



Review of the Literature on Jail Diversion Programs and Summary Recommendations for the Establishment of a Mental Health Court and Crisis Center within Douglas County, Kansas

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INTRODUCTION

PROJECT BACKGROUND

In September 2014 and based in part on a referral from Dee Halley, corrections program specialist with the National Institute of Corrections, Dan Rowe, President of Treanor Architects contacted University of Kansas Professor Margaret Severson about a potential consultation related to the intake, housing, and management of persons with mental illnesses who are admitted into the Douglas County Correctional Facility (DCCF) in Lawrence, Kansas. Having worked on similar issues with Douglas County Sheriff Ken McGovern for many years and with Sheriff Trapp before him, this consultation was pursued with the hope of contributing objective and evidence supported information about established diversion programs and services, including mental health courts and crisis intervention centers that might be successfully implemented in Douglas County.

The review of the diversion literature that appears in the following pages was completed by Professors Margaret Severson and Jason Matejkowski and, as requested, gives particular emphasis to identifying the aspects of certain diversion programs that might be seen as keys to their success and/or contributors to their partial or complete failure. Overarching principles and trends have been identified in the literature and are reviewed in this document, as are the successes and failures experienced, which are often site-specific. Thus, the elements of success and failure are also reported here and are often related to the construction and management of the program itself in a particular jurisdiction.

In our review of the literature we kept in mind the current DCCF operation and the express interests of Douglas County stakeholders, which include Douglas County elected and appointed officials, including Sheriff McGovern, mental health and health agency administrators, local judges and attorneys, and residents of the Douglas County community who participated in town hall meetings where information was exchanged and ideas, questions, and hopes for the future of the community were solicited.

THE SITUATIONAL CONTEXT

That jails and prisons across the United States are struggling to manage persons with acute and chronic mental health needs, not only by trying to identify best practices in corrections-based treatment interventions but also by looking at effective strategies for total population management, is not new. The challenges facing jails in terms of housing more and more persons with serious mental illnesses was the focus of the first National Institute of Corrections' seminar on the topic held in the mid-1980s. The only national jail suicide studies were completed during the same period. By the late 1980s and well into the 1990s, a mass of publications pointed to the reality and existence of a "criminalization" process, where persons who might have previously been hospitalized in inpatient psychiatric units were, as a consequence of state and local psychiatric hospital closures, instead detained for preventive detention or arrested and held in the local county jail as a means of containment [1].

This burgeoning mentally impaired population, when combined with more severe arrest policies and sentencing laws, resulted in an explosion of inmate populations at both local and state levels. To complicate matters even more, an alarming increase in the rate of imprisonment of women, in facilities ill-equipped – environmentally and programmatically – to attend to them, in some cases caused gridlock inside correctional institutions. This influx served to thwart efforts to contemporize inmate classification procedures consistent with constitutional mandates, so that operational efficiencies in housing and

program involvement could be achieved. In reality, many jails struggled with overcrowding and worse: having empty beds in some specially designed housing units while in some general population units, inmates could be found sleeping on the cell floors. Indeed, this classification / housing squeeze became a management conundrum for nearly every jail manager in the country. Many counties and states attempted to build their way out of the gridlock, but the relief offered by new and larger facilities was often short-lived.

In the late 1990s, jail diversion programs, many especially geared toward those with mental health challenges, began to emerge around the country. New and modified diversion strategies have also been implemented in the last 15 years. These are highlighted and reviewed in the pages that follow.

The Douglas County Correctional Facility shares the fate of many detention centers around the country. Increases in its average daily population and average length of stay over time, dramatic increases in the numbers of women prisoners being admitted into and staying in the jail, significant rates of mental illness and substance use exhibited among its incarcerated population, and housing gridlock have all impacted DCCF operations. At the same time, a robust reentry program, a mental health collaboration initiative, and considerable programming opportunities have likely helped to mitigate some of the common consequences of these population changes and challenges. Still, at the outset it is important to keep in mind, as one reads the literature review presented in the following pages, that population management and diversion strategies comprise two different challenges and call for two different types of responses. Both sets of challenges must be addressed, but by using different strategies. To that end, the literature review that follows is designed only to inform strategies that might result in more effective *diversion* of persons with mental illnesses and co-occurring disorders from the jail system.

THE WORK PROCESS

To prepare for the literature search and review, several important inquiries were made. First, we set out to define the problem to be explored in the literature review. There were three types of activities pursued that were related to this process. First, over a period of several months, we met with key county officials, including Sheriff McGovern, Commissioners Jim Flory or Mike Gaughan, Douglas County administrator Craig Weinaug, David Johnson CEO of the Bert Nash Community Mental Health Center, and representatives of Treanor Architects, to explore the challenges facing the DCCF with regard to admitting and managing persons with serious mental illnesses. We identified the need to secure data that would allow us to quantify, where possible, these challenges as well as provide us with a starting place for exploring diversion options that already exist elsewhere in the United States.

Second, we engaged in key fact-finding activities, for example, talking with colleagues around the country about their research and their knowledge of diversion programs. We also met with key Douglas County jail and Bert Nash representatives and toured the DCCF in order to better understand the existing and emergent population-related pressures impinging on the jail staff and on the jail environment. Over time we met with city and district court personnel, including judges and prosecutors, in order to listen to their perspectives and identify their interests in and questions about jail diversion programs already underway in other areas of the state and country.

Third, we participated in site visits to other jurisdictions, exploring not only the operation and layout of certain jail facilities, but also the development, design and operating procedures of mental health courts and crisis intervention centers. In this regard, we made site visits to Bexar County, Texas and to Fayette

County, Kentucky. We also toured both the Rainbow Crisis Center located in Kansas City, Kansas and the Valeo Crisis Intervention Center located in Topeka, Kansas.

In sum, this literature review is the product of a six-month process of interviews, discussions with stakeholders, site visits, reviews of the relevant published peer-reviewed research, and perusals of the contemporary practice literature.

AUTHORS/CONSULTANTS

Margaret Severson is a Professor at The University of Kansas School of Social Welfare, joining the faculty in 1996. In the 1980s she developed and administered a comprehensive mental health and suicide prevention program in the El Paso County Jail in Colorado Springs, Colorado. In the 1990s, while on the faculty at the Louisiana State University School of Social Work, Professor Severson was appointed the federal court expert in *Hayes Williams v. McKeithen*, a long standing civil rights case that resulted in decades of federal court supervision over the operation and practices of all of Louisiana's prisons and local parish jails. She has provided technical assistance related to mental health and suicide prevention for the US Department of Justice since 1990, for its National Institute of Corrections and the Civil Rights Division. Professor Severson's research scholarship is focused on mental health, suicide, incarcerated women, and reentry – all within the context of the correctional environment.

Jason Matejkowski is an Assistant Professor at The University of Kansas School of Social Welfare, joining the faculty in 2012. He has worked on a variety of projects involving justice-involved adults with serious mental illness (SMI) and co-occurring substance use disorders. He has served as investigator on state and federally-funded projects that examined integrated services for recently released inmates with SMI, the relationships among SMI, criminal risk factors, and parole release decisions, and effective data collection and information sharing between treatment and recovery services and the criminal justice system.

LITERATURE REVIEW

STRUCTURE

The sequential intercept model [2] provides a framework to study how people with mental illnesses interact with the criminal justice system. The model identifies a series of intercept points in criminal justice processing at which an intervention can be employed to divert individuals from penetrating further into the criminal justice system. It is important to note that the developers of the sequential intercept model assert that “an accessible, comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders is undoubtedly the most effective means of preventing the criminalization of people with mental illness” (p. 545). This truism is reflected in the subsequent review of community crisis centers and the highlighting of community support services necessary to buttress the remaining diversion programs discussed below.

Early interception points reflect law enforcement and emergency services and progress through interception in jails, initial hearings and courts to community reentry and community supervision. The adoption of the sequential intercept model by jurisdictions attempting to identify methods for intervening with people who have mental health problems to reduce their justice involvement and jail stays signals the appropriateness of the model for structuring this literature review. As such, we review the intercept points in the following order:

1. Community crisis centers
2. Law enforcement
3. Post-booking intercepts in jails and at initial hearings
4. Mental health courts

Given the scope of our assigned work, i.e., to focus on diversion programs that may help to ease jail overcrowding, reentry programs were not reviewed for this report.

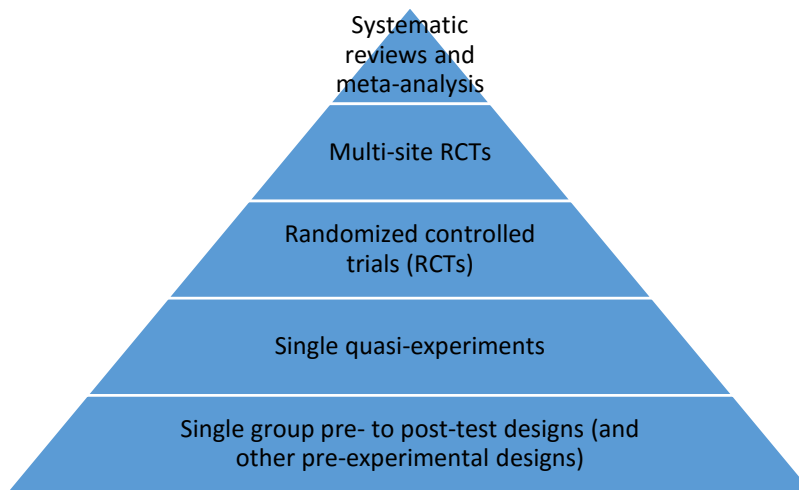
A NOTE ABOUT “EVIDENCE”

The quality of the research supporting each category of diversion programs reviewed is highlighted by identification of the associated research methodology. Research methodologies differ as to the extent that they can provide the evidence to support causal relationships. **Experimental designs** that employ randomization to treatment and control groups are most effective at providing evidence to support whether or not some manipulation of “A” *caused* a change in “B”. **Quasi-experimental designs** may employ a treatment and comparison group but lack the randomization of study participants to these groups that would facilitate causal attribution. Therefore, studies that utilize quasi-experimental designs provide a lower level of evidence than experimental designs (see figure below).

Lower still on the evidence hierarchy are **pre-experimental designs** that lack random assignment and the control groups that are a central part of good experimental designs. Due to the dubious nature of the conclusions that can be drawn from pre-experimental designs, effectiveness research using these designs is not reviewed here.

Research that systematically reviews and analyzes the data from multiple studies (preferably from studies that have utilized experimental designs) can provide a summary of the state of the evidence on a

particular causal relationship and its generalizability to different contexts. These systematic reviews and meta-analyses provide valuable sources of evidence that support the development of clinical guidelines.



It is important that when results from studies are reported that the research methodology be identified. Doing so allows the reader to gain a better understanding of the veracity of the findings. For example, if findings from a study of a mental health court that utilized randomization of study participants to a mental health court or to usual criminal justice processing found that those in the mental health court condition had fewer subsequent arrests than those in the usual processing group, then we could be fairly certain that the mental health court was responsible for (i.e., caused) the reduction in arrests. If similar findings were reported from a study that did not utilize randomization to a treatment or control group (i.e., that used a quasi-experimental design) or compared arrest days pre- and post-participation in a mental health court (i.e., a pre-experimental design), then we would have less confidence that the reduction in arrests was due to participation in the mental health court.

INTERCEPTS

(1) COMMUNITY CRISIS CENTERS

Mental health crisis centers have long been available to the public and to law enforcement as a place for assessment of individuals in need of psychiatric attention as a result of displaying behavior perceived to have potential for harming themselves or others [3]. Core elements of crisis centers have been proposed by the Substance Abuse and Mental Health Services Administration (SAMHSA) [4]; however, these guidelines are not specific to crisis centers that have been established primarily to support jail diversion efforts. Steadman and colleagues [5] identify these more “specialized crisis response sites” as an integral component of pre-booking jail diversion programs for people with psychiatric and substance use disorders. While admitting at the time of their report (2001) that no client outcome data were available to measure the impact of these programs on recidivism or engagement with treatment services, Steadman et al., identify basic elements of these crisis response sites to include the following features.

