



**National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314**

Assessment #10

Behavioral Health and Criminal Justice Systems: Identifying New Opportunities for Information Exchange

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The authors of this report are Vera Hollen, Glorimar Ortiz, and Lucille Schacht of the National Association of State Mental Health Program Directors Research Institute (NRI), Inc. For questions or additional information about the content of this report, please contact the authors at:

NRI
3141 Fairview Park Drive, Suite 650
Falls Church, VA 22042
Phone: 703-738-8160
Email: NRI@nri-inc.org
<http://www.nri-inc.org>

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Preface

State Behavioral Health Agency administrators have increasingly been called to action to address the overrepresentation of persons with a mental illness involved in the criminal justice system. While the ability to address the issue within the confines of the public mental health system has improved through clinical expertise coupled with better data systems and active collaboration for alternatives to incarceration, the identification of persons needing mental health care and provision of appropriate services within the criminal justice system continues to lag behind. State Behavioral Health Agency administrators have a unique opportunity and responsibility for defining the minimum standards for mental health data, services, and networks for persons with mental illness, regardless of the venue of service.

This report serves to provide State Behavioral Health Agency administrators with a knowledge base on the multiple and various sources of data used by agencies that are engaged with justice-involved persons who have a mental illness. The identification of key attributes of these data sources and potential mechanisms for strengthening these data are provided to illuminate the culture, language, and definitions of success for the criminal justice systems. Throughout the report, parallel developments in mental health data and services are used to highlight progress made by the mental health agency; these advancements could serve as a basis for collaborative dialogue with the criminal justice system.

The highlighted data are placed within the context of a continuum of care, whether for safety or treatment, for persons with mental illness involved in the criminal justice system. While the discussion is centered on the jail system, the principles have wider application. Developing a common language will ultimately enable addressing the continuum of the issue from prevalence of mental health illness in jail detainees to effective diversion programs and effective treatment while maintaining safety. Valid and well-defined data and information acceptable to both the mental health and criminal justice systems provide a powerful foundation to meet the complex needs of persons with mental illness involved in the criminal justice system.

Introduction

Communities across the country are struggling to address the over-representation of persons with mental illnesses in the criminal justice system. Approximately 14.5 percent of men and 31.0 percent of women in jails experience serious mental illness¹ compared to 4.2 percent of the general population.² Public systems that work with these individuals, within both the justice and the mental health systems, have taken notice of the issue and recognize that without appropriate care, these individuals face daunting barriers to recovery and are at higher risk for re-incarceration.

In May 2015, The National Association of Counties (NACo), the Council of State Governments (CSG), and the American Psychiatric Foundation (APF) partnered to create the Stepping Up Initiative³, a nationwide initiative to provide coordinated support to counties to help people living with mental illnesses stay out of jail and on a path to recovery. The initiative involves six key steps to helping counties reduce the number of people with mental illnesses in jail: (1) establishing a diverse team of leaders and stakeholders, (2) collecting and reviewing data on the prevalence of people with mental illnesses in jails, (3) reviewing existing mental health treatments and identifying policy and resource barriers, (4) developing an action plan with measurable outcomes, (5) implementing research-based approaches, and (6) creating a process to track and report on progress. Counties across the country are joining the pledge to take action. Within the first four months of the initiative (as of August 2015), 92 counties had passed resolutions declaring their intent to participate.

The issue of the over-representation of persons with mental illness being brought into the criminal justice system is complex. These individuals may have co-occurring substance use disorders, medical illnesses, inadequate housing, and unstable employment. The criminal justice system was not established to serve as a healthcare provider; however, incarcerated individuals have a constitutional right to basic health care, including mental healthcare,⁴ which presents an opportunity to identify and treat individuals in need of mental health care who are

¹ Steadman, H. et al. Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60 (6). 761 – 765 (June 2009).

² Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: United States, 2014*. HHS Publication No. SMA-15-4895. Rockville, MD: Substance Abuse and Mental Health Services Administration, (2015).

³ <https://www.stepuptogether.org>

⁴ Cohen, F., and Dvoskin, J. , “Inmates with Mental Disorders: A Guide to Law and Practice,” *Mental and Physical Disability Law Reporter* 16 (3-4): 339-346, 462-470 (May-June 1992).

within the jurisdiction of the criminal justice system. Effective interventions can only be designed through coordination among criminal justice, mental health, substance use treatment, and other involved agencies. While multiple state agencies often serve the same individuals, each agency has its own treatment philosophies and areas of focus. To aid in planning, coordinating, delivering and evaluating effective treatment, agencies need accurate information about the individual, the services needed and received, and the planned outcomes.

