terry E. Branstad
Governor

cc: Secretary of the Senate
Clerk of the House



Senate File 2312

AN ACT
RELATING TO PERSONS WITH MENTAL HEALTH ILLNESSES AND
SUBSTANCE-RELATED DISORDERS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section 80B.11, subsection 1, paragraph c, Code 2011, is amended by adding the following new subparagraph:

NEW SUBPARAGRAPH. (3) In-service training under this paragraph "c" shall include the requirement that all law enforcement officers complete a course on mental health at least once every four years. In developing the requirements

for this training, the director shall seek input from mental health care providers and mental health care consumers.

Sec. 2. Section 125.91, subsection 1, Code Supplement 2011, is amended to read as follows:

1. The procedure prescribed by this section shall only be used for an intoxicated person who has threatened, attempted, or inflicted physical self-harm or harm on another, and is likely to inflict physical self-harm or harm on another unless immediately detained, or who is incapacitated by a chemical substance, if that person cannot be taken into immediate custody under sections 125.75 and 125.81 because immediate access to the court is not possible an application has not been filed naming the person as the respondent pursuant to section 125.75 and the person cannot be ordered into immediate custody and detained pursuant to section 125.81.

Sec. 3. Section 135C.3, subsection 1, Code 2011, is amended to read as follows:

1. A licensed nursing facility shall provide an organized twenty-four-hour program of services commensurate with the needs of its residents and under the immediate direction of a licensed nurse. Medical and nursing services must be provided under the direction of either a house physician or an individually selected physician. Surgery or obstetrical care shall not be provided within the facility. An admission to the nursing facility must be based on a physician's written order certifying that the individual being admitted requires no greater degree of nursing care than the facility to which the admission is made is licensed to provide and is capable of providing. The nursing facility is not required to admit an individual through court order, referral, or other means without the express prior approval of the administrator of the nursing facility.

Sec. 4. Section 135C.4, Code 2011, is amended to read as follows:

135C.4 Residential care facilities.

1. Each facility licensed as a residential care facility shall provide an organized continuous twenty-four-hour program of care commensurate with the needs of the residents of the home and under the immediate direction of a person approved and certified by the department whose combined training and supervised experience is such as to ensure adequate and competent care.

2. All admissions to residential care facilities shall be

based on an order written by a physician certifying that the individual being admitted does not require nursing services or that the individual's need for nursing services can be avoided if home and community-based services, other than nursing care, as defined by this chapter and departmental rule, are provided.

3. For the purposes of this section, the home and community-based services to be provided shall be limited to the type included under the medical assistance program provided pursuant to chapter 249A, shall be subject to cost limitations established by the department of human services under the medical assistance program, and except as otherwise provided by the department of inspections and appeals with the concurrence of the department of human services, shall be limited in capacity to the number of licensed residential care facilities and the number of licensed residential care facility beds in the state as of December 1, 2003.

4. A residential care facility is not required to admit an individual through court order, referral, or other means without the express prior approval of the administrator of the residential care facility.

Sec. 5. Section 228.1, subsection 6, Code 2011, is amended by striking the subsection and inserting in lieu thereof the following:

6. "Mental health professional" means an individual who has either of the following qualifications:

a. The individual meets all of the following requirements:

(1) The individual holds at least a master's degree in a mental health field, including but not limited to psychology, counseling and guidance, nursing, and social work, or is an advanced registered nurse practitioner, a physician assistant, or a physician and surgeon or an osteopathic physician and surgeon.

(2) The individual holds a current Iowa license if practicing in a field covered by an Iowa licensure law.

(3) The individual has at least two years of post-degree clinical experience, supervised by another mental health professional, in assessing mental health needs and problems and in providing appropriate mental health services.

b. The individual holds a current Iowa license if practicing in a field covered by an Iowa licensure law and is a psychiatrist, an advanced registered nurse practitioner who holds a national certification in psychiatric mental health care registered by the board of nursing, a physician assistant

practicing under the supervision of a psychiatrist, or an individual who holds a doctorate degree in psychology and is licensed by the board of psychology.

Sec. 6. Section 229.1, Code Supplement 2011, is amended by adding the following new subsection:

NEW SUBSECTION. 8A. "*Mental health professional*" means the same as defined in section 228.1.

Sec. 7. Section 229.1, subsection 14, Code Supplement 2011, is amended by striking the subsection.