- A central drop-off site available 24-hours daily that serves as a point of entry into the substance abuse and mental health services systems and provides linkages to community services. A survey of experts on crisis intervention services [6] reported that 87% of those surveyed considered 24/7 availability of mental health services to be a “very important” component of

pre-booking diversion programs for people with mental illnesses. The same survey found 55% of experts thought that a single point of entry to mental health services was a very important component of prebooking diversion programs and 60% reported that referral to outpatient community treatment providers was a very important feature of these programs.

- A “no refusal” policy that expedites the officers’ immediate return to their duties. This policy recognizes the likelihood that officers will be deterred from bringing an individual to a crisis center (and, instead, make an arrest) if they believe the person in custody will not be accepted for evaluation by center staff. Eighty percent of crisis intervention experts surveyed identified having a no-refusal policy as a very important component of a police diversion program [6]. It should be noted however, that a survey of 54 police departments from the U.S., Canada, the U.K., and Australia reported that no-refusal policies were rarely available to pre-booking diversion programs serving people with mental illnesses [7].
- A streamlined intake process that minimizes officer time at the center and maximizes patrol time. Slightly more than 85% of experts surveyed reported rapid transfer of responsibility as being a very important component of mental health services supporting a pre-booking diversion program [6].
- A legal foundation that allows the crisis center to accept and detain a person who may or may not have pending criminal charges [5]. Two-thirds (67%) of experts identified legal grounds for detention as an important component of mental health services supporting police diversion programs [6].

According to Compton et al. [8], there is consensus in the field that a designated emergency mental health drop-off site with a no-refusal policy is crucial to improving officers’ linking of people with mental illnesses to needed services. However, the lack of specific research makes it unclear the impact that crisis centers, *independent of the diversion programs discussed below*, have on engaging in services and reducing the incarceration of people with mental illnesses. The research reviewed below, while identifying referral to services as an outcome, does not track individuals beyond the initial crisis drop-off point to evaluate whether these crisis services are effective at keeping an individual engaged in treatment or out of jail.

Indeed, there is some debate as to whether mental health services can actually reduce the criminal involvement of most offenders with mental illnesses. Mental health treatment approaches aimed at reducing psychiatric symptoms have often been employed with offenders who have mental illnesses under the premise that symptom amelioration will reduce criminal involvement [9]. This approach is at the heart of the diversion-to-treatment programs reviewed here. However, research has shown that employing with justice-involved individuals those evidence-based practices that have been effective at reducing psychiatric hospitalizations and psychiatric symptoms does not translate to reductions in criminal behavior and incarceration [10-14]. This has led some to suggest that mental illness plays a minor role in the criminal involvement of this population and that services for offenders with mental illness should focus on addressing other factors that are more strongly related to criminal behaviors [9, 15].

The predominant, evidence-based approach in offender rehabilitation today is based upon the risk-needs-responsivity model [RNR; 16]. This model asserts that: (1) an offender’s level of risk for criminal behavior can be assessed and that offender treatment services should be proportional to this risk level; (2) *this treatment should be focused on removing those dynamic risk factors (termed criminogenic needs)*

that are directly related to criminal behavior [mental illness is not a criminogenic need]; and, (3) this treatment should be responsive and tailored to an individual's personal characteristics that facilitate learning new behaviors and cognitions. Criminogenic needs are the same for individuals regardless of whether they have a mental illness [17-19] and include antisocial cognitions, antisocial peers, substance abuse and lack of involvement in school and/or work. However, the presence of a mental illness is a personal characteristic to which programs targeting criminogenic needs must be responsive. Research has indicated programs that adhere to the RNR principles can reduce offender recidivism by up to 35% [20].

In the end, if reduction in criminal behavior and incarceration is the aim, then services should: 1) be provided at an intensity commensurate with an individual's level of need, 2) target criminogenic needs, and 3) be delivered in a way that is responsive to an individual's health and mental health conditions. There is nothing fundamentally at odds with providing needed mental health services while adopting an RNR approach with those clients who are engaging in criminal behaviors.

In the absence of peer-reviewed literature on the effectiveness of crisis centers at reducing jail stays or days, the authors visited two nearby crisis centers; one in Wyandotte County and one in Shawnee County. One author also visited a crisis center in Bexar County, Texas.

Rainbow Services Inc.

Rainbow Services Inc. in Wyandotte County is a 24-hour facility that offers assessment and triage, crisis observation, a sobering unit, and a short-term crisis stabilization unit. According to the Executive Director, RSI serves as a resource to individuals, families and law enforcement, and to prevent unnecessary hospitalization or incarceration of persons who can benefit from community-based resources [21]. The RSI sobering unit serves individuals who are intoxicated or impaired from substance abuse. Diverting such individuals from hospital emergency rooms and jails, the unit provides brief stays (no longer than 10 hours) for up to 10 persons at a time. At the conclusion of their stay, sobering unit consumers may be transferred to local detoxification facilities or discharged to community-based services, or the individual may simply exit the facility without a service plan.

The RSI observation unit is staffed by a multi-disciplinary team of professionals providing clinical assessments, treatment, and observation lasting up to 23 hours per admission). The unit has a capacity to serve 10 persons at a time. Individuals may be discharged to community-based services, admitted to an inpatient psychiatric hospital, or transferred to RSI's crisis stabilization unit. The crisis stabilization unit provides short term care (up to 10 days) for up to 10 clients. Upon completion of their stay, individuals may be referred to co-occurring substance abuse or other community-based services or admitted to an inpatient psychiatric hospital.

Written RSI materials suggest that 45% of the persons referred to their services are accompanied by law enforcement, 19% are self-referrals, 25% are accompanied by family or friends, and others are brought in by community mental health centers (Wyandot Center/Johnson County Mental Health) or other community agencies. The RSI protocol is to quickly process all law enforcement referrals so that officers can immediately return to their patrol duties. Between April and August 2014, RSI served a total of 559 individuals; of those, 516 were unduplicated. Though it is unclear how the following figures were obtained, RSI reports that had their services not been available 17% of RSI clients would have been transported to a state hospital (91 individuals), 48% would have been seen in local hospitals (262

individuals), 11% would have gone to jail (61 individuals) and 24% to other community mental health services.

Since its inception, RSI has operated primarily with funding allocated by the State of Kansas's Department of Aging and Disability Services. This funding will extend three years after which RSI must become self-supporting, relying on grants and donations for its operation.

Valeo

Opened in October 2014, Valeo's Regional Center for Mental Health Emergency Care consolidates crisis services that were dispersed over eight locations into one central location [22]. Services include crisis intake and assessment as well as screening for state or local hospital admissions, counseling, and crisis stabilization. In regards to the latter, Valeo has 26 crisis stabilization beds that are available for stays up to 5 days. Valeo also provides crisis intervention training to local law enforcement agencies.

In an adjacent facility, Valeo provides 11 beds for substance detoxification services lasting between four and five days. For those individuals for whom long-term treatment is indicated, Valeo operates a 50-bed, long-term (i.e., 3 to 4 week) residential substance abuse treatment facility.

The Valeo facilities offer law enforcement officers a quick assessment/acceptance policy that allows officers to return to their patrol duties within a very short period of time. Only persons physically violent or deemed to be at imminent risk for violence are refused admission at the center.

Valeo officials report that approximately 40 percent of people brought to its crisis facility in the midst of a mental health crisis come by way of the Topeka Police Department [23]. It is noted that Valeo's budget for this crisis facility is dependent in part on the referral of persons from law enforcement agencies outside of Shawnee County, including referrals from the Bert Nash Mental Health Center and transports by the Lawrence Police Department. Indeed, it is clear that as other jurisdictions plan the development of crisis intervention services, Valeo's budget will be negatively impacted. The Valeo crisis center operates on a profit-making basis, i.e., it is designed to be self-supporting. Part of the budget design includes an expectation of receipt of payments for services offered to residents of other counties. Private health insurance, Medicaid, and other payment sources are billed for services rendered.

Having been open for approximately only eight months at the times of our visit, Valeo could not provide any data on the new crisis center's current or potential impact on the justice involvement of the clients it has served. It is important to note that Valeo has a very high staff turnover rate. Clearly, the intensity of the needs among the population served takes its toll on staff. The potential for violence in the center, the potential for personal injury, and the difficulty inherent in managing a large population of persons in crisis all play out in staff turnover.

Bexar County

The Crisis Care Center (CCC), the crisis intervention center in Bexar County, Texas, serves the city and suburbs of San Antonio – a metropolitan population of almost 1.9 million - in several physical locations, with additional site expansion planned for the future. A site visit was made to the near-downtown location, which consists of a complex of buildings that provide crisis intervention, chemical dependency, health, and homelessness services for thousands of people each year. The complex is operated under the collaborative auspices of Texas's Center for Health Care Services and other state funded agencies,

and is one component of a menu of specialty programs – including a variety of therapeutic justice programs - available to Bexar County justice-involved residents. This is a very expensive and largely privately and grant-funded enterprise.

The Crisis Care Center is also a jail diversion resource available in the county, and provides a panoply of professional staff (medical, psychiatric, social work) round-the-clock, enabling a “drop off” response system that allows law enforcement officers to return to their duties immediately after bringing someone to the physical crisis center location. In addition to providing mental health assessments and treatment, the CCC also provides a sobering area and an inpatient detoxification unit [24]. Further, in a separate building on adjacent grounds, the Haven of Hope center provides structured interventions for homelessness, focused on identifying and treating the root causes of homelessness. The Hope Haven safe shelter (the “courtyard”) sometimes sees a nighttime population of more than 600 people who sleep outside in a secure area.

One published report [24] indicates that in a 12 month period during 2010-2011, 5,100 persons were screened, referred, or received some level of services in the CCC and 8,000 people used the drug-related services available on the same grounds.

There are no known peer-reviewed and published evaluations of the Bexar County diversion programs. While these programs have received considered attention in the trade literature and from the constituents of communities across the country that struggle with the same issues of mental illness, addictions, homelessness, and poverty, independent reports of treatment and fiscal outcomes, including resource savings, were not found in the refereed literature. However, Dr. Tony Fabelo, the research division director for the Justice Center, Council of State Governments (CSG), summarizing the recent CSG activity in Bexar County, provided this feedback about the Bexar County program outcomes:

Bexar County has good CIT training for police and the police uses (sic) their restoration center and Havens for Hope programs to take mentally ill persons there instead of booking. So this is good. However, they do a very poor job of screening, assessing and diverting mentally ill persons to treatment programs at booking. They also do not have enough program capacity, nor do they do a good job in retaining those that are diverted to treatment. ... the mental health system is very deficient and does not have capacity to address many of the needs of mentally ill people in general, but in particular, those in the justice system (personal communication July 24, 2015).

Summary

There are several critical lessons to be learned from the literature and from the experiences of other crisis intervention centers. First, no one ventures down this road without a fervent wish for success. These desires can often yield inflated appraisals of “success” and estimated conclusions of positive outcomes. The evidence, however, of both success and failure is missing. There are no known, peer-reviewed, and published empirical studies using random assignment and there are also no quasi-experimental studies reporting the impact of crisis centers on the justice-involved population to be found in the literature. In part or in full, this total absence of good, trustworthy evaluations is a result of not developing an evaluation strategy concurrent with the development of the crisis intervention center itself. In essence, we have only stories and obscure percentages of success and failure to rely on. This does not mean that crisis intervention centers are ineffective; it only means that we do not know which are and which are not and why either is the case.