In an extensive review of the literature on the prevalence of persons in the criminal justice system with mental illnesses, two observations become immediately apparent. First, the work that states have done estimating the need of justice-involved persons for mental health care is limited in the professional literature. Many of the reports were obtained from talking with state-level leadership. Second, there is no standardization among data sources or data definitions that are used to inform policy decisions, limiting the scalability of the results of these single state analyses. To begin a national dialogue there must be a baseline from which to measure the effectiveness of interventions.

A 2015 report that summarized the pivotal factors in bringing a community to address the issues of persons with serious mental illness in jails identified information sharing as a core problem.⁵ The criminal justice system, whose primary responsibility is public safety, seeks mental health information to inform arrest and sentencing decisions. The mental health system seeks information on service needs for those incarcerated as well as planning for services upon release to ensure continuity of care. Information-sharing that meets the needs and responsibilities of each system is crucial to building effective services.

To establish strong interagency collaborations, each partner must understand the distinct culture, language, and definitions of success of the other agency. Mental health planning and advisory councils are encouraged to develop measures of success for addressing the issue of persons with mental illness in the criminal justice system.⁶ As more states undertake the same analysis, the public mental health system can identify common versus singular patterns, and take informed action based on sound, science-based evidence. A standardized framework also promotes attention to direct service needs of persons with mental illness, the clinicians providing care, and the administrators enabling a viable system. The criminal justice system has not been formally tasked with developing measures of success for persons with mental illness. Reports from federal agencies, such as the Bureau of Justice Statistics, are highlighting prevalence estimates suggesting a higher level of focus on this special population. As

⁵ Steadman, H., Morrissey, J., & Parker, T.. When Political Will is Not Enough: Jails, Communities and Persons with Mental Health Disorders. Delmar, New York: Policy Research Associates (2015).

⁶ National Association of Mental Health Planning and Advisory Councils. Jail Diversion Strategies for Persons with Serious Mental Illness. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005)

administrators of public behavioral health services, state agency leaders have a unique opportunity and responsibility for defining the minimum standards for mental health data, services, and networks for persons with mental illness, regardless of the venue of service.

Focus of this Report

Acknowledging that each agency has its own unique culture, language, and philosophy, a crucial step toward effective partnerships requires developing a fundamental understanding of each other's approaches to care and goals for success. This paper is written for mental/behavioral health administrators, policy makers, providers, and researchers to understand the basic mechanisms that criminal justice agencies use to convey the mental health status and needs of persons in their custody, while recognizing that the level of sophistication among systems differs greatly. Behavioral health agencies can use this overview to develop an initial competency as they work to strengthen partnerships with criminal justice and work together to design effective programs.

This paper summarizes the multiple and various sources of data used by agencies that are engaged with justice-involved persons who have a mental illness. The flow of data, from data originator across successive data stewards, and roadblocks that are encountered along the way are discussed. Discrete information available from the criminal justice system that identify persons with mental illness which can address fundamental questions being asked by both the behavioral health and criminal justice systems are highlighted. Insights for behavioral health administrators are featured throughout this report to highlight potential opportunities for strengthening partnerships with criminal justice.

Discrete information available from the criminal justice system that identify persons with mental illness which can address fundamental questions being asked by both the behavioral health and criminal justice systems are highlighted throughout this report.



As the paper will show, some progress has been made in incorporating mental health data in justice data systems. Still, more work needs to be done to facilitate interagency collaborations as well as knowledge-transfer. Through the identification of available data sources, the similarities, differences, and opportunities for improvement and collaboration can be illuminated. As data become more congruent, not only can analyses be standardized, but benchmarks and national aggregates can be brought into the conversation to inform policy development for both state behavioral health and justice agencies to address the unique and complex needs of justice-involved persons with mental illness.



Insights

for behavioral health administrators are featured throughout this report which summarize potential opportunities for strengthening partnerships with criminal justice.



The scope of this report is centered around to adults in jail settings, as opposed to prisons or the community re-entry process, as several national and state initiatives are specifically focused on reducing the number of persons with mental illnesses in jails. Young individuals with mental illness that are involved with the juvenile justice system are also beyond the scope of this paper; further work may focus on the complex interaction among agencies that provide educational, familial, and other social services to these youth.