Sec. 8. Section 229.1, subsection 16, Code Supplement 2011, is amended to read as follows:

16. "*Serious emotional injury*" is an injury which does not necessarily exhibit any physical characteristics, but which can be recognized and diagnosed by a licensed physician or other qualified mental health professional and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill.

Sec. 9. NEW SECTION. 229.5A Preapplication screening assessment — program.

Prior to filing an application for involuntary hospitalization pursuant to section 229.6, the clerk of the district court or the clerk's designee shall inform the interested person referred to in section 229.6, subsection 1, about the option of requesting a preapplication screening assessment through a preapplication screening assessment program. The state court administrator shall prescribe practices and procedures for implementation of the preapplication screening assessment program.

Sec. 10. Section 229.6, Code 2011, is amended to read as follows:

229.6 Application for order of involuntary hospitalization.

1. Proceedings for the involuntary hospitalization of an individual may be commenced by any interested person by filing a verified application with the clerk of the district court of the county where the respondent is presently located, or which is the respondent's place of residence. The clerk, or the clerk's designee, shall assist the applicant in completing the application. The application shall:

~~1-~~ a. State the applicant's belief that the respondent is seriously mentally impaired.

~~2-~~ b. State any other pertinent facts.

~~3-~~ c. Be accompanied by any of the following:

~~a-~~ (1) A written statement of a licensed physician in

support of the application ~~or~~.

~~b.~~ (2) One or more supporting affidavits otherwise corroborating the application ~~or~~.

~~c.~~ (3) Corroborative information obtained and reduced to writing by the clerk or the clerk's designee, but only when circumstances make it infeasible to comply with, or when the clerk considers it appropriate to supplement the information supplied pursuant to, either ~~paragraph "a" or paragraph "b" of this subsection~~ subparagraph (1) or (2).

2. Prior to the filing of an application pursuant to this section, the clerk or the clerk's designee shall inform the interested person referred to in subsection 1 about the option of requesting a preapplication screening assessment pursuant to section 229.5A.

Sec. 11. Section 229.10, subsection 1, paragraph b, Code 2011, is amended to read as follows:

b. Any licensed physician conducting an examination pursuant to this section may consult with or request the participation in the examination of any ~~qualified~~ mental health professional, and may include with or attach to the written report of the examination any findings or observations by any ~~qualified~~ mental health professional who has been so consulted or has so participated in the examination.

Sec. 12. Section 229.12, subsection 3, paragraph b, Code 2011, is amended to read as follows:

b. The licensed physician or ~~qualified~~ mental health professional who examined the respondent shall be present at the hearing unless the court for good cause finds that the licensed physician's or ~~qualified~~ mental health professional's presence or testimony is not necessary. The applicant, respondent, and the respondent's attorney may waive the presence or the telephonic appearance of the licensed physician or ~~qualified~~ mental health professional who examined the respondent and agree to submit as evidence the written report of the licensed physician or ~~qualified~~ mental health professional. The respondent's attorney shall inform the court if the respondent's attorney reasonably believes that the respondent, due to diminished capacity, cannot make an adequately considered waiver decision. "Good cause" for finding that the testimony of the licensed physician or ~~qualified~~ mental health professional who examined the respondent is not necessary may include but is not limited to such a waiver. If the court determines that the testimony of the licensed

physician or ~~qualified~~ mental health professional is necessary, the court may allow the licensed physician or the ~~qualified~~ mental health professional to testify by telephone.

Sec. 13. Section 229.19, subsection 1, paragraph d, Code 2011, is amended by adding the following new subparagraph:

NEW SUBPARAGRAPH. (7) To utilize the related best practices for the duties identified in this paragraph "d" developed and promulgated by the judicial council.

Sec. 14. Section 229.19, subsection 1, Code 2011, is amended by adding the following new paragraph:

NEW PARAGRAPH. e. An advocate may also be appointed pursuant to this section for an individual who has been diagnosed with a co-occurring mental illness and substance-related disorder.

Sec. 15. Section 229.22, subsection 1, Code Supplement 2011, is amended to read as follows:

1. The procedure prescribed by this section shall ~~not~~ be used ~~unless when~~ it appears that a person should be immediately detained due to serious mental impairment, but ~~that person cannot be immediately detained by the procedure prescribed in sections 229.6 and 229.11 because there is no means of immediate access to the district court~~ an application has not been filed naming the person as the respondent pursuant to section 229.6, and the person cannot be ordered into immediate custody and detained pursuant to section 229.11.