Second, mental health intervention alone may not have a significant impact on the total jail population; we simply do not know for sure. Once referred individuals enter into the mental health system, they fall off the radar screen. There are no known rigorous national studies that follow people referred to crisis centers to identify their outcomes, including their future interface with the mental health system and with law enforcement and the criminal justice system. As identified above, some scholars suggest that mental health interventions may have limited impact on the criminality of people with SMI who are justice-involved. The lesson here is one of prioritizing what needs to be addressed in an intervention system. Mental health needs are one set of potentially many needs to be addressed and targeting criminogenic needs may provide more positive and enduring justice-related outcomes. Both can be targeted in a crisis intervention center, but often are not.

Nationwide, some 80% of justice-involved persons has a substance use problem. Estimates in Douglas County echo this finding. Many of these persons also have co-occurring mental disorders that will be difficult to assess and treat until the person is sober and stable. Thus, a crisis center is not just a mental health venue; it must also be a venue to provide sobering and addiction treatment services.

Relatedly, the crisis intervention center must be developed to serve the entire community; not just the law enforcement community. Not only will this encourage widespread support for its development and services, crisis intervention centers have the potential to divert non-justice involved persons from becoming involved in the justice system because of their mental conditions.

Finally, thinking about sustainability in the developmental stages is critical. Fiscal sustainability as well as staff sustainability must be considered when designing the physical and ambient environment of the center itself.

(2) LAW ENFORCEMENT RESPONSES

There are frequent references in the professional and trade literature to the many calls for police officers to respond to scenes involving individuals experiencing a mental health crisis. Consequently, law enforcement officers play an important role in determining whether to resolve these situations with arrest and incarceration or with diversion of the individual into treatment services [25-27]. Key members of the Lawrence and Douglas County communities (i.e., the Sheriff, Police Chief, and Municipal Court Judge) report the same trends in this jurisdiction, though evidence of the extent of this activity is not readily available. Nationally, the most common law enforcement-based specialized response program is the Crisis Intervention Team (CIT) model [28]. The CIT model was developed in Memphis, Tennessee and involves the training of police officers to de-escalate crises and, when appropriate, to divert to treatment services instead of arresting individuals who are in the throes of a mental health crisis [29].

Resources

Essential elements of officer-based diversion programs are outlined in the literature [30, 31]. These include specialized training of officers and dispatchers, and meaningful collaborations among criminal justice and mental health professionals to support planning and implementation of the CIT program and custodial transfers to comprehensive and effective community-based treatment, supports, and services [30].

Training. The Memphis CIT model involves 40 hours of training for police officers to learn and master crisis intervention skills [32]. Supplemental training can also be provided to emergency dispatchers to

facilitate their identification of calls for service that may require a CIT response [31, 33]. During the training, officers interact with individuals who have lived experiences in order to develop a better understanding of challenges associated with mental illness; are instructed on mental health diagnoses, psychiatric medications, and drug abuse and dependence; and receive intensive training in verbal de-escalation skills [34]. Qualitative and pre-experimental research involving officers trained in CIT has found these officers to express greater understanding of mental illnesses and increased empathy and patience towards people with mental illnesses, and to consider more options (e.g., redirection away from jail) when deciding the outcomes of crisis calls [35-38].

Quasi-experimental research on the impact of the 40-hour CIT training has indicated that training increases officers' sense of self-efficacy and preparedness in effectively responding to the needs of individuals with mental health problems [39-41]. In one study, Compton and colleagues [42] compared CIT-trained officers to non-CIT-trained officers in their perceived need to use force in response to a series of vignettes depicting an escalating crisis situation involving a person with psychotic symptoms. The responses of CIT-trained officers to these scenarios reflected less escalation and a lower endorsement of the use of physical force in responding to the individual experiencing psychosis [42]. Additionally, CIT training appears to reduce feelings of social distance and stigma toward the population of persons with mental illnesses who come to the attention of the police [39, 41, 43, 44]. Retention of knowledge gained from CIT training has been shown not to differ based upon age, gender, level of education, or whether the officer volunteered for training [45].

Behavioral health partners. Behavioral health partners are a critical ingredient of the CIT model of diversion [30]. Mental health and substance abuse treatment professionals provide the necessary crisis treatment and support services that function as an alternative to jail and they also provide the training described above to officers and criminal justice personnel [31]. It is important that, to maximize officer presence in the community, mental health partners provide quick handoffs to supportive and crisis services [46]. Crisis services (usually a dedicated crisis center) should have a no refusal policy and accept all referrals regardless of diagnosis or financial status [7]. However, police should receive training on who is appropriately safe for diversion to these crisis centers. For example, individuals whose crisis resulted in injury to self or others or who remain agitated and potentially violent are not good candidates for diversion to noncustodial, nonmedical crisis centers. Policies should be set to ensure minimal turnaround time for the CIT Officers, so that it is less than or equivalent to the turnaround time necessary in transporting a person and processing him into jail [31]. Additionally, the facility will need access to a wide range of emergency health care services and disposition options, as well as alcohol and drug emergency services. The importance of effective mental health partnerships cannot be overstated. Simply put, by Watson and colleagues [47],

In order to divert individuals with mental illness to the mental health system, officers must interact with providers from the mental health system. This can only occur if responsive mental health services exist; and if officers are able to efficiently link individuals to treatment to resolve a mental health call. Police must also have access to community mental health resources to respond to individuals who are in need of services but do not meet criteria for emergency evaluation at the hospital (p. 364).

Quasi-experimental evidence

Quasi-experimental research examining disposition outcomes involving CIT is sparse. One study comparing the characteristics and psychiatric dispositions of individuals referred to mental health crisis services by CIT officers, by family members or through self-referral concluded that CIT police officers were able to adequately identify appropriate people for referral to emergency psychiatric services [48]. In another study involving 180 officers (91 with CIT training and 89 without) in six departments across the State of Georgia, Compton et al. [49] found that among 1063 encounters CIT officers did not generally differ from non-CIT officers in the use of force, nor did they differ in the percentage of calls that was resolved on-site (about half for each group). However, referral to services was significantly more likely and arrest was significantly less likely for those individuals in crisis who encountered a CIT-trained officer versus a non-CIT-trained officer [49].

Research comparing outcomes of calls responded to by either CIT officers, a co-responder (CR) pairing of an officer and a mental health professional, or a civilian community service officer (CSO) trained in social work or related fields [50] found percentages of arrest dispositions varied from 2% (CIT) to 13% (CSO). In 75% of cases responded to by CIT officers the individual in crisis was transported to treatment; this disposition occurred in 42% of CR responses and 20% of CSO responses. The authors suggest that the large differences in treatment disposition were due to the availability of a crisis drop-off center in the jurisdiction served by CIT officers [50].

Other quasi-experimental research has shown CIT training to increase direction to mental health services and, to a lesser extent, reduce arrest and use of force with those individuals in a psychiatric crisis who are brought to the attention of the police [51-53]. In comparing CIT to non-CIT officers in Chicago policing districts with high/low mental health resources, Watson and colleagues [54] found no effect of either CIT training or resource availability on arrest but did observe CIT trained officers were more likely to direct individuals to mental health treatment than non-CIT trained officers. However, the effect was moderated by the availability of mental health services. In districts with high levels of mental health resources the relationship persisted while in low resource districts, the relationship between CIT training and referral to services was nonsignificant; highlighting again the need for adequate mental health support services for diversion efforts to be effective.

It is important to note that the studies reviewed here looked specifically at the actions of CIT vs. non-CIT trained officers. The studies did not include investigations of what occurred after referrals to mental health and support services were made, e.g., whether the person actually accessed services on an ongoing basis.

Experimental evidence

No studies utilizing an experimental design were located.

Systematic reviews and meta-analysis

Two systematic reviews have been conducted of the research examining the effectiveness of CIT on various outcomes. In 2008, Compton and colleagues [55] conducted a qualitative review of the extant research that included evaluations, surveys and outcome studies involving CIT. They identified three studies reporting on dispositions of calls eliciting a CIT response (all were reviewed above; [48, 50, 52]). While noting “serious methodological limitations” (p. 53), the authors concluded the evidence provides

preliminary support for CIT as an effective method for connecting to mental health services those individuals experiencing a psychiatric crisis and who come to the attention of the police.

A more recent quantitative meta-analysis by Taheri [56] focused specifically on studies that reported on arrests, use of force and officer injury. The review was limited to available quasi-experimental or experimental research. Seven studies were included in the meta-analysis. Again, no studies utilizing an experimental design were located. The five studies that were able to be pooled for meta-analysis resulted in a nonsignificant difference in arrests between CIT and non-CIT officers; though the average number of arrests for CIT officers was lower. Similarly, the five studies that were able to be pooled for meta-analysis resulted in a nonsignificant difference in use of force between CIT and non-CIT officers; though results favored the non-CIT group on average. Only two studies reported on officer injury and therefore no pooled analysis was possible on this outcome. Findings led Taheri to conclude that,

There appears to be some evidence that CIT has no effect on outcomes of arrest, nor on officer use of force, with the overall findings being mixed. Paired with findings from the Compton et al. (2008) review, these results raise some concern about the widespread implementation of CITs (p. 15).

Summary

That there are no published, peer-reviewed experimental and few quasi-experimental studies completed on the outcomes of CIT training for officers should not be overlooked when considering implementation of a widespread CIT program. Certainly, increasing one's understanding of mental illness and of effective ways to interdict in crises is significant in its own right. That said, it is important not to conflate knowledge acquisition with actual outcomes. If the purpose of implementing CIT training is to increase officers' understanding of mental health crisis, CIT is clearly an appropriate strategy to employ. If, however, the purpose is instead to reduce arrests and subsequent incarceration and substantially improve people's access to mental health resources, CIT has not yet been firmly established as a viable method to do so.

In recent years, the CIT program originally developed at the University of Memphis has morphed into something more abbreviated than the original and well-known 40 hour copyrighted course. Correction officers, for example, may now take a 1 or 2-day crisis resolution course [e.g., 57]. These abbreviated curricula have not been subject to rigorous evaluation.

What is consistently clear in the research that has been published is the importance of the mental health resources in the community to which CIT trained and non-CIT trained officers can refer. Further, these resources, including crisis centers, must have the capability to quickly assume physical responsibility for the person referred, so the officer can return to his/her patrol duties in a timely manner. Additionally, "mental health" should be interpreted broadly, to include crisis detox services for persons severely intoxicated who are detained by law enforcement for their protection or whose families are unable to manage the intoxicated person safely.

Finally, there simply isn't enough research published to make definitive statements about the best structure of a CIT program. Whether CIT is more effective when responses are made by CIT trained officers alone or in dyads with mental health co-responders has not been established. At present, in most communities, the availability of human and service resources will determine the program model.

(3) POST-BOOKING DIVERSION STRATEGIES

Post-booking diversion programs often begin with screening and, when indicated, assessment to identify individuals with mental illness who may be appropriate for diversion to treatment services [58, 59].

Diversion may take the form of transfer to a secure forensic treatment setting, conditional release to treatment services or release to treatment with charges dropped [59, 60]. Individuals eligible for diversion are typically those who have been charged with a nonviolent misdemeanor or low-level felony offense; those with other charges may be admitted depending on the program-specific criteria [61].

Post-booking diversion programs may be categorized based upon their administration and location as either jail-based diversion, court-based diversion, and specialized diversion courts [62, 63]. Only the first two models are discussed here, while the third, mental health courts, are discussed separately below. Jail-based diversion programs are often operated by pretrial or specialty jail or mental health personnel who screen and assess for diversion individuals booked into the jail. Identification of who meets eligibility and is offered diversion to treatment and support services is determined in conjunction with the prosecutor, defense attorney and judge [64]. In some cases community supervision may accompany diversion; in others, diversion to treatment and support services ends the individual's episode of justice involvement [62]. Postarrest, court-based diversion can occur at any stage in the criminal justice process prior to sentencing. Court-based diversion programs vary in degree of court monitoring and type of sanction imposed, but are typically decentralized, with diversion staff working in multiple courts and in the community, providing case management and/or a liaison role between community service providers and the court [65]. Again, here, the focus is court-based diversion programs that have little to no involvement beyond the initial screening and referral. Models with more extensive court oversight (i.e., problem-solving courts, mental health courts) are discussed separately below.