While some persons with a mental illness enter the criminal justice system because they have committed serious crimes, others repeatedly appear before judges and cycle in and out of jail for low-level crimes that often result from exhibiting psychiatric symptoms in public. Findings from an analysis of persons known to the justice and behavioral health systems in Miami-Dade County, Florida provides solid data on the phenomenon of recidivism: over a five-year period, 97 individuals accounted for nearly 2,200 arrests, 27,000 days in jail and 13,000 days in crisis units, state hospitals and emergency rooms, at a cost of approximately \$13 million, with virtually no return on investment in the form of either a reduced number of encounters with the justice system or improved mental health.⁷

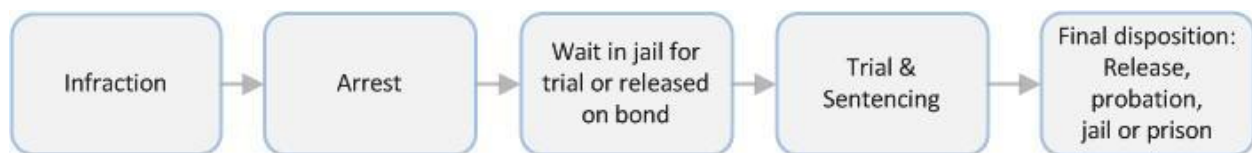
Successfully addressing the number of persons with mental illness in jails will only be achieved through a comprehensive systems approach that includes housing, healthcare, and employment. This paper focuses on information sharing between state behavioral health agencies and criminal justice merely in the interest of report length, but this focus is not meant to minimize the opportunities that exist in collaborating with other public entities, agencies, and services.

⁷ Presentation by Judge Steven Leifman, NASMHPD Annual 2015 Commissioners Meeting: Washington D.C. (July 20, 2015).

A Review of Criminal Justice Information Flow

At the risk of oversimplification, the following scenario (see Figure 1) describes a typical encounter with the criminal justice system involving a person without a mental illness: a law is violated, police become involved, a suspect is identified, the person is subject to arrest, the person awaits a trial while in jail or out on bond, and then, after the court hearing, the person may receive a sentence of probation or incarceration, or may be released. The criminal justice agency is the primary agency responsible for the detainee.

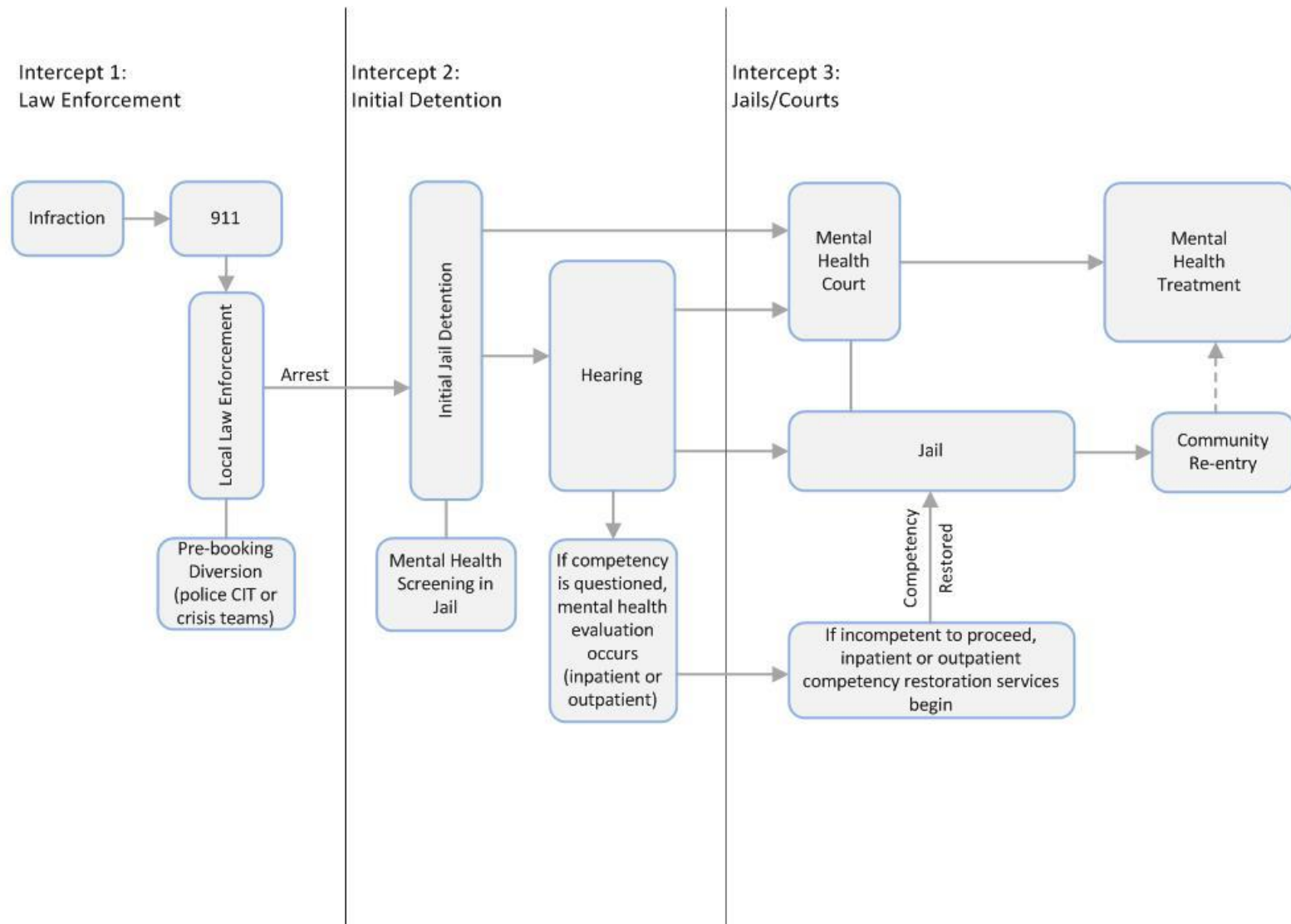
Figure 1: Example Scenario for an Encounter with the Criminal Justice System