Sec. 16. Section 602.1209, Code 2011, is amended by adding the following new subsection:

NEW SUBSECTION. 15A. Prescribe practices and procedures for the implementation of the preapplication screening assessment program referred to in section 229.5A.

Sec. 17. CONTINUATION OF WORKGROUP BY JUDICIAL BRANCH AND DEPARTMENT OF HUMAN SERVICES — CONSOLIDATION OF SERVICES — PATIENT ADVOCATE. The judicial branch and department of human services shall continue the workgroup implemented pursuant to 2010 Iowa Acts, chapter 1192, section 24, subsection 2, and extended pursuant to 2011 Iowa Acts, chapter 121, section 2, to study and make recommendations relating to the consolidation of the processes for involuntary commitment for persons with substance-related disorders under chapter 125, for intellectual disability under chapter 222, and for serious mental illness under chapter 229. The workgroup shall also include representatives from the department of public health. The workgroup shall also study and make

recommendations concerning the feasibility of establishing an independent statewide patient advocate program for qualified persons representing the interests of patients suffering from mental illness, intellectual disability, or a substance-related disorder and involuntarily committed by the court, in any matter relating to the patients' hospitalization or treatment under chapters 125, 222, and 229, and shall also include recommendations for a patient advocate representing the interests of patients found not guilty of a crime by reason of insanity. The workgroup shall also consider the implementation of consistent reimbursement standards for patient advocates supported by a state-funded system and shall also consider the role of the advocate for a person who has been diagnosed with a co-occurring mental illness and substance-related disorder. The workgroup shall solicit input from current mental health advocates and mental health and substance-related disorder care providers and individuals receiving services whose interests would be represented by an independent statewide advocate program and shall submit a report on the study and make recommendations to the governor and the general assembly by December 1, 2012.

Sec. 18. COMPREHENSIVE JAIL DIVERSION PROGRAM — MENTAL HEALTH COURTS — STUDY. The division of criminal and juvenile justice planning of the department of human rights shall conduct a study regarding the possible establishment of a comprehensive statewide jail diversion program, including the establishment of mental health courts, for nonviolent criminal offenders who suffer from mental illness. The division shall solicit input from the department of human services, the department of corrections, and other members of the criminal justice system including but not limited to judges, prosecutors, and defense counsel, and mental health treatment providers and consumers. The division shall establish the duties, scope, and membership of the study commission and shall also consider the feasibility of establishing a demonstration mental health court. The division shall submit a report on the study and make recommendations to the governor and the general assembly by December 1, 2012.

Sec. 19. PRIOR LAW ENFORCEMENT MENTAL HEALTH TRAINING. A law enforcement officer who has completed academy-approved mental health training within the twelve-month period prior to the effective date of this Act, either through in-service or academy-approved basic training, shall be considered to have

met the first four-year mental health training requirement of section 80B.11, subsection 1, paragraph "c", subparagraph (3), as enacted in this Act.

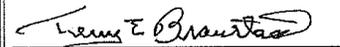

JOHN P. KIBBIE
President of the Senate


KRAIG PAULSEN
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 2312, Eighty-fourth General Assembly.


MICHAEL E. MARSHALL
Secretary of the Senate

Approved April 12, 2012


TERRY E. BRANSTAD
Governor

Appendix B

Christy, Poythress, Boothroyd, Petrila, & Mehra (2005). "Evaluating the efficiency and community safety goals of the Broward County mental health court."

The purpose of this study was to assess the *efficiency* and *safety* of Broward MH court. The data examined included time spent in jail, pre-and post-arrest, and violent (resulted in injury)/aggressive (did not result in injury) behavior self-reported by offenders (collected in retrospective interviews). The researchers hypothesized that Broward County MH court participants would spend fewer days in jail and would have lower rearrest and violence/aggression than the matched comparison sample in Hillsborough, a neighboring county that did not have MH court.

Site: Broward County (Fort Lauderdale area), Florida was one of the first MH courts in the U.S., starting operation in 1998. Program admission criteria exclude those with felonies, domestic violence, and driving under the influence. The court accepts clients pre-adjudication. Several reports published over the years have suggested that the court is effective. An earlier study showed that Broward MH participants were more likely than similarly situated people in another county who did not participate to report satisfaction with court outcomes, face minimal coercion, be more active in their court case, and have more access to services. Potential participants were screened while in jail by college students and were required to answer multiple choice questions to ensure that they were able to give consent to participate. The comparison group was matched on age, gender, race, and symptom severity and excluded those who didn't speak English and fugitives from another state due to the difficulty in tracking these offenders. The study tracking period included 12 months pre- and 12 months post-arrest.