Quasi-experimental evidence of effectiveness

Prearrest programs. Hoff and colleagues [66] compared 314 offenders with a SMI who had been enrolled in a diversion program between December 1994 and March 1997 to 124 individuals who were eligible for diversion but were not diverted during the same time period. In the year after the index arrest, those diverted had significantly reduced jail days compared to those who had not been diverted (40.51 versus 172.84 days). However, this relationship was moderated by seriousness of the index offense. That is, diversion only reduced subsequent days in jail among those initially charged with more serious offenses (low-level felonies and high-level misdemeanors) compared to those who were charged with moderate to low-level misdemeanors. Another quasi-experimental evaluation of jail-based diversion programs in Arizona, Hawaii and New York, compared persons released from jail through prearrest diversion and those who were released without diversion, on the number of arrests and on having any arrests during the past 30 days at three and 12 months post-release, and found no significant differences between the two groups [62].

Postarrest programs. Included in the report on the outcomes of eight jail diversion programs cited above was the evaluation of one diversion program in Connecticut that was conducted during the arrest phase of criminal justice processing [62]. Comparisons of 3- and 12-month outcomes of those diverted and those not diverted resulted in no significant differences between the two groups in whether individuals had been arrested or in each group's average number of arrests during the past 30 days. Another study conducted in Connecticut with a smaller sample that included individuals not diverted and individuals participating in a court-based diversion program found no difference between

the two groups in arrest rates or time to arrest; however, the diversion group spent significantly fewer days incarcerated in the year following the index arrest, and were also less likely to be re-incarcerated [67].

Rivas-Vasquez and colleagues compared arrest outcomes of individuals diverted, at arraignment, to an integrated health/mental health and relationship-based care program to the outcomes of individuals diverted to a variety of standard (non-integrated, not relationship focused) programs [68]. Individuals in the relationship focused program were encouraged (through the professionals' concerted use of empathy, respect and connectedness) to develop relationships with staff and each other as well as with their health care network. Those in the standard diversion programs did not evidence a reduction in number of arrests in the year following diversion. Individuals in the enhanced diversion programs had a lower average number of arrests compared to the year prior to diversion and compared to the individuals who received standard care.

Either pre- or postarraignment programs. A study by Shafer and colleagues' [69] included individuals with SMI and substance use disorders who had been arrested and booked for misdemeanor offenses. Diverted individuals included those who were released on conditions prior to trial, who received deferred prosecution, or who received summary probation and court monitoring. These participants' violent and criminality outcomes at 3 and 12 months were compared to those of similarly situated nondiverted participants. Analyses found no main effects for diversionary status or time on having been arrested or self-reported perpetration of violent acts at both follow-up points.

Within the New York City LINK diversion program, Broner and colleagues [70] compared the 3- and 12-month outcomes of individuals diverted through the program's prearraignment, jail-based diversion track (the nonmandated track) to the outcomes of individuals diverted through the program's postarraignment, court-based track (the mandated track). Those in the nonmandated track were diverted from jail and received case management without specific court involvement or any mandated sanctions. Those in the mandated track were diverted through the court with diversion conditioned on treatment involvement, mandatory case management reporting, and with court sanctions for noncompliance. In addition to each other, group outcomes were compared to another group of similar offenders who did not receive diversion. Findings suggest that mandated diversion is more effective than nonmandated diversion or standard criminal justice processing "in terms of reducing the number of days incarcerated in prison, increasing the number of days spent in the community (not in a hospital or incarcerated), reducing drug use during the course of a year, and effectively creating treatment linkages." (p. 43).

Experimental evidence of effectiveness

No studies utilizing an experimental design were located.

Systematic reviews and meta-analysis of effectiveness

Lange and colleagues [58] conducted a systematic review of the research on jail-based diversion programs for adults in North America and published between 1995 and 2011. They concluded that jail-based (prearraignment) diversion has "a high degree of effectiveness in reducing recidivism ... and moderate effectiveness in reducing the number of days incarcerated" (p. 210). They also concluded that court-based diversion (postarraignment) programs evidenced "moderate effectiveness for reducing

recidivism ... [and] the number of days incarcerated.” However, these conclusions were based upon the inclusion in their review of questionable findings from several pre-experimental research studies (e.g., [71-73]). Higher quality studies that were included in their review only partially supported their conclusions (all of these studies were referenced above in the section entitled “Quasi-experimental evidence of effectiveness”).

Ryan et al. reviewed the literature published between 1999 and 2008 examining postbooking diversion programs targeting individuals with serious mental illness [74]. Unfortunately, results reported conflate mental health court outcomes (discussed separately below) with outcomes of diversion programs that are not court-based. However, quasiexperimental studies included in the review by Ryan and colleagues are summarized above.

Bail reform

While not an approach taken to specifically reduce the numbers of individuals with SMI in jail, it is worth noting here the attention that no-bail programs have been receiving across the country as a method to reduce jail populations. For example, in 2010, Human Rights Watch called for implementation of policies that prevent the incarceration of misdemeanants because of their inability to afford financial conditions of release imposed to secure their appearance at a subsequent court date [75]. The group suggests a number of policies that could be implemented by prosecutors, judges and defense counsel that eliminate bail in most cases and that, when necessary, promote financial conditions that are affordable to the defendant. The policies called for by Human Rights Watch are now being implemented [76]. For example, according to the New York Times, bail reform has been enacted to reduce jail overcrowding as well as facilitate access to behavioral health treatment for those in need:

Reducing the population to make the jail complex more manageable was one of the central objectives, and along with the bail changes, the city is also expanding public health services and other programs for people with mental health and substance abuse problems [77].

In Washington, D.C., bail has been essentially eliminated. Eighty percent of defendants are released without financial bonds and 15% are held without bond. The remaining 5% are held on a financial bond, and upon request from the defendant, receive credit for time served if convicted [78]. The Pretrial Services Agency for the District of Columbia reports that 88% of released defendants (many of whom are supervised in the community) make all court appearances, and the same percentage complete the pretrial release period without any new arrests [79]. Similar rates of success have been reported in other jurisdictions that have employed risk assessment tools to identify individuals appropriate for pretrial release [80-82]. In one study of state court *felony* defendants in the 75 largest counties in the United States [83], failure to appear rates were slightly higher releases on recognizance than for those on conditional releases (26% and 22% respectively), and rearrest rates (17% and 15%) were similar to those of jurisdictions cited in this paragraph. Defendant characteristics associated with pretrial misconduct include being male or a racial minority, having a prior arrest record or current drug offense [83, 84]. Supervision of the defendant upon release is also associated with decreased arrest and increased court appearance rates [85].

Summary

While once again we were unable to find any published experimental studies related to bail reform, it is a strategy to be considered in any endeavor that seeks to reduce the total jail population. Its potential is perhaps best summarized in a recent report on pretrial release programs [86], where the National Association of Counties found that the majority of people held in county jails is of pretrial status and of low risk to public safety. Their report recommends expanded use of pretrial release and pretrial supervision and concludes with a call to action for county boards:

County boards have the convening power of all the parties in the pretrial system and courts have the authorizing power over pretrial release. Any long term sustainable solution for pretrial release requires collaboration across the county justice system, including local law enforcement, the court and corrections system. Counties are in a strong position to lead the way in pretrial release, developing strategies and leveraging resources that not only assist in managing the county jail population, but safeguarding public safety [86].

MENTAL HEALTH COURTS

Because unmanaged psychiatric impairment can be the primary contributing factor in some criminal acts, standard criminal justice responses may be viewed as scientifically and therapeutically baseless. For these individuals, a model that incorporates both criminal justice supervision *and* structured therapeutic intervention may be more effective for addressing the dual objectives of public health and public safety. Mental health courts (MHCs) are specialized dockets for defendants with mental illnesses that seek the adjudication of criminal charges and municipal code violations by using a problem solving model. Eligible clients voluntarily participate in a judicially supervised course of treatment developed by a team that includes mental health professionals. Modeled after drug treatment courts, MHCs provide an alternative to incarceration for mentally ill individuals charged with criminal offenses. The number of MHCs has expanded since their inception in 1997 to the point that there are now approximately 350 such courts operating in the U.S. [87].

It is important to note that there is no consensus on what constitutes a mental health court; they are developed in the context of community need and they function differently based upon the range and availability of treatment and court resources in that community and service catchment area [88-90]. As such, the following descriptions of populations served, court structures and resources should be viewed as guidelines and generalizations about their effectiveness should be approached with caution.

Population and eligibility

Mental health courts typically target individuals with SMI [91-93]. Co-occurring substance use disorders are common among this population as well [91, 92, 94]. However, the target populations of MHCs can vary and are “often shaped by state mental health ‘priority population’ definitions because these definitions affect the relative availability of treatment services that community providers can offer and be reimbursed for by the state or federal government” [95]. Arraignment for a nonviolent violence is often a requirement for admittance to a MHC [96], though involvement of individuals charged with a violent offense or history of violence may be considered on a case-by-case basis [91, 97]. Mental health courts may serve individuals with both misdemeanor and felony charges [93, 94]. As in regular court proceedings, defendants must be competent to proceed and capable of providing consent to voluntarily

participate in the MHC [96]; though the question of whether the voluntary nature of participation is always clear to defendants is an ongoing one [96].

Coercion

While enrollment in a MHC is presumed to be a voluntary choice, once admitted, the participant's adherence to the court-imposed treatment plan is leveraged through the threat of sanctions and the possibility of reinstatement to standard criminal justice processing for the criminal charges that initially brought the individual to the attention of law enforcement. The extent to which such mechanisms of a MHC are perceived to be coercive can depend upon 1) the transparency of the defendant's consent and enrollment process, 2) the ability of the defendant to withdraw from the MHC and to refuse treatment without additional penalties and 3) the defendant's experience of procedural justice within the MHC. Regarding the first point, mental health advocates [98] recommend that an individual's decision to participate in a MHC should involve the same level of choice as that of a criminal plea; that terms of participation should be discussed and documented and the decision to participate should not be made until after advisement from competent legal counsel has been offered. Making explicit to defendants that they have a choice to participate in MHC can significantly reduce feelings of coercion among MHC participants [99]. Similarly, an individual's choice to refuse a particular treatment or to withdrawal from a MHC should not engender undue duress. Advocates have recommended that MHCs establish a process for the review of treatment refusals by MHC participants "so that any decision to reinstate charges is made in an informed manner after all reasonable alternatives have been exhausted" [98].

It has also been suggested that feelings of coercion can be minimized when the use of rewards and sanctions to promote treatment adherence occurs in the context of a therapeutic relationship [100]. In MHCs, the relationship of focus tends to be the one between the judge and the MHC participant and the quality of this relationship often involves the participant's sense of procedural justice [101]. Indeed, procedural justice, or participants' perceived fairness of legal procedures [102], can have substantial impact on his/her satisfaction and compliance with MHC [99, 101]. As such, communication with MHC participants that imparts knowledge of court procedures and that promotes involvement of clients in determining sanctions and rewards can minimize feelings of coercion, increase perceived procedural justice and improve MHC outcomes [99, 101, 103].

Structure

Mental health courts provide a post-booking alternative to the incarceration of mentally ill individuals charged with criminal offenses. Offenders may enter mental health courts prior to pleading to their charge(s) or may enter the MHC post-arraignment or post-adjudication [97]. Some MHCs require participants to plead guilty to their charged offense(s) in order to participate, with record expungement upon graduation. Other MHCs may not require a guilty plea, will dismiss or reduce charges upon graduation and will pursue charges for those that are unsuccessful in the MHC structure. It should be noted that some critics view the requirement of a guilty plea as precluding the earliest possible criminal justice diversion and as contributing to the further criminalization of this population [98].