When a person with a mental illness is the suspect in a crime, the scenario is much more complex and often involves multiple public agencies in order to maximize opportunities for effective mental health treatment and to protect public safety (see Figure 2). The well-known Sequential Intercept Model provides a helpful framework for conceptualizing justice system decision points as opportunities for an intervention to prevent the individual from entering or penetrating deeply into the criminal justice system.⁸ The Model describes five interception points: law enforcement, initial detention, jails/courts, reentry from jails/prisons/forensic hospitalization, and community corrections (probation or parole). Each point can be considered a “filter”, and ideally, most people with mental illness will be intercepted at the earliest points based on the severity of the crime, leaving few to be drawn too deeply into the criminal justice system. Individuals caught up in the justice system owing to nuisance infractions resulting from their mental illness is an indicator of a fragmented system in need of improvement. The interception points are failing to identify and effectively mitigate the effects of the mental illnesses.

⁸ Munetz, M. and Griffin, P., Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness. *Psychiatric Services*, 57(4), 544-549 (2006).

Figure 2: Scenario for a Person with a Mental Illness Encountering the Criminal Justice System



Intercepts excerpted from: Munetz, M. and Griffin, P. Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness. *Psychiatric Services*, 57(4), 544-549 (2006).

As state and local governments analyze their existing systems using Sequential Intercept Mapping, many have discovered that while a wealth of data is collected by the various agencies that work with this population, efforts at information sharing are disjointed, and there are no formalized processes in place to review relevant data to substantiate the benefits and utility of existing programs. In this paper, a description, in general terms, of the types of data that are collected, the sources of aggregated data, and the survey methods used to collect national data sets on persons with mental illness who come into contact with the criminal justice system are presented, noting the opportunities and limitations for knowledge exchange. Suggestions for how these data sources can be better used to address policy questions are provided. Throughout the discussion, a guiding principle is that data must be valuable enough to the mission of the entity collecting the information for data integrity to remain a priority. Poor data integrity and quality pose a threat to the reliability and validity of the information, potentially rendering it useless.

Law Enforcement Data Systems

An individual's first point of contact with the criminal justice system is typically when a police officer is called to a scene. For individuals with mental illness, the police are often called for disruptive nuisance behaviors attributable to their psychiatric illnesses.⁹ According to estimates, approximately seven to ten percent of police calls in large metropolitan areas involve persons with mental health issues.^{10, 11} While these situations do not represent the majority of police calls, they are among the most complex and time-consuming calls.¹² Responding officers must stabilize the situation, determine if the person poses a threat to himself/herself or others, and establish the appropriate response, which may involve a wide



Insight

Being able to accurately measure the number and characteristics of mental health-related calls enables agencies to identify, enumerate, review, and analyze how individuals with mental illness come into contact with the criminal justice system, for the consumer's protection and for better law enforcement services.

⁹ van den Brink, R.H., et al. Role of the police in linking individuals experiencing mental health crises with mental health services, *BMC Psychiatry* 2012 12:171. Doi: 10.1186/1471-244X-12-171(2012).