Results showed a statistically significant difference between MH participants and the comparison group in the number of days in jail for the current offense (3 vs. 12 days). A comparison of the one year recidivism rates showed a lower rate of rearrest for MH participants (47% vs. 56%) and lower mean number of rearrests (1 vs. 1.4) but the differences were not significant. There was a significant change in pre-post- arrests for both groups, and the analysis suggests that the number of pre-enrollment arrests was not related to the number of post enrollment arrests. The number of prior arrests was significantly associated with the time to rearrest. The comparison group was 2.6 times more likely to report aggression before the study, but the difference in aggression among the groups in the post-follow-up were not statistically significant. Although both groups exhibited decreased aggression over time, the decrease in aggression was more pronounced for the comparison group. Both groups exhibited

decreased violence over time, but the decrease in violence was slightly more pronounced for the participant group. The difference was not significant.

Broward County MH court was successful on components of efficiency and the findings didn't suggest that the court is a detriment to public safety, although differences between groups on recidivism in slight favor of MH court participants were not significant. Recidivism rates for both groups were reduced over time.

The study may be limited in that the groups differed before enrollment, with the comparison group having more pre-study arrests and being more likely to report aggression. The group may have also differed on other variables not studied (possibly, the comparison group had more jail days because of overburdened docket caseloads/slower processing). Also, due to data quality issues, time at risk (jail days) in the follow-up period were not examined. MH court participants may have had more opportunity to recidivate due to spending fewer days in jail.

Feder (1991). "A comparison of the community adjustment of mentally ill offenders with those from general population: An 18-month follow-up."

The study examined the validity of the public perception that mentally ill offenders are more dangerous and threatening to public safety than other offenders. It sought to explain whether criminological variables were equally as important as mental illness in explaining any differences between mentally ill offenders (MIO) and non-mentally ill offenders (non-MIO). The outcomes of the study group of MIO and a comparison group of non-MIO were tracked over the course of 18 months post-prison.

Data collected in New York State was on prisoners in the 1980s and included an examination of their post-prison arrests and arrest-related psychiatric hospitalizations. MIO was defined as those receiving psychiatric hospitalization while in prison. The researchers were reasonably certain that these offenders did have severe emotional disturbance and had not simply been labeled by the prison guards, noting that referrals for service came from mental health staff and not corrections staff.

The study found that the characteristics and prior histories of MIOs significantly differed from non-MIOs: MIOs were older, held less stable employment history, less educated, had lower IQs, less likely to have been married, had many prior hospitalizations, and more likely to have been previously institutionalized in prison or hospital. There were no differences in the numbers having been arrested previously, but MIOs were more likely to have had a prior violent arrest and to have served time in prison.

During prison, MIOs were more likely to have had behavioral incidences and infractions and were less likely to have been paroled. Upon prison release, 20% were directly committed to psychiatric care facilities, and they were also significantly less likely than non-MIOs to receive support from friends and family. A large number resisted community treatment once released. Half experienced a psychiatric hospitalization in the 18 month follow-up (a third of those were due to subsequent criminal behavior).

Differences between groups in rearrest rates were insignificant; however, non-MIOs had significantly higher rates of drug related arrests. MIOs were less likely to be revoked than the comparison group, but when they were revoked, they were more likely to have technical violations (vs. absconding or rearrest). Also, MIOs were less likely to have charges dropped for nuisance arrests and more likely for drug arrests. When convicted of nuisance or drug charges, MIOs were more likely to serve time in jail or prison. MIOs lower rates of re-incarceration (36% vs. 42%), but this could be explained by fewer living in the community after release (51% vs. 62%).

After controlling for psychiatric variables (prior hospitalization and age) and criminogenic variables (prior arrest, incarceration, and age), only age and prior incarceration, two factors most often associated with re-offense, were found to be significant predictors of arrests for new offenses in the typical relational direction; however these factors only accounted for 8% of the variance between groups in rearrest.

MIOs do differ from non-MIOs, but not on the issue of public safety. MIOs recidivate, but recidivate no more often or with more serious crimes than does the general prison population. The public perception may be that mentally ill are “mad and bad,” but the data do not support that they are truly more dangerous. The rates and types of rearrest did not differ from others. Rearrest of MIOs is better explained by criminogenic than psychiatric factors. Resistance to community treatment suggests the need to have conditional release with mandatory treatment and access to half way houses and employment services. Compliance should be monitored by a multidisciplinary team. Barriers of equal access to community services need to be resolved, as many mentally ill offenders are banned from community services because of their severe illnesses and criminal histories.