Although these courts may differ somewhat in structure, objectives, and function by jurisdiction [104], the essential elements of MHCs include: multidisciplinary planning and administration, clear terms of participation and informed choice to participate, confidentiality safeguards and, among others, increasing participants' access to evidence-based treatments and services as well as monitoring of

participants' adherence to court conditions and incentives for adherence [105, 106]. In a survey of 90 MHCs in 2005, the median number of active clients being served at the time of the survey was 36 and the mode was 30 [94].

Resources

The typical MHC team includes the Judge, court administrator/coordinator, treatment providers/case managers, prosecuting and defense attorneys [91] and often (in the case of post-adjudication, felony admitting MHCs [107]) probation officers [94]. Given the emphasis on non-adversarial court proceedings, the roles of attorneys appear to be minor during hearings [96]. Attorneys play supportive and collaborative roles, with the defendant's success mutually embraced as the MHC goal. The average length of expected participation in a mental health court program is 12-18 months [95], with 12 months most common [93].

Judge/court. The majority of MHCs surveyed in 2005 had clients return to court either weekly or monthly in the beginning period of their participation [94]. Participants move through phases that gradually require less frequent status hearings before the judge [108]. During court, each participant speaks with the judge and the judge receives updates on whether the participant met mental health service and court obligations for the week or for the period between court meetings. In one process evaluation, status hearings averaged 4.1 minutes per client [91]. Conversations between the judge and defendant tend to focus on treatment-related issues [96]. Praise is offered for those who have met obligations and encouragement for those struggling to get theirs met. Praise is offered more often than sanctions [108]. However, a variety of sanctions may be meted out for noncompliance, in graduated fashion ranging from adjustments to treatment plans to written assignments to community service to more frequent status hearings to jail time [91]. Research suggests that the judge is instrumental in promoting procedural justice (i.e., a sense of fairness in the application of rewards and sanctions) among court clients, in part, through the use of transparent and collaborative decision-making with clients and treatment providers [109].

Treatment and support services. Case managers are responsible for evaluating eligible defendants, developing treatment plans and linking clients with necessary community support services including mental health treatment services. As mentioned above, those courts that utilize a post-adjudication model and that admit felony and/or violent offenders, may also incorporate probation officers into supervision and support services [107]. In a systematic review of MHC effectiveness studies, Cross found that services provided through the MHCs varied but often included clinical counseling, case management, substance abuse treatment, money management education, employment counseling, entitlement program assistance, and self-help and support groups [93]. The availability and quality of mental health and supportive services, or lack thereof, have been identified as limiting factors in the effectiveness of the MHC model [92, 110].

Quasi-experimental evidence of effectiveness

As mentioned above, quasi-experimental designs lack the randomization of study participants to treatment (e.g., MHC) and control groups (e.g., traditional court processing) that equalizes the characteristics of participants in the two groups and facilitates causal attribution of observed outcomes to the intervention (i.e., MHC). Some designs will use statistical methods that attempt to equalize the experimental and comparison groups (e.g., propensity score matching), while others will simply assign

those that opt out of the intervention (or who are wait-listed) to the comparison group. In either case, there remain differences between participants in the experimental and comparison groups that can explain differential outcomes between the two groups (e.g., MHC participants could be more motivated to treatment). With this in mind, the results of several quasiexperimental studies are summarized below.

Research utilizing matched sample comparisons found that participants in MHCs displayed a lower overall rate of recidivism (10% vs. 28% within 12 months following the index offense that led them to court) and longer time to rearrest (11.3 vs. 9.6 months) for a new charge [111]. Similarly, compared to a matched sample of individuals diagnosed with a mental disorder receiving usual processing through the San Francisco jail, MHC participants experienced a longer time without incurring any new criminal charges or new charges for violent crimes [112]. However, using a matched sample of misdemeanor court defendants with mental illnesses, Christy and colleagues [88] found no significant differences between the two groups in percentage rearrested or in time to rearrest in the 1 year study period. The authors suggest this non-effect was due to a lack of additional funding for the local mental health system to support the expanded demand that resulted from the newly developed MHC [110].

Using a nonequivalent comparison group design Moore and Hiday [113] found MHC participants, compared to traditional court participants with mental illnesses, had fewer arrests and were arrested for less severe crimes during the twelve months following entry into either the mental health or traditional court. In a multi-site study evaluating four MHCs with a nonequivalent comparison group of subjects who were eligible for the MHC but were never referred to it or were never rejected from the MHC, Steadman and colleagues [114] observed MHC participants to be significantly less likely to be rearrested than comparison group participants in the 18 months following enrollment (MHC) and jail admission (comparison group).

Using non-equivalent comparison groups, Frailing [108] found MHC participants had reduced jail days, decreased hospitalizations and decreased positive drug and alcohol tests while Boothroyd and colleagues found increased utilization of mental health services [96] compared to non-MHC participants. Similarly, comparing MHC opt-in participants to a nonequivalent group of opt-out referrals in two Washington state MHCs, Trupin and Richards [115] found a medium effect of MHC participation on both decreased bookings and decreased annualized jail days. Using non-equivalent samples, other researchers [116, 117] have found relative reductions in the incidence of arrest among mental health court participants. Indeed, aside from a recent study by Campbell et al., which found mental health court completers had a similar rate of new charges to comparisons not enrolled in mental health court [118], the quasiexperimental evidence has generally shown a positive relationship between MHC participation and criminal justice and clinical outcomes.

Experimental evidence of effectiveness

In one of the only two experimental studies of a mental health court, Cosden and colleagues [97] found that participants in mental health court had similar gains to participants receiving traditional court processing in measures reflecting life satisfaction and alcohol use. In addition, a similar proportion of clients in each condition had been booked at least once and spent some time in jail. However, MHC participants showed greater improvements in level of distress, independent functioning, and drug use over time. And a lower percentage of MHC participants, than traditional court participants, were convicted of a new crime. There was also evidence that study participants processed in traditional courts were convicted of more serious charges than those MHC participants who received a conviction. It should be noted that MHC participants were supported by an assertive community treatment (ACT) team during their court tenure which included the 6- and 12-month follow up data collection points

summarized here. ACT is a highly intensive treatment model involving a multidisciplinary team of professionals supporting people with SMI/SPMI in the community.

In another experimental study conducted in Butte County, CA, mentally ill adults who committed a qualifying offense (nonviolent, not a serious felony) were randomly assigned to either enhanced treatment, which had as its centerpiece a MHC, or to the community's usual standard of care [119]. Within a six-month follow-up period, 22.2% of MHC participants compared to 46.2% of non-MHC participants were booked into jail at least once. On average, MHC participants also spent five fewer days in jail. Due to the small sample (18 MHC and 26 non-MHC), statistical significance tests were not conducted. A larger sample was available for testing clinical outcomes. The researchers found statistically significant improvements over the control group in each of the standardized measurements of client functioning and symptomatology [119].

Systematic reviews and meta-analysis of effectiveness

In a meta-analytic review of 18 studies published prior to 2009 and that contained quantifiable recidivism data on MHC participants in the United States, Sarteschi and colleagues [92] found a significant effect of MHC participation on recidivism reduction (with a moderate effect size; $g = -.54$). Sarteschi et al. found too much heterogeneity in mental health outcomes to allow for pooling of study results; likely reflecting the variability of mental health services availability at study sites [92].

A meta-analysis conducted by Cross [93] reviewed 20 experimental or quasi-experimental studies published between 1997 and 2011 that reported at least one quantifiable indicator of recidivism or a clinical outcome for adult MHC participants in the U.S.. This review differed from Sarteschi's in that it excluded pre-experimental studies and multiple studies using the same sample (in the case of the latter, the most recent study was included). Mental health courts were found to have a significant but small effect ($d = 0.32$) on reducing recidivism and a nonsignificant effect on clinical outcomes. Effect sizes for recidivism outcomes did not differ based upon an indicator of the methodological quality of the study, whether the study was published or not, or whether the study experienced greater than 10% attrition of study participants. However, studies that used comparison groups comprised of individuals who had opted-out of the MHC, had higher effect sizes than studies which utilized matched sample comparisons receiving treatment as usual; the latter being a more rigorous design feature than the former.

The Washington State Institute for Public Policy [120] analyzed studies of MHC outcomes that utilized experimental or quasiexperimental designs. They did not include in their meta-analysis studies that had only MHC completers in their treatment group (i.e., they included only studies that utilized outcomes for all individuals originally enrolled in the treatment condition). The six studies had a small but significant pooled effect in favor of MHC on recidivism ($ES = -.22$). The focus of this meta-analysis however, was on cost-savings to be gained through MHCs. Their results indicate a benefit-to-cost ratio of 6.96. That is, for every dollar spent on MHCs, tax payers and others (e.g., those not victimized by crime) reap nearly seven dollars in savings [120].

Factors related to outcomes among mental health court participants

Completion. Gender has not been found to influence MHC completion [117, 121-125]. Prior criminal behaviors (particularly a felony versus a non-felony [126]) and failure to appear, drug use and noncompliance with the conditions of the court positively predict noncompletion of a MHC program [116, 122, 123] as has residential instability [125]. Mixed findings have been observed with older age; having been found associated with completion [117] as well as found not associated with completion [122, 125].

Recidivism. The factor most commonly observed to determine recidivism of MHC participants is graduation status, with MHC graduates much less likely to reoffend compared with nongraduates [92, 112-114, 117, 121, 122, 126]. The number of prior arrests has also been shown to be positively related to number of arrests and jail days during follow-up [114], so that individuals who have a greater history of arrests are more likely to have a greater number of arrests and jail days during the follow up period. Research has also found “perceptions of ‘negative pressures,’ a component of coercion, were important predictors of criminal justice involvement in the 12 month period following MHC admission, even when controlling for other factors that were related to criminal justice outcomes” [103]. In one study, MHC defendants charged with a misdemeanor had a significantly higher occurrence of rearrest, relative to those charged with a felony, but those charged with violent and nonviolent offenses did not differ on any recidivism outcomes [111]. Gender has not been found to be associated with rearrest outcomes among MHC participants [113, 117, 121, 126].

Summary of the Research

The paucity of experimental research with MHCs precludes its status as an evidence-based practice [90]. However, the mounting evidence of the efficacy of these courts in reducing re-arrest and days in jail is promising. The table (**Recidivism Rates of Mental Health Court Participants**) on the next page summarizes the (pre-experimental and quasi-experimental) research that provides findings related to recidivism rates of mental health court participants. For example, in the first row, Steadman and colleagues (2010) observed that 49% of MHC participants were rearrested within 18 months of their entry into the MHC program. Recent research has indicated that reductions in costs associated with justice system processing may not be offset by the increased behavioral services costs associated with participation in a mental health court [127].

Site Visits

Site visits to two jurisdictions were made during the period when this consultation was delivered and this literature review was underway. Each jurisdiction differed in its approach to building its MHC and also in its length of experience. Both jurisdictions boast good MHC outcomes, but details about these outcomes and the methodologies used to determine them were not forthcoming. In both cases, however, the real numbers of persons served (relative to the county population and the jail average daily population) suggests that significant positive impacts on jail inmate population reductions, if any, would be difficult to substantiate.

Bexar County, Texas Mental Health Court

Initiated in 2008, the Bexar County MHC is described as:

A voluntary 12 month program of supervised probation. Persons accepted into the program will receive treatment and medications, intensive case management services and supervision based on their treatment and supervision plan. There is ongoing collaboration among the Judge, Mental Health Court staff, probation and treatment providers to monitor and support defendants’ compliance with treatment and medications, abstinence from drugs and alcohol and successful completion of probation conditions (see: [128]).