¹⁰ MA Dept. of Mental Health Forensic Services. Pre-Arrest Law Enforcement-Based Jail Diversion Program Report, July 1, 2011 to January 1, 2014, <http://www.mass.gov/eohhs/docs/dmh/forensic/jail-diversion-program-2014.pdf>.

¹¹ Teller, J.L. et al., "Crisis Intervention Team training for police officers responding to mental disturbance calls," *Psychiatric Services*. Feb;57(2):232-7 (2006).

¹² Reuland, M., Schwarzfeldm, M., and Draper, L. Law Enforcement Responses to People with Mental Illnesses. New York: Council of State Governments Justice Center (2009).



Insight

CIT is founded on a commitment of law enforcement, mental health and addictions professionals, and mental health advocates to develop a program tailored to the community, implement the training, support interagency agreements, and provide ongoing collaboration.¹³ To reinforce the success of such programs for both public safety and personal safety, fundamental data on utilization is necessary.

All emergency psychiatric evaluation centers should be able to enumerate the level of service and basic characteristics of services to support their utilization in the continuum of care and the benefits to the overall systems of care.

range of community services. A national survey of senior law enforcement personnel found that the estimated amount of time sent on these call, from the

onset of the call for service, inclusive of transportation and time in the mental health facility, is between one to two hours (31 percent of respondents) and three to four hours (26 percent of respondents), which translates into a significant cost per call.¹³

Based on the level of criminal infraction, police have the discretion to resolve the situation at the scene, transport the individual to a mental health facility for evaluation, or arrest the individual. An increasing number of jurisdictions across the country are implementing police crisis intervention team (CIT) training to identify the signs and symptoms of mental

The use of police crisis intervention teams and the availability of psychiatric emergency evaluation centers are front-line components for the integration and coordination of behavioral health and criminal justice for persons with mental illness.



illness, de-escalate the situation, and bring the person in crisis to a treatment center.¹⁴ These initial encounters with police represent the preliminary point of information-gathering on the person's mental status, and are instrumental in the determination of whether or not the person may require mental health services.

Identifying obstacles to collecting and analyzing data on mental health police calls is a vital first step to begin improving the system's response to mental health police calls. Some jurisdictions

¹³ Biasotti, M.C., Management of the Severely Mentally Ill and Its Effects on homeland Security. Thesis (2011), <http://mentalillnesspolicy.org/crimjust/homelandsecuritymentalillness.pdf>.

¹⁴ A method for identifying calls that are suspected of involving a person with a mental illness must first be in place to identify when a CIT response is warranted. For recommendations how police dispatch calls can use non-stigmatizing plain language to replace 10 codes, see the GAINS Center's report "Law Enforcement-Mental Health Collection Data Practices for Specialized Policing Response Programs". http://gainscenter.samhsa.gov/pdfs/jail_diversion/PERF.pdf.



Insight

Incorporating more robust descriptions pertaining to the police call into standard forms better prepares the responder and allows for a more explicit summary of police interactions with persons with mental illness.

To support police department claims that interactions with persons with mental illness are more difficult, the police departments need to validate the assertions through data; if validation can be demonstrated, supports from other agencies should be more forthcoming.

operate Computer Aided Dispatch (CAD) Systems which maintain important data elements on all police calls. These systems can track calls based on their geographic location and can show numbers and types of calls over time. Although not all departments have a CAD system, all maintain some system for tracking calls for service. In addition to calls from the public where the police can determine the level of information required, many calls are initiated through the 911 system. Often, an initial 911 call is not identified as involving a person with a mental health issue because it may be initially identified as a domestic disturbance call or be otherwise misclassified. The police responding to the call may not be aware of the complex nature of the call.

Additional data may be captured in Records Management Systems (RMS), which include information about contacts with the police up to and including arrest. The Bureau of Justice Statistics reports that in 2013, 68 percent of police departments nationwide transmitted incident reports electronically from the field to a central information system, 25 percent of departments used paper

In all systems, the level of information collected must meet the needs of the system; missing data leads to erroneous assumptions.

- 1. Emergency communications (911/dispatch) generally run independent of other systems but need to coordinate response with multiple agencies; these systems need to be sensitive to a variety of needs while also being efficient enough to provide a quick response.*
- 2. Computer-Aided Dispatch (CAD) Systems track calls to police, so the information content is under the control of the police. These systems are caller-oriented, much like collateral contacts in the behavioral health system.*
- 3. Records Management Systems track contacts with the police up to and including arrest; these systems are suspect-oriented much like consumer/patient contacts in the behavioral health system.*



reports, and 7 percent used voice transmission.¹⁵ This data may be analyzed to detect crime patterns and to evaluate the police response to calls involving persons with mental health issues.