MIOs did differ from the general population but only on variables know to be associated with recidivism (age and criminal history). Other factors not examined in study may be better predictors of rearrest (i.e. extent of emotional instability). Also, if the groups had been more comparable, perhaps MIOs would have showed lower rates of recidivism.

Heilbrun, DeMatteo, Yasuhara, Brooks-Holliday, Shah, King, Dicarolo, Hamilton, & Laduke (2012). "Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research."

This report provided a review of empirical studies that examined the effectiveness of MH court, using the sequential intercept model to categorize types of court programs based on the point at which the program intervenes. The report presents tables of the studies reviewed with a short description of study design (control or comparison group), N, research questions, outcomes, significance testing, findings, and study design.

Most studies reviewed in the report were conducted within the past decade. The conclusion of the researchers was that public safety does *not* appear to be adversely affected by diversion and may in fact be enhanced by these programs, although it is too early to reach a definitive conclusion. Diversion and post-incarceration programs may be more costly than traditional community programs, but less costly than residential placements in prison, jails, and hospitals.

Law enforcement/emergency programs: only a modest number of studies consider the crisis intervention team (CIT) approach. Research supports that these programs can effectively divert individuals and possibly even result in the use of less police force. However, although these programs result in cost savings in the CJ system, they may shift costs to the behavioral health system. The review cannot definitively establish an effect on recidivism in the long-term (over 12 months) and when compared to a comparison group, due to the sparse number of studies conducted on these programs.

Post arrest/initial hearing programs: research suggests that program participants spend more time in the community, participate more often in treatment, have greater variety of treatment options, and possibly are less likely to be rearrested. However, the number of studies conducted on these programs are relatively small, study designs vary, and programs included in this stage of diversion often use different approaches, goals, and intensity contributing to difficulty in generalizing findings.

Post initial hearing programs: these programs have been most widely researched. This category encompasses all specialty courts, including drug courts, MH courts, and community courts. Studies on these programs have used better research designs, larger sample sizes, significance testing, and wide range of research questions. MH courts use a wide variety of approaches. Many are pre-adjudication but the number of post-adjudication programs has increased as more courts are accepting felony cases. Results are largely favorable for specialty courts – clients receive appropriate services, report favorable perceptions of the program, and are less likely to be rearrested and re-incarcerated.

Reentry from jail, prison, hospital programs: this category includes ACT (assertive community treatment), ICM (intensive case management), and correctional reentry programs. The number of studies on these programs is limited, but existing studies generally show positive recidivism outcomes for those participating in ACT and ICM. Mental health outcomes are mixed, but some studies show favorable mental health and community adjustment. There needs to be more well-designed studies on these types of programs.

Community corrections/ Probation and Parole: specialty agencies show considerable promise on measures of clinical and criminal outcomes; however, individual factors, especially client receptiveness and motivation are important for success. The strength of the relationship between the case manager/probation officer and the offender is also important in success (i.e. coercion is possible). Co-occurring offenders are less likely to have good relationships with treatment providers, more likely to feel coerced, and often engage in riskier behavior.

Herinckx, Swart, Ama, Dolezal, & King (2005). "Rearrest and linkage to mental health services among clients of the Clark County mental health court program."

The purpose of the study was to examine changes in MH court participants 12 months pre- vs. post enrollment on measures of recidivism and the receipt of mental health services.

Site: Clark County MH Court is located in Vancouver, Washington. The program is voluntary and screening and referral take place within 24 hours of arrest. Eligibility criteria includes adults with Axis I diagnosis that have been charged with a misdemeanor. Those with a developmental disability or Axis II personality disorder are not eligible. Master's level coordinators assess individuals and make referrals. Clients must plead guilty before enrolling in the program and charges are expunged upon successful program completion. Participants are referred to mental health services within 24 hours after enrollment.

After participation in the program, the percentage of offenders having been rearrested and the average number of rearrests dropped. There was a significant 62% drop in number of probation violations. Completers were 3.7 times less likely to be rearrested for new crimes after participation than non-completers, and those still enrolled were 2.3 times less likely to be rearrested than those terminated. Rearrest was also more likely among those hospitalized or booked in jail pre-enrollment and was less likely for schizophrenics compared to those with other disorders.