Mental health court participants, limited to a maximum of 250 at any given time, may have been arrested on misdemeanor charges, with acceptance into the court of those with violent charges being made on a case-by-case basis. The MHC team consists of the judge, the prosecuting attorney, a mental health case manager, and a probation officer. Defense attorneys play minimal roles in the MHC, not unlike other court models reviewed.

Recidivism Rates of Mental Health Court Participants

| | Percentage who are ... | | | |
|---------------------------------------|--|--------------|---|--|
| | rearrested | re-convicted | reincarcerated (booked) | within |
| Steadman, et al., 2010 [114] | 49% | | | 18 months post-entry to MHC |
| Moore & Hiday, 2006 [113] | 43% | | | 12 months post-entry to MHC |
| Hiday & Ray, 2010 [117] | Completed program = 28% Ejected from program = 81% | | | 2 years of exiting a MHC |
| Cosden, et al., 2003 [97] | | 47% | 76% booked at least once and spent some time in jail | 12 months post-enrollment |
| Christy, et al., 2005 [88] | 47% | | | 12 months following the initial court appearance from which they were recruited into the study |
| Dirks-Linhorst & Linhorst, 2012 [116] | positive terminators = 14.5%; chose not to participate = 25.8%; negative terminators = 38.0% | | | 12 months of discharge from the program |
| Law & Policy Associates, 2013 [129] | | | Completers in-program = 42.4%; Completers 2-yrs post-program = 24.2% Non-completers in-program = 100%; Completers 2-yrs post-program = 95% | |
| Bess Associates, 2004 [119] | | 11.1% | 22.2% | 6 months after point-of-exit |
| Herinckx, et al., 2005 [121] | 46% | | | 12 months postenrollment |
| Comartin, et al., 2015 [130] | 28% | | | 12 months following MHC discharge |
| Anestis & Carbonell, 2014 [111] | 10% | | | 12 months after the index offense |
| McNiel & Binder, 2007 [112] | Probability of any new charge at: 6 months = .23 12 months = .34 18 months = .42 24 months = .46 | | | |

While the MHC is seen as part of the larger Bexar County system of mental health resources, it is unclear how responsive these resources are to MHC referrals and how well the involved agencies interface with each other. A recent initial evaluation of the Bexar County mental health system found that there are low numbers of persons with mental illnesses diverted into treatment after being booked into the jail; there are “deficient screening, assessment, and diversion protocols” for these persons; there are high recidivism rates among people with mental illness, and a “shortage or inadequate use of” behavioral health services among diverted persons [131].

Fayette County, Kentucky Mental Health Court

Initiated in 2014 after several years of planning, the Fayette County MHC is truly a “home-grown” effort, with officials having foregone technical assistance and federal grant funding in order to fashion, build, and implement their own vision of a properly functioning court. Serving only 15 persons at present, with little or no expansion in capacity seen in the near-term, the Fayette County MHC Judge reports using case conferences, weekly (initially) meetings with defendants, and linkages to mental health services particularly those offered through the National Alliance on Mental Illness, Lexington, which is a direct provider of many mental health services in Kentucky.

As with Bexar County, the MHC team consists of the judge, the prosecuting attorney, a mental health case manager, and a probation officer. The input of others may be received, depending on the case. One person who is regularly involved in these cases is the Fayette County homelessness coordinator who works to find secure housing when needed, for court participants.

The judge and mental health court staff emphasized the importance of having key thinkers and supporters at the table when planning and implementing the court. In the Fayette County case, a specific member of NAMI Lexington pushed for the development of a court, and remained active in the planning stage to shepherd the system collaborations that would assure that the services needed would be available to MHC participants. In addition, while there is not a crisis center in Lexington, there are hospital systems, including one state hospital, located in the area and willing to complete the initial evaluations on persons brought to them by law enforcement.

Summary

While the experimental and quasi-experimental research is limited, particularly given the number of specialty courts in the United States, there are some promising results from those studies that have been published. We can say with some confidence that the outcomes of MHCs appear to be equal across gender lines, that there is some measurable, though perhaps small, reductions in recidivism rates among those defendants involved in a MHC, at least in the 12 month period following court involvement.

There are common and important elements to the structure, composition, and operation of MHCs found across the country. Each offers defendants a range of rewards and sanctions in order to capture their attention and shape behavior going forward. There is generally a graduated reduction in the frequency of status hearings, progressively decreasing the amount of court appearances as the defendant’s compliance with the court orders strengthens. In every court, the role of the judge in promoting procedural justice is central to the process: the judge directs both the court process and the defendant’s case plan. The latter then is facilitated and monitored by the MHC team, which generally includes the prosecutor, a case manager, and a probation officer.

The existing research reports and narratives about MHCs provide cautions about their operations and their outcomes as well. While the development of MHCs has been largely subsidized by the federal

government, they are not inexpensive to operate, especially when one considers the average number of persons that can be followed by the court at any given time. Perhaps the best philosophical approach when considering the development of a MHC is to consider the benefits of it in support of maintaining and promoting the dignity and health of the consumer, leaving the goals of jail population reductions and cost reductions out of the equation.

Further, jurisdictions with MHCs report that, similar to the experience of CIT programs, without a range of community resources to which defendants can be referred and treated, the MHC will have little impact. The judge must have the resources with which a treatment plan can be devised. The research points especially to the need for ACT services, i.e., intensive, multi-disciplinary mental health teams that carry small caseloads and provide ongoing, often daily services to consumers. There are currently no ACT services in operation in Douglas County.

While recidivism rates among defendants involved in a MHC appear to be lower than those among non-MHC participants, these reductions will not necessarily yield reductions in total jail populations. In many ways, recidivism rates among one group have nothing to do with arrest rates of another group of persons with similar characteristics. Thus, when thinking about designing a system that will address the challenges that come with managing persons with SMIs and co-occurring disorders and reducing jail populations, MHCs should be seen as one of several strategies that must be simultaneously in operation. It calls for a tripartite approach: Well-staffed courts, community resources, and smart arrest and diversion policies and procedures.

RECOMMENDATIONS

The literature reviewed for this report, the fact-finding activities undertaken, including data gathering and review, and the site visits completed over the last six months, point to several important components of diversion processes that we believe are fundamental to the effective operation of a crisis center or mental health court and that could assist jail diversion efforts for people with serious mental illness who become justice-involved in Douglas County.

Crisis/Restoration Center

- ❖ The crisis center should belong to the community; that is, not solely used for jail diversion by law enforcement (e.g., CIT). The crisis center should be open to individuals seeking assistance with behavioral health needs for themselves and for their friends and family members. This open door policy will encourage widespread support for its development and continued services. The open door policy also has the potential to divert non-justice involved persons from becoming involved in the justice system because of their mental conditions.
- ❖ When the safety of staff and the individual in crisis can be managed, the crisis center should maintain a “no refusal” policy that maximizes the potential for individuals with behavioral health needs to access and engage with needed services. Risk of violent behavior should be assessed on the basis of knowledge of the person’s history of violence and on the viability of a person’s threats of violence. Personal safety, while never a guarantee, can be optimized via quick handoffs by law enforcement (who may be the trigger for aggressions) and the presence of capable behavioral health personnel trained in verbal de-escalation techniques.
- ❖ The crisis center should have policies in place for law enforcement referrals (e.g., CIT) that expedite handoff to the crisis center staff and officers’ return to duty. No refusal and quick handoff policies will reduce the likelihood that law enforcement officers will be deterred from bringing an individual to the crisis center (due to beliefs that the person in custody will not be accepted for evaluation by the center or that transfers at the center will take longer than at the jail).
- ❖ The mental health crisis observation unit should be staffed by qualified mental health professionals who can provide 24-hour services, including clinical assessments, treatment (including trauma-informed care) and observation. For those determined to be in need of longer-term stabilization (e.g., 5 – 10 days), an appropriate number of short-term stabilization beds should be provided. The number of beds dedicated to stabilization should be determined by a structured community needs assessment.
- ❖ In addition to mental health treatment and referral, the design and implementation of the crisis center should include the space and personnel to accommodate both males and females experiencing a crisis and provide sobering and addiction treatment services. Consultation with local addiction treatment providers is essential to cull their knowledge on the appropriateness and magnitude of these services when offered within a local crisis center. Visits to neighboring crisis centers suggest that the inclusion of a sobering unit that provides brief stays (up to 10 hours) is a minimal requirement for inclusion in the crisis center.
- ❖ The crisis center should provide linkages to community services. Upon completion of their stay, individuals should be linked to appropriate services including stabilization beds, inpatient psychiatric services, detoxification facilities, co-occurring substance abuse treatment, long term/residential addictions treatment or other community-based services that target behavioral health and criminogenic needs.

- ❖ Ongoing evaluation of the effectiveness of the crisis center at meeting its objectives (e.g., reduced jail stays, reduced hospitalizations, increased treatment access and engagement) is essential. There are no known rigorous national studies that follow people referred to crisis centers to identify their outcomes. It cannot be assumed that the development of a crisis center that provides the above-identified services will produce desired outcomes. Regular assessment of outcomes and subsequent service modifications and enhancements will be necessary to effectively incorporate the crisis center within the existing community mental health service system.

Mental Health/Problem-Solving Court

- ❖ Extensive development work remains before a mental health (or other problem-solving) court can be implemented in Douglas County. Continued planning activities should be conducted with municipal and district court staff and officials to identify non-duplicative, court-based diversion efforts that can most efficiently reach those individuals identified as being potentially eligible for a mental health court, as outlined by the recent report submitted by Huskey and Associates.
- ❖ While in the pages of this literature review we identify common elements of mental health courts, these are truly flexible and dynamic entities, that is, the city of Lawrence and Douglas County have the freedom to design one or more mental health courts in ways thought most likely to satisfy clearly articulated objectives. Evaluative feedback mechanisms should be simultaneously implemented with the court(s) so that modifications, if implicated, can be made quickly and with minimal disruption.
- ❖ The Huskey report identifies potential eligibility criteria for a mental health court as well as length of stay in the program. However, screening, referral and admission mechanisms to the court-based program will need to be developed. Criteria for progression through and graduation from the mental health court program as well as mechanisms for transfer to appropriate community based services still need to be established.
- ❖ Recruitment to and enrollment in the mental health court should minimize the potential for coercion. An individual's decision to participate in a mental health court should be informed and should only be provided after advice from competent legal counsel has been offered. Participants' decision to withdraw from the mental health court or to refuse treatment should not encumber additional penalties. Transparent and collaborative decision-making with clients and treatment providers should occur throughout an individual's participation in the court.
- ❖ Quality mental health and supportive services must be integrated into the mental health court program. These services, at the very least, must include ongoing clinical assessment, clinical counseling, psychopharmacology where indicated, case management, and substance abuse treatment and should also include programs targeting criminogenic needs, housing assistance, money management education, employment counseling, entitlement program assistance, and self-help and support groups. Given the need to alleviate female overcrowding at DCCF (as well as the higher rates of SMI among female inmates), it is likely that many women will be identified as eligible for MHC. Therefore, MHC services should be able to address the histories of trauma that are common among this population. Intensive and integrated supportive services that can address the complex needs of the population typically seen in a mental health court are recommended (i.e., assertive community treatment or other intensive, community based wraparound services).
- ❖ As with crisis centers, ongoing evaluation will be indispensable for assessing the effectiveness of the mental health court program at achieving program objectives and for informing enhancements to the program that can improve outcomes.