The Council of State Governments Justice Center, in partnership with the Police Executive Research Forum (PERF) and the Bureau of Justice Assistance (BJA), worked jointly to address gaps in data collection practices for specialized police responses, as part of the “Law Enforcement-Mental Health Data Collection Practices for Specialized Policing Response Programs” project. The Justice Center/PERF team identified common systemic problems with law enforcement mental health data collection practices, which included the following:

1. Inconsistency in call identification—Many agencies do not have a code for calls that they believe involve an individual with a mental illness.
2. Insufficient data management system—Many small law enforcement agencies lack the software or hardware system capacity to collect and maintain data.
3. Paperwork compliance—Officers may be unable to complete additional forms due to time constraints or other barriers.
4. Missing data—Most encounters involving persons with mental illnesses are due to low-level offenses or nuisance behaviors. Officers may not be required to record the final dispositions of those calls if they did not take any formal action (i.e., citation, arrest, or mental health evaluation).¹⁶

In the event that the officer initiates arrest, the individual is taken to jail for booking. The information obtained by the arresting officer regarding the person’s mental status may be incomplete, resulting in the booking jail knowing very little about the detainee during processing.



Insight

Transitions in care are where the most important information needs to be passed to the next provider, to improve continuity of care, continued improvement in functioning, and reduce relapse potential. For the police to jail transition, a primary concern is community safety; for the personal safety of the detainee, information about mental health status and health conditions are among the most critical pieces of information to be communicated.

¹⁵ Bureau of Justice Statistics. Local Police Departments, 2013: Equipment and Technology (2013).

¹⁶ Council of State Government Justice Center, “Law Enforcement-Mental Health Data Collection Project” <http://csgjusticecenter.org/law-enforcement/projects/mental-health-data-collection-project/>.



Insight

Behavioral health systems, whether inpatient or community, are familiar with the diversity of clinical records, from paper-based to fully integrated EHR. Regardless of the “system,” key elements are required to ensure accurate patient counts, plan appropriate treatment, develop programs, and allocate resources. This information is also necessary to move from paper-based to fully integrated systems. Sharing behavioral health’s learnings in this area can greatly assist criminal justice systems to avoid time-consuming and costly dysfunction.

Local Jail Data

Jails are locally operated correctional facilities that hold offenders for a short period of time pending arraignment, trial, conviction, and sentencing. Local jails range in size from very small, with a capacity of less than 25 inmates, to more than 1,000 inmates. Jail sentences average 23 days.¹⁷ Local jails also find themselves holding detainees with mental illnesses awaiting referral to appropriate mental health facilities. With the exception of those in large metropolitan areas, most jails are quite small, so it is impractical for them to develop a comprehensive array of mental health services within the jail. Jails must partner with other community agencies to provide these services.

Much emphasis is being placed on the rise in pre-adjudicated persons with mental illness in jails, and policy makers are grappling with how to address the issue as well as how to assess the effectiveness of interventions. As Cook County Sherriff Thomas Dart wrote in his July 14, 2015 blog on the Safety and Justice Challenge website:¹⁸

“Police have discretion on whether to arrest, prosecutors have discretion on whether to charge, and judges have discretion on what bond to set. But jail administrators alone have little discretion. We do not control who comes into our custody, and we cannot say “no” when [persons with mental illness] are sent our way for indeterminate amounts of time”.

In the 2006 and most recent Bureau of Justice Census of Jail Facilities, there were roughly 3,283 local jails across the United States,¹⁹ with data systems so varied it is difficult to

¹⁷ Subramanian, R. et al., *Incarceration’s Front Door: The Misuse of Jail in America*. New York, NY: Vera Institute of Justice, (February 2015), <http://www.safetyandjusticechallenge.org/wp-content/uploads/2015/01/incarcerations-front-door-report.pdf>.

¹⁸ Dart, T.J., “Looking Past the Numbers at Who’s in Our Jails and Why,” <http://www.safetyandjusticechallenge.org/2015/07/looking-past-the-numbers-at-whos-in-our-jails-and-why/>

¹⁹ 2006 Census of Jail Facilities, Washington, D.C. Bureau of Justice Statistics. Available at <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=2205>

generalize about how a “typical” data system is structured and what types of data are contained therein. The National Institute of Corrections (NIC) provides guidance to jail administrators on the types of mental health data that should be collected.²⁰

NIC recommendations for the collection of detainee-level information include:

1. Past or present treatment of mental illness;
2. Type of treatment (e.g. inpatient or outpatient);
3. Whether a mental health crisis worker saw the detainee at time of intake; and
4. Whether special housing is required because of a psychiatric condition.