Findings indicate that the program helps reduce repeat offending. There is a relationship between graduation status and rearrest, even when controlling for extraneous variables (demographic characteristics, mental health treatment, prior arrest, and diagnosis).

Surprisingly, mental health service intensity was not associated with rearrest. Qualitative aspects that were not examined in the study (the relationship between clients and team and the collaboration among service providers) likely reduced the number of rearrests. The study was not able to establish the reason why graduates have better outcomes in the program and motivation may play a role. The number of days in the program was not found to be a significant predictor of rearrest in this study.

Hiday & Ray (2010). "Arrests two years after exiting a well-established mental health court."

Site: The North Carolina MH court has jurisdiction over two small towns and is in its fifth year of operation. The court accepts clients who have been diagnosed with mental illness (often also with substance abuse problems) both pre- and post- adjudication. Clients may have misdemeanors or felonies for violent or nonviolent offenses. The duration of the program and monitoring is six months. Treatment is tailored to the defendant's needs and available services. This study used administrative data and tracked participants over the course of a two year follow-up period to examine pre- and post- program arrests for completers vs. non-completers. Participants had a 48% rearrest rate, which was lower than pre-program arrest rates, and also had a lower mean number of rearrests than pre-program. Completing the program was associated with a significantly greater reduction in recidivism. Controlling for other variables, the study found that only one predictor, number of prior arrests, significantly increased the likelihood of rearrest. Completing the program significantly reduced the chances of rearrest (those who completed the court process were 88% less likely to be rearrested than those who did not) and was significant in predicting the time to the first arrest (longer time to rearrest). Study did not control for jail time; however, it is likely that jail time would only have been brief considering most participants were misdemeanants and would have participated in pre-trial release. Having mental illness in addition to substance abuse, which was not examined in the study, may have affected completion and rearrest. Also, there was no comparison group of similarly situated offenders not participating in MH court.

Lamb, Weinberger, & Parham (2001). "Court intervention to address the mental health needs of mentally ill offenders."

Site: Los Angeles County forensic mental health court diversion program offers mental health consultation to the courts early in the legal process to divert offenders from punishment to treatment. The program diverts defendants at an early stage in the legal process. One such court, the Hollywood Municipal court, was chosen as the site of this study. A clinical psychologist consultant works with court officers and staff, provides evaluations, plans treatment, and identifies services. The study tracked participants on arrest, psychiatric hospitalization, violence against persons, and homelessness for one year.

The study found that those mandated to judicially monitored treatment had significantly better one year outcomes than those not mandated to receive monitored treatment (59% vs. 28% had a good outcome). Also, those mandated to judicially monitored treatment had better outcomes than those mandated to non-monitored treatment (59% vs. 29%).

A couple factors were involved in determining the likelihood of good outcomes for clients: *mandated* and *monitored* mental health treatment. The study suggests that a judge should monitor treatment and mandate that defendants attend treatment. It is also important for non-clinician staff in the criminal justice system to assistance in identifying and recognizing those in need of assistance. The mental health program staff should keep court officers and judges informed of progress and make release arrangements for living situation, finances, and support.

Lovell, Gagliardi, & Peterson (2002). "Recidivism and Use of Services among Persons with Mental Illness after Release from Prison."

The purpose of this study was to provide a picture of released mentally ill offenders, their prerelease characteristics, community services they typically receive in Washington, the seriousness and amounts of recidivism crimes, and prerelease variables that best predict recidivism.

Site: the study was conducted in Washington State. In Washington, MH care is provided solely by the Department of Corrections rather than an outside agency, and after release, services are provided by treatment providers associated with the Department of Social and Health Services. The study tracked all seriously mentally ill prisoners released in the year of 1996 to 1997 who suffered from serious mental illness (not personality disorders). The study population was identified using records of prison hospitalization, mental health residential placement, screening assessments, medicine intake, medical charts, and participation in more than 30 days of the prison mental health program.

Data collected included demographics – sex, age, ethnicity; criminal history –past charges, dispositions, convictions; prison terms, mental health bed use, infractions, segregation; post-release use of general state assistance (food stamps, drug/alcohol abuse services); pre-incarceration and post-release data on days in inpatient service and hours in outpatient service; in-state post-release charges, dispositions, technical violations, felony sentence lengths; and out-of-state arrests.

Compared with all offenders released from prison that study year, more MI offenders were white and fewer were black, fewer had drug offenses and more had sex offenses, and more had

served longer time in prison for the current offense. Women were overrepresented in the mentally ill population. MI women were more likely than men to suffer from depression and to have a history of drug abuse.