REFERENCES

1. Lamb, H.R. and L. Weinberger, E., *Persons with severe mental illness in jails and prisons: A review*. *Psychiatric Services*, 1998. **49**(4): p. 483-492.
2. Munetz, M. and P. Griffin, *Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness*. *Psychiatric Services*, 2006. **57**(4): p. 544-549.
3. Newhill, C.E., *Psychiatric emergencies: Overview of clinical principles and clinical practice*. *Clinical Social Work Journal*, 1989. **17**(3): p. 245-258.
4. Center for Mental Health Services, *Practice guidelines: Core elements for responding to mental health crises*. 2009, Substance Abuse and Mental Health Services Administration: Rockville, MD.
5. Steadman, H.J., et al., *A specialized crisis response site as a core element of police-based diversion programs*. *Psychiatric Services*, 2001. **52**(2): p. 219-222.
6. McGuire, A.B. and G.R. Bond, *Critical elements of the crisis intervention team model of jail diversion: An expert survey*. *Behavioral sciences & the Law*, 2011. **29**(1): p. 81-94.
7. Hartford, K., R. Carey, and J. Mendonca, *Pre-arrest diversion of people with mental illness: Literature review and international survey*. *Behavioral Sciences & the Law*, 2006. **24**(6): p. 845-856.
8. Compton, M.T., et al., *System-and policy-level challenges to full implementation of the crisis intervention team (CIT) model*. *Journal of Police Crisis Negotiations*, 2010. **10**(1-2): p. 72-85.
9. Skeem, J., S. Manchak, and J.K. Peterson, *Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction* *Law and Human Behavior*, 2011. **35**(2): p. 110-126.
10. Calsyn, R.J., et al., *Impact of assertive community treatment and client characteristics on criminal justice outcomes in dual disorder homeless individuals*. *Criminal Behaviour and Mental Health*, 2005. **15**(4): p. 236-248.
11. Epperson, M., et al., *The next generation of behavioral health and criminal justice interventions: Improving outcomes by improving interventions*. 2011, Center for Behavioral Health Services and Criminal Justice Research, Rutgers, The State University of New Jersey: New Brunswick, NJ.
12. Peterson, J., et al., *Analyzing offense patterns as a function of mental illness to test the criminalization hypothesis*. *Psychiatric Services*, 2010. **61**(12): p. 1217-1222.
13. Peterson, J.K., et al., *How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness? Law and Human Behavior*, 2014. **38**(5): p. 439-449.
14. Skeem, J., et al., *Psychosis uncommonly and inconsistently precedes violence among high-risk individuals*. *Clinical Psychological Science*, 2015. **online first**.
15. Bonta, J. and D.A. Andrews, *Risk-need-responsivity model for offender assessment and rehabilitation*. 2007, Public Safety Canada: Ottawa.
16. Andrews, D.A. and J. Bonta, *The psychology of criminal conduct*. 5th ed. 2010, New Providence, NJ: Matthew Bender.
17. Hodgins, S. and C.-G. Janson, *Criminality and violence among the mentally disordered: The Stockholm Project Metropolitan*. 2002, Cambridge: Cambridge University Press.
18. Bonta, J., M. Law, and K. Hanson, *The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis*. *Psychological Bulletin*, 1998. **123**: p. 123-142.
19. Bonta, J., J. Blais, and H.A. Wilson, *A theoretically informed meta-analysis of the risk for general and violent recidivism for mentally disordered offenders*. *Aggression and Violent Behavior*, 2014. **19**(3): p. 278-287.

20. Andrews, D.A. and J. Bonta, *Rehabilitating criminal justice policy and practice*. Psychology, Public Policy, and Law, 2010. **16**(1): p. 39-55.
21. Horvat, T. *Rainbow Services Inc. crisis stabilization center to open April 7*. 2014 June 23, 2015]; Available from: <http://www.kckansan.com/2014/03/rainbow-services-inc-crisis.html>.
22. Ranney, D. *Crisis intervention center to open in Topeka*. 2014 June 23, 2015]; Available from: <http://www.khi.org/news/article/crisis-intervention-center-open-topeka/>.
23. Anderson, P. *Valeo shows off new crisis center to supporters*. 2014 June 23, 2015]; Available from: <http://cjonline.com/news/2014-10-02/valeo-shows-new-crisis-center-supporters>.
24. Grantham, D., *Right place, right time, right approach: Texans collaborate to build a "model" jail diversion and crisis mental health system*. Behavioral Healthcare, 2011 **31**(8): p. 14-19.
25. Canada, K.E., B. Angell, and A.C. Watson, *Crisis intervention teams in Chicago: Successes on the ground*. Journal of Police Crisis Negotiations, 2010. **10**(1-2): p. 86-100.
26. Green, T.M., *Police as frontline mental health workers: The decision to arrest or refer to mental health agencies*. International Journal of Law and Psychiatry, 1997. **20**(4): p. 469-486.
27. Lamb, H.R., L.E. Weinberger, and W.J. DeCuir, *The police and mental health*. Psychiatric Services, 2002. **53**(10): p. 1266-1271.
28. Reuland, M., L. Draper, and B. Norton, *Improving responses to people with mental illnesses: Tailoring law enforcement initiatives to individual jurisdictions*. 2010, Council of State Governments Justice Center: New York.
29. Cochran, S., M.W. Deane, and R. Borum, *Improving police response to mentally ill people*. Psychiatric Services, 2000. **51**(10): p. 1315-1316.
30. Schwarzfeld, M., M. Reuland, and M. Plotkin, *Improving responses to people with mental illnesses: The essential elements of a specialized law enforcement-based program*. 2008, Council of State Governments Justice Center: New York.
31. Dupont, R., S. Cochran, and S. Pillsbury, *Crisis intervention team core elements*. 2007, University of Memphis, School of Urban Affairs: Memphis, TN.
32. Dupont, R. and S. Cochran, *Police response to mental health emergencies-barriers to change*. Journal of the American Academy of Psychiatry and the Law, 2000. **28**: p. 338-344.
33. Ritter, C., et al., *Crisis intervention team officer dispatch, assessment, and disposition: Interactions with individuals with severe mental illness*. International Journal of Law and Psychiatry, 2011. **34**(1): p. 30-38.
34. University of Memphis, CIT Center. *Training*. n.d. [cited June 20, 2015; Available from: <http://www.cit.memphis.edu/overview.php?page=3>].
35. Canada, K., B. Angell, and A.C. Watson, *Intervening at the entry point: Differences in how CIT trained and non-CIT trained officers describe responding to mental health-related calls*. Community Mental Health Journal, 2012. **48**(6): p. 746-755.
36. Hanafi, S., et al., *Incorporating crisis intervention team (CIT) knowledge and skills into the daily work of police officers: A focus group study*. Community Mental Health Journal, 2008. **44**(6): p. 427-432.
37. Demir, B., et al., *Beliefs about causes of schizophrenia among police officers before and after crisis intervention team training*. Community mental health journal, 2009. **45**(5): p. 385-392.
38. Bonfine, N., C. Ritter, and M.R. Munetz, *Police officer perceptions of the impact of Crisis Intervention Team (CIT) programs*. International Journal of Law and Psychiatry, 2014. **37**(4): p. 341-350.
39. Bahora, M., et al., *Preliminary evidence of effects of crisis intervention team training on self-efficacy and social distance*. Administration and Policy in Mental Health and Mental Health Services Research, 2008. **35**(3): p. 159-167.

40. Borum, R., *Police perspectives on responding to mentally ill people in crisis: Perceptions of program effectiveness*. Behavioral Sciences & the Law, 1998. **16**: p. 393-405.
41. Compton, M.T., et al., *The police-based crisis intervention team (CIT) model: I. effects on officers' knowledge, attitudes, and skills*. Psychiatric Services, 2014. **65**(4): p. 517-522.
42. Compton, M.T., et al., *Use of force preferences and perceived effectiveness of actions among crisis intervention team (CIT) police officers and non-CIT officers in an escalating psychiatric crisis involving a subject with schizophrenia*. Schizophrenia Bulletin, 2011. **37**(4): p. 737-745.
43. Compton, M.T., et al., *Crisis intervention team training: Changes in knowledge, attitudes, and stigma related to schizophrenia*. Psychiatric Services, 2006. **57**(8): p. 1199-1202.
44. Ellis, H.A., *Effects of a crisis intervention team (CIT) training program upon police officers before and after crisis intervention team training*. Archives of Psychiatric Nursing, 2014. **28**(1): p. 10-16.
45. Michael T. Compton , M.D., M.P.H. and B.A. Victoria H. Chien *Factors related to knowledge retention after crisis intervention team training for police officers*. Psychiatric Services, 2008. **59**(9): p. 1049-1051.
46. Hollander, Y., et al., *Challenges relating to the interface between crisis mental health clinicians and police when engaging with people with a mental illness*. Psychiatry, Psychology and Law, 2012. **19**(3): p. 402-411.
47. Watson, A.C., et al., *Improving police response to persons with mental illness: A multi-level conceptualization of CIT*. International Journal of Law and Psychiatry, 2008. **31**(4): p. 359-368.
48. Strauss, G., et al., *Psychiatric disposition of patients brought in by crisis intervention team police officers*. Community Mental Health Journal, 2005. **41**(2): p. 223-228.
49. Compton, M.T., et al., *The police-based crisis intervention team (CIT) model: II. Effects on level of force and resolution, referral, and arrest*. Psychiatric Services, 2014. **65**(4): p. 523-529.
50. Steadman, H.J., et al., *Comparing outcomes of major models of police responses to mental health emergencies*. Psychiatric Services, 2000. **51**: p. 645-649.
51. Watson, A.C., et al., *Outcomes of police contacts with persons with mental illness: The impact of CIT*. Administration and Policy in Mental Health and Mental Health Services Research, 2010. **37**(4): p. 302-317.
52. Teller, J.L., et al., *Crisis intervention team training for police officers responding to mental disturbance calls*. Psychiatric Services, 2006. **57**(2): p. 232-237.
53. Morabito, M.S., et al., *Crisis intervention teams and people with mental illness: Exploring the factors that influence the use of force*. Crime & Delinquency, 2012. **58**(1): p. 57-77.
54. Watson, A.C., et al., *CIT in context: The impact of mental health resource availability and district saturation on call dispositions*. International Journal of Law and Psychiatry, 2011. **34**(4): p. 287-294.
55. Compton, M.T., et al., *A comprehensive review of extant research on Crisis Intervention Team (CIT) programs*. Journal of the American Academy of Psychiatry and the Law, 2008. **36**(1): p. 47-55.
56. Taheri, S.A., *Do crisis intervention teams reduce arrests and improve officer safety? A systematic review and meta-analysis*. Criminal Justice Policy Review, 2014(online first).
57. Aufderheide, D. *Crisis intervention teams: Improving outcomes for inmates with mental illness*. CorrectCare, 2012. **26**, 10-12.
58. Lange, S., J. Rehm, and S. Popova, *The effectiveness of criminal justice diversion initiatives in North America: A systematic literature review*. International Journal of Forensic Mental Health, 2011. **10**(3): p. 200-214.
59. Clark, J. and D. Henry, *Pretrial services programming at the start of the 21st century: A survey of pretrial services programs*. 2003, U.S. Department of Justice, Bureau of Justice Assistance: Washington, DC.