Some small jails still employ paper-based systems while larger jails have established robust management information systems. Nevertheless, the goal should be to highlight the importance of incorporating information about a person’s mental health status in the information system, independent of the level of sophistication of the system. When reliable and valid mental health data are available, detainees with mental health issues are more likely to receive the appropriate care.

Mental Health Screenings in Jails

Mental health screening tools are used as a quick way to identify persons who should be referred for a more robust mental health evaluation. Given the short amount of time that an individual stays in a jail, it is important to quickly screen all inmates for mental health issues and connect them to the appropriate treatment.

For jails that are accredited through the National Commission on Correctional Health Care (NCCHC), the Standards for Mental Health Services require that incarcerated persons receive a mental health screening within 14 days of intake,²¹ but does not dictate the type of screening that should occur. Less than one-sixth of jails were NCCHC-accredited in 2014, ranging in size from an average daily population of 10 to close to 9,400.

²⁰ Elias, G., *How to Collect and Analyze Data: A Manual for Sheriffs and Jail Administrators*, 3rd edition. U.S. Department of Justice, National Institute of Corrections, Washington, D.C. (July 2007), <https://s3.amazonaws.com/static.nicic.gov/Library/021826.pdf>.

²¹ National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities*, Standard J-E-05 (2015), as cited in *CorrectCare* Volume 26, Issue 2 (Spring 2012), <http://www.ncchc.org/mental-health-screening-evaluation>.



Insight

*The type of mental health screening process used in local jails can be an indicator of the accuracy of reported prevalence rates. The **two recommended mental health screening tools for jails** should be examined to determine the standard components for all screening:*

Correctional Mental Health Screen

Brief Jail Mental Health Screen

Much like screenings in inpatient psychiatric care for specific issues, the focus should be on achieving the minimum required components, not the specific tool.

The U.S. Department of Justice provides a guide to mental health screening tools that are recommended for use with persons admitted to jail.²² This resource describes two tools, the Correctional Mental Health Screen (gender-specific screening tools) (CMHS) and the Brief Jail Mental Health Screen (BJMHS). Both the BJMHS and the two gender-specific versions of CMHS are available at no cost and are scientifically validated for quick mental health screening of large numbers of persons during intake.

For jails that are not accredited, there may be no standardized, objective mental health screening tool in place. Subjective measures of a person's mental health status are still employed in some settings which include recording behavioral observations such as "acting bizarrely," "overt suicidal ideation," etc.²³ The Module 2 Planning Guide for the Council of State Governments' Stepping Up Initiative recommends that jails ascertain how a person in need of mental illness or substance use treatment is being identified. Jail staff should understand whether a standardized screening tool is in place, whether everyone is screened at a specified time (such as within 48 hours of booking), whether a follow-up assessment process is in place for persons screening positive, and how data are collected regarding positive screens.²⁴ Again, as with the NCCHC Standards, there is no standardized recommendation for how data should be captured or flagged.

In sum, although jail booking data typically flag detainees with mental health needs, in practice, these flags may be determined based on objective or subjective means. Jail staff may flag a person for mental health issues based solely on personal observation of the inmate's

²² Mental Health Screens for Corrections. Washington, D.C., U.S. Department of Justice (May 2007), at <https://www.ncjrs.gov/pdffiles1/nij/216152.pdf>

²³ Technical Assistance Module 2 Planning Guide: Collect and Review Data on the Prevalence of People With Mental Illnesses In Jails And Assess Their Treatment Needs. Lexington, KY Council of State Governments Justice Center. (2015), <https://stepuptogether.org/toolkit>.

²⁴ Ibid

behavior. More reliable methods may include recording the results of a formal mental health screen or the detainee's own disclosure of mental health issues. Some large jurisdictions employ more sophisticated methods such as matching booking records with mental health system records.