Post-release community social services data (average of 31 months follow-up) showed that participants most received social service or financial assistance after prison, and a quarter were hospitalized. Social service, financial assistance, and drug/alcohol services, however, were not steadily received within the first year of release, a critical period of time in recovery when services are most needed, and the intensity of service (hours) was low. Although those offenders with more serious new felonies received fewer mental health services later (delayed), the difference was not statistically significant and the causality was not proven due to several confounding factors.

Recidivism (average 39 months follow-up) was the norm, but MI offenders recidivated with somewhat less serious offenses. 77% of recidivism occurred within the first year of release. Released offenders with mental illness had a very low rate of recidivism for high-profile violent offenses such as homicide and rape, which does not support the public perception that MI offenders are dangerous. Findings strongly suggest that even MI offenders who have been convicted of serious felonies rarely commit serious violent crimes after release. Recidivism for the released offenders with mental illness within the study period was similar to the non-mentally ill offenders. Serious new offenses were rare in both groups. Repeated arrests and detention time for minor public offenses such as public intoxication, trespass, and drug possession interrupt treatment and social support development, and often result in jail time. Having a minor offense often acts as a harbinger of future prison sentences and is good time to intervene.

McNiel & Binder (2007). "Effectiveness of a mental health court in reducing criminal recidivism and violence."

In its first two years of operation, the study examined outcomes (violence and recidivism) of all people enrolled in San Francisco MH court vs. a matched comparison group of mentally ill people in jail during the same time. The purpose was to determine whether or not MH court reduced time to recidivism and the time to violent recidivism. The study also compared participants' outcomes by completion status.

Site: The San Francisco mental health court was established in 2003 and accepts people charged with felonies who also have an Axis I diagnosed disorder and are "amenable" to treatment. Criminal charges are not dismissed while in the program and are not necessarily

dismissed upon successful completion. The program acknowledges that relapse occurs over the lifelong course of mental illness and focuses on positive reinforcement.

The study used a propensity weighted score to identify a comparison group similar to participants and to correct for baseline differences between the groups and selection bias that could affect results. The study collected pre-participation/arrest variables 12 months before study entry and controlled for demographic characteristics, criminal history, and diagnosis. Recidivism was defined as a new charge or a new violent charge within an 18 month follow-up period.

The researchers conducted a survival analysis to look at recidivism over time. After controlling for other variables (prior charges, diagnosis, propensity scores, and demographics), they found that participation in MH court predicted a longer time to having any new charge and a new violent charge. The effect of participation on reducing the likelihood of having new charges increased over time – a 26% reduction by the 18 month follow-up of having any new charge; a 55% reduction of having a new violent charge compared with the comparison group. Having completed the program (graduation) was also associated with reductions in the likelihood of having new charges over time compared to the comparison group – a 39% reduction by the end of follow-up of having any new charge; a 54% reduction of having a new violent charge. This reduced recidivism was maintained even when graduates were no longer under court supervision. Reductions in recidivism were especially evident after one year.

Moore & Hiday (2006). “Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants.”

The study hypothesized that completing the program, not just entering the program, is the more important factor in contributing to successful outcomes. Staying longer in the program increases the chances of receiving mental health services thus increases the likelihood of positive changes (“full dose” vs. “partial dose” of treatment).

Site: The mental health court is located in the Southwest U.S. It accepts people with mental illness and/ or substance abuse issues who don’t pose a serious threat to public safety. Potential participants are screened by assistant DA; defendants come to court monthly for monitoring. The program lasts six-months and upon completion, all charges are dropped. A matched comparison group was compared to participants, completers and non-completers. MH court was effective – the outcomes were better for successful MH court participants than unsuccessful completers and a comparison group of traditional court participants. The comparison group of traditional court defendants was more likely to have been rearrested in the 12 month follow-up and also had more severe rearrest offenses than did MH participants

(MH had half the rate of rearrest). Also, MH completers had lower rates of rearrest than MH non-completers and even lower rates than traditional defendants. Severity of rearrest among traditional defendants, completers, and non-completers did not significantly differ.

The evaluators had no evidence to believe that causation flowed in the reverse direction and that re-arrest caused non-completion. They also noted that the demographic and criminal history differences observed between comparison groups (age, race, prior offense severity) were controlled in the model to minimize the chances that the outcomes of the groups could have been attributed to anything other than differences in mental health services received.