60. Draine, J. and P. Solomon, *Describing and evaluating jail diversion services for persons with serious mental illness*. *Psychiatric Services*, 1999. **50**(1): p. 56-61.
61. Boccaccini, M.T., et al., *Rediversion in two postbooking jail diversion programs in Florida*. *Psychiatric Services*, 2005. **56**(7): p. 835-839.
62. Broner, N., et al., *Effects of diversion on adults with co-occurring mental illness and substance use: Outcomes from a national multi-site study*. *Behavioral Sciences & the Law*, 2004. **22**(4): p. 519-541.
63. Broner, N., R. Borum, and K. Gawley, *Criminal justice diversion of individuals with cooccurring mental illness and substance use disorders: An overview*, in *Serving mentally ill offenders and their victims: Challenges and opportunities for mental health professionals*, G. Landsberg, et al., Editors. 2002, Springer: New York. p. 83–106.
64. Lamberti, J.S. and R. Weisman, *Persons with severe mental disorders in the criminal justice system: Challenges and opportunities*. *Psychiatric Quarterly*, 2004. **75**(2): p. 151-164.
65. Lattimore, P.K., et al., *A comparison of prebooking and postbooking diversion programs for mentally ill substance-using individuals with justice involvement*. *Journal of Contemporary Criminal Justice*, 2003. **19**(1): p. 30-64.
66. Hoff, R.A., et al., *The effects of a jail diversion program on incarceration: A retrospective cohort study*. *Journal of the American Academy of Psychiatry and the Law*, 1999. **27**(3): p. 377-386.
67. Frisman, L.K., et al., *Outcomes of court-based jail diversion programs for people with co-occurring disorders*. *Journal of Dual Diagnosis*, 2006. **2**(2): p. 5-26.
68. Rivas-Vazquez, R.A., et al., *A relationship-based care model for jail diversion*. *Psychiatric Services*, 2009. **60**(6): p. 766-771.
69. Shafer, M.S., P.D.B. Arthur, and M.J. Franczak, *An analysis of post-booking jail diversion programming for persons with co-occurring disorders*. *Behavioral Sciences and the Law*, 2004. **22**: p. 771-785.
70. Broner, N., D.W. Mayrl, and G. Landsberg, *Outcomes of mandated and nonmandated New York City jail diversion for offenders with alcohol, drug, and mental disorders*. *The Prison Journal*, 2005. **85**(1): p. 18-49.
71. Case, B., et al., *Who succeeds in jail diversion programs for persons with mental illness? A multi-site study*. *Behavioral Sciences & the Law*, 2009. **27**(5): p. 661-674.
72. Gordon, J.A., C.M. Barnes, and S.W. VanBenschoten, *The dual treatment track program: A descriptive assessment of a new in-house jail diversion program*. *Federal Probation*, 2006. **70**: p. 9-18.
73. Lamberti, J.S., et al., *The mentally ill in jails and prisons: Towards an integrated model of prevention*. *Psychiatric Quarterly*, 2001. **72**(1): p. 63-77.
74. Ryan, S., C. Brown, and S. Watanabe-Galloway, *Toward successful postbooking diversion: What are the next steps?* *Psychiatric Services*, 2010. **61**(5): p. 469-477.
75. Human Rights Watch, *The price of freedom: Bail and pretrial detention of low income nonfelony defendants in New York City*. 2010, Author: Washington, DC.
76. Goodwyn, W., *New York bail reform is part of trend away from cash punishment*, in *National Public Radio*,. 2015.
77. Rojas, R., *New York City to relax bail requirements for low-level offenders*, in *New York Times*. 2015.
78. Pretrial Justice Institute, *Rational and transparent bail decision making: Moving from a cash-based to a risk-based process*. 2012, Author: Gaithersburg, MD.
79. Pretrial Services Agency for the District of Columbia, *The D.C. Pretrial Services Agency: Lessons from five decades of innovation and growth*. 2010, Author: Washington, DC.

80. VanNostrand, M. and K.J. Rose, *Pretrial risk assessment in Virginia: The Virginia Pretrial Risk Assessment Instrument*. 2009, Virginia Department of Criminal Justice Service: Richmond, VA.
81. Austin, J., R. Ocker, and A. Bhati, *Kentucky pretrial risk assessment instrument validation*. 2010, The JFA Institute: Washington, DC.
82. Justice Policy Institute, *Bail fail: Why the U.S. should end the practice of using money for bail*. 2012, Author: Washington, DC.
83. Cohen, T. and B. Reaves, *Pretrial release of felony defendants in state courts*. 2007, Bureau of Justice Statistics: Washington, DC.
84. Johnson, B., C. Kierkus, and C. Yalda, *Who skips? An analysis of bail bond failure to appear*. *Journal of Applied Security Research*, 2014. **9**(1): p. 1-16.
85. Lowenkamp, C.T. and M. VanNostrand, *Exploring the impact of supervision on pretrial outcomes*. 2013, Laura and John Arnold Foundation: Houston, TX.
86. Ortiz, N., *County jails at a crossroads*. 2015, National Association of Counties: Washington, DC.
87. GAINS Center. *Adult mental health treatment courts database*. 2013 June 2, 2014]; Available from: http://gainscenter.samhsa.gov/grant_programs/adultmhc.asp.
88. Christy, A., et al., *Evaluating the efficiency and community safety goals of the Broward County Mental Health Court*. *Behavioral Sciences & the Law*, 2005. **23**(2): p. 227-243.
89. Steadman, H., S. Davidson, and C. Brown, *Mental health courts: Their promise and unanswered questions*. *Psychiatric Services*, 2001. **52**(4): p. 457-458.
90. Honegger, L.N., *Does the evidence support the case for mental health courts? A review of the literature*. *Law and Human Behavior*, 2015(online first): p. 1-11.
91. Farley, E., *A process evaluation of the Manhattan mental health court*. 2015, Center for Court Innovation: New York.
92. Sarteschi, C.M., M.G. Vaughn, and K. Kim, *Assessing the effectiveness of mental health courts: A quantitative review*. *Journal of Criminal Justice*, 2011. **39**(1): p. 12-20.
93. Cross, B. *Mental health courts effectiveness in reducing recidivism and improving clinical outcomes: A meta-analysis*. *Graduate Theses and Dissertations 2011 June 13, 2015*]; Available from: <http://scholarcommons.usf.edu/etd/3052>.
94. Redlich, A.D., et al., *Patterns of practice in mental health courts: A national survey*. *Law and Human Behavior*, 2006. **30**(3): p. 347-362.
95. Criminal Justice/Mental Health Consensus Project, *Mental health courts: A guide to research-informed policy and practice*. 2009, Council of State Governments: New York.
96. Boothroyd, R.A., et al., *The Broward Mental Health Court: Process, outcomes, and service utilization*. *International Journal of Law and Psychiatry*, 2003. **26**(1): p. 55-72.
97. Cosden, M., et al., *Evaluation of a mental health treatment court with assertive community treatment*. *Behavioral Sciences & the Law*, 2003. **21**(4): p. 415-427.
98. National Association of Mental Health Planning and Advisory Councils, *NAMHPAC policy statement: Mental health courts*. 2005, Author: Alexandria, VA.
99. Poythress, N., et al., *Perceived coercion and procedural justice in the Broward mental health court*. *International Journal of Law and Psychiatry*, 2002. **25**(5): p. 517-534.
100. Monahan, J., M. Swartz, and R.J. Bonnie, *Mandated treatment in the community for people with mental disorders*. *Health Affairs*, 2003. **22**(5): p. 28-38.
101. Redlich, A.D. and W. Han, *Examining the links between therapeutic jurisprudence and mental health court completion*. *Law and Human Behavior*, 2014. **38**(2): p. 109-118.
102. Tyler, T.R., *What is procedural justice-criteria used by citizens to assess the fairness of legal procedures*. *Law & Society Review*, 1988. **22**(1): p. 103-136.

103. Pratt, C., et al., *Predictors of criminal justice outcomes among mental health courts participants: The role of perceived coercion and subjective mental health recovery*. International journal of forensic mental health, 2013. **12**(2): p. 116-125.
104. Wolff, N. and W. Pogorzelski, *Measuring the effectiveness of mental health courts: Challenges and recommendations*. Psychology, Public Policy and Law, 2005. **11**: p. 539-605.
105. Thompson, M., F. Osher, and D. Tomasini-Joshi, *Improving responses to people with mental illnesses: The essential elements of a mental health court*. 2007, Council of State Governments; Bureau of Justice Assistance: Washington, DC.
106. Council of State Governments, *Mental health courts: A primer for policymakers and practitioners*, Criminal Justice/Mental Health Consensus Project, Editor. 2008, Bureau of Justice Assistance: Washington, DC.
107. Redlich, A.D., et al., *The second generation of mental health courts*. Psychology, Public Policy, and Law, 2005. **11**(4): p. 527.
108. Frailing, K., *How mental health courts function: Outcomes and observations*. International Journal of Law and Psychiatry, 2010. **33**(4): p. 207-213.
109. Wales, H.W., V.A. Hiday, and B. Ray, *Procedural justice and the mental health court judge's role in reducing recidivism*. International Journal of Law and Psychiatry, 2010. **33**(4): p. 265-271.
110. Boothroyd, R., et al., *Clinical outcomes of defendants in mental health court*. Psychiatric Services, 2005. **56**: p. 829-834.
111. Anestis, J. and J.L. Carbonell, *Stopping the revolving door: Effectiveness of mental health court in reducing recidivism by mentally ill offenders*. Psychiatric Services, 2014. **Online First**: p. 1-8.
112. McNiel, D. and R. Binder, *Effectiveness of a mental health court in reducing criminal recidivism and violence*. American Journal of Psychiatry, 2007. **164**(9): p. 1395-1403.
113. Moore, M. and V. Hiday, *Mental health court outcomes: A comparison of re-arrest and re-arrest severity between mental health court and traditional court participants*. Law and Human Behavior, 2006. **30**(6): p. 659-674.
114. Steadman, H.J., et al., *Effect of mental health courts on arrests and jail days: A multisite study*. Archives of General Psychiatry, 2010. **68**(2): p. 167-172.
115. Trupin, E. and H. Richards, *Seattle's mental health courts: Early indicators of effectiveness*. International Journal of Law and Psychiatry, 2003. **26**(1): p. 33-54.
116. Dirks-Linhorst, P.A. and D.M. Linhorst, *Recidivism outcomes for suburban mental health court defendants*. American Journal of Criminal Justice, 2012. **37**(1): p. 76-91.
117. Hiday, V.A. and B. Ray, *Arrests two years after exiting a well-established mental health court*. Psychiatric Services, 2010. **61**(5): p. 463-468.
118. Campbell, M.A., et al., *Multidimensional evaluation of a mental health court: Adherence to the risk-need-responsivity model*. Law and Human Behavior, 2015(online first).
119. Bess Associates, *Mentally ill offender crime reduction grant program. Butte County Forensic Research Team (FOREST)*. 2004: Oroville, Ca.
120. Lee, S., et al., *Return on investment: Evidence-based options to improve statewide outcomes*. 2012, Washington State Institute for Public Policy: Olympia, WA.
121. Herinckx, H., et al., *Rearrest and linkage to mental health services among clients of the Clark County mental health court program*. Psychiatric Services, 2005. **56**(7): p. 853-857.
122. Aldigé Hiday, V., B. Ray, and H.W. Wales, *Predictors of mental health court graduation*. Psychology, Public Policy, and Law, 2014. **20**(2): p. 191-199.
123. Burns, P.J., V.A. Hiday, and B. Ray, *Effectiveness 2 years postexit of a recently established mental health court*. American Behavioral Scientist, 2013. **57**(2): p. 189-208.
124. Redlich, A.D., et al., *The use of mental health court appearances in supervision*. International Journal of Law and Psychiatry, 2010. **33**(4): p. 272-277.

125. Verhaaff, A. and H. Scott, *Individual factors predicting mental health court diversion outcome*. Research on Social Work Practice, 2015. **25**(2): p. 213-228.
126. Ray, B., et al., *Mental health court outcomes by offense type at admission*. Administration and Policy in Mental Health and Mental Health Services Research, 2014(online first): p. 1-9.
127. Steadman, H., et al., *Criminal justice and behavioral health care costs of mental health court participants: A six-year study*. Psychiatric Services, 2014. **Online First**: p. 1-5.
128. The State of Texas, County of Bexar. *Mental health court/initiative* n.d. August 5, 2015]; Available from: <http://www.bexar.org/503/Mental-Health-CourtInitiative>.
129. Law & Policy Associates, *Seattle municipal mental health court evaluation*. 2013: Seattle, WA.
130. Comartin, E., et al., *Short-and long-term outcomes of mental health court participants by psychiatric diagnosis*. Psychiatric Services, 2015(online first).
131. Council of State Governments, *Bexar County smart justice*. 2015, Bureau of Justice Assistance: Washington, DC.