Sirotich (2009). "The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of the Evidence."

The purpose of this review was to answer the following questions: Do jail diversion programs for seriously MI reduce recidivism? Do they reduce jail time?

The report reviewed research from 21 publications of programs in the U.S. (including studies on co-occurring programs; excluding youth programs and pre-post designs that are regarded as weak evidence in program evaluation). The studies chosen had to have a comparison group and an examination of recidivism as an outcome variable.

The findings suggest that *pre-booking* programs, especially the police based specialized response model, reduce the amount of jail time, though there was little evidence to support reducing recidivism. *Jail diversion* programs did not result in reduced recidivism relative to a non-diverted comparison group, but may reduce rearrest among low-level misdemeanants. Evidence is sparse and more research is needed. *Court based diversion* programs reduced the length and prevalence of incarceration among seriously MI but evidence did not suggest that they reduce recidivism. *Mental health courts* - findings on the effects of reducing jail time vary, which may be attributed to wide variations among the courts. The results cannot be used to draw conclusions because the therapeutic use of jail among some MH courts has not yet been explored and may be a mediating factor in jail time and recidivism. Overall diversion programs do not reduce recidivism among those with mental illness, but they do reduce time spent in custody (jail time). Court based programs are more effective than jail-based or treatment-as-usual at reducing recidivism. Pre-booking programs also have a discernible impact on reducing incarceration time.

The findings are preliminary. There were limitations in the studies reviewed, but these limitations would likely not have changed the conclusions in relation to recidivism rates; however they may have limited the validity of the findings on the effects of diversion on

incarceration time. It is difficult to generalize the findings to other jurisdictions since programs vary organizationally and structurally across contexts. Jail diversion has little impact on recidivism.

Future studies should consider contextual factors and access to community services (housing, employment, medical); control for factors that may mediate the relationship between diversion programs and recidivism (availability of treatment); determine who is most helped by diversion (symptomatology, insight, and motivation) – research could use validated risk instruments, such as HCR-20 and LSIR to identify subgroups who may most benefit (criminal history, violent offenders, etc.); use randomized control trials or matched-pair designs to reduce selection bias; make a distinction when measuring recidivism between technical violations and new convictions (to identify whether differences in recidivism may be due to increased monitoring); and examine the clinical effects on patient’s health and quality of life.

Steadman, Cocozza, & Veysey (1999). “Comparing outcomes for diverted and nondiverted jail detainees with mental illnesses.”

The purpose of the study was to: 1) determine the characteristics of who is selected for the diversion program 2) examine outcomes, such as rearrest, hospitalization, and quality of life. Site: The jail diversion program is a pre-arraignment program located in a medium Midwestern city and provided funding by the state. Most referrals are made by the public defenders and some from pre-trial services. Referrals are evaluated by a court liaison and a judge makes a decision on admission to the program. The decision to divert is made based on a mental health service history and symptomatology, especially focusing on serving those with less serious charges who are not a threat to public safety. The program releases defendants on own-recognition bonds so they can receive community treatment. If sentenced to jail by the judge, the offender receives services in jail and post-release planning.

Study data was collected from client and staff interviews at program entry, post-release client interviews that occurred two months after diversion, and criminal records.

Study subjects had extensive mental health treatment histories (95% had prior hospitalization) and many had been engaged in substance abuse treatment (75% had inpatient treatment). Differences between groups (diverted and non-diverted) existed on only a few measures of the severity of mental illness and drug/alcohol problems (those diverted had less severe paranoid ideology and were less likely to have an alcohol problem).

At the two-month follow-up interviews with clients, there were a few differences between groups. All diverted individuals were released into the community compared to only about two-thirds of the non-diverted group. The diverted group was also more likely to have had a

subsequent hospitalization, probably as part of the treatment program, whereas none of the non-diverted group was hospitalized. The groups did not differ in subsequent arrest rates, symptomatology, or quality of life – both groups showed improvement on symptom levels and quality of life.

In this study, no criminal justice variable was predictive of diversion – all were perceived as being non-threatening to public safety. Age and sex were also predictive of diversion (older women are more likely to be diverted because they were presumably less likely to have criminal histories). Those with alcohol problems were less likely to be diverted, but those with other mental health problems were much more likely to be diverted. The fact that offenders who were diverted were all released from jail would be associated with cost savings. The lack of differences in subsequent arrests may be due to having a short two-month follow-up period, as the non-diverted group may have still been in jail and would not have had the opportunity to recidivate.