It should also be noted that a person's mental status may change post-intake, so NCCHC recommends that processes be in place to periodically re-assess a detainee's mental status during their incarceration, and after any subsequent incarcerations.²⁵

Mental Health Evaluations of Jail Detainees

Individuals requiring a more in-depth mental health evaluation are identified based on the results of the mental health screening. Additionally, when a judge, prosecutor or defense attorney questions the competency of a defendant, a judge may initiate a court-order for a mental health evaluation. In nearly every state, mental health evaluations, including determinations of competency to stand trial, are made by the public mental health authority,²⁶ and state behavioral health agencies are experiencing a rapid increase in the number of referrals for forensic mental health evaluations. In a 2014 NASMHPD state survey, 15 states reported conducting over 1,000 evaluations annually, with some states conducting as many as 5,000.²⁷

Nineteen states (of 32 responding) reported conducting the majority of evaluations on an outpatient basis, mostly by community evaluators in jail settings. Some states reported an increasing demand for inpatient evaluation.²⁸ In addition, 79 percent of states reported that a court could order defendants admitted for an inpatient evaluation, regardless of the preferred approach of the mental health agency. In each case, the results of these evaluations are entered into the person's disposition record at the criminal justice agency.

States are experiencing a number of barriers to meeting the demand for court-ordered mental health evaluations. The most significant barriers are inadequate evaluator reimbursement rates and training, and disparate evaluation reports. Completing a competency evaluation for a

²⁵ National Commission on Correctional Health Care, Standards for Mental Health Services in Correctional Facilities, Standard J-E-05 (2015), as cited in *CorrectCare* Volume 19, Issue 2 (Spring 2005), <http://www.ncchc.org/mental-health-screening-evaluation>.

²⁶ In a 2014 survey by NASMHPD, a few states reported that mental health evaluations for competency to stand trial are provided privately, and funded by the courts or privately.

²⁷ Fitch, W.L., *Forensic Mental Health Services in the United States: 2014*. A report from the National Association of State Mental Health Program Directors, Alexandria, V.A. (2014).

²⁸ Ibid.



Insight

Mental health evaluations are made by the public mental health authority, which should have the authority to standardize the process, training, and evaluation reports and ensure compliance with standard training and documentation protocols in coordination with the criminal justice system.

In addition, the mental health authority should have the authority to save additional data (evaluators, number of evaluations, duration of evaluation, findings, etc.) in the public mental health data systems for evaluations done under the authority of the public mental health system.

person who is cognitively impaired takes a considerable amount of time and the reimbursement caps in most states are insufficient to attract qualified staff.

National data on the compensation rates to community-based evaluators ranges from \$300 to \$3,000 per evaluation; however, the response rate on the state survey was quite low. Seventeen states reported reimbursement rates between \$500 and \$1,000, and four States reported paying over \$1,000.²⁹

Mental health screening data and mental health evaluations should be stored in both the public mental health systems and the criminal justice systems to reflect the shared liability/responsibility for persons with mental illness.



Once evaluators are hired, there is often a lack of enforcement of the regulations regarding standardized, systematic training and centralized oversight of outpatient evaluators. Recipients of the competency evaluation reports (i.e., public defenders, prosecutors, judges, and mental health treatment providers) frequently indicate that there is a lack of standardization among reports. Various models exist to provide good training on forensic evaluations,³⁰ and a few states, such as Massachusetts, Georgia, Oregon, and Virginia, require a formal certification procedure and are experiencing successful results. Having quality assurance procedures among evaluators through peer review has been shown to significantly increase the reliability of the findings.³¹

²⁹ Ibid.

³⁰ Frost, L.E., deCamara, R.L., & Earl, T.R. Training, certification, and regulation of forensic evaluators. *Journal of Forensic Psychology Practice*, 6, 77-91 (2006).

³¹ Gowensmith, W.N., Murrie, D.C., and Boccaccini, M.T., Field reliability of competence to stand trial opinions: How often do evaluators agree, and what do judges decide when evaluators disagree? *Law and Human Behavior*, 36(2):130-9 (2012).

Mental Health Court Data

The passage of the Law Enforcement and Mental Health Project Act in 2000 paved the way for the expansion of mental health courts as a method to divert persons with mental illness from incarceration. Implementation of the Act varies considerably from state to state in terms of eligibility criteria and methods to resolve charges filed against a referred individual. Some operate using a pre-adjudication model whereas others receive cases post-adjudication.

All individuals accepted into mental health courts have been deemed mentally competent to proceed through the judicial process. Local jails may be unaware of the other eligibility requirements, particularly when the jail has a high rate of cases rejected by the mental health court. The goals of such programs are to connect detainees having mental health and/or substance use issues to treatment resources, to encourage engagement in positive life activities such as school and work, and to help facilitate court mandates such as completing community service. A person that has been diverted via a mental health court is then tracked by at least two public systems: the justice agency and the behavioral health agency.

If a detainee was assessed and found not eligible for mental health court, this new information needs to be incorporated into the jail data and shared with the mental health system so their needs can be addressed through a different approach. At a minimum, the mental health court should be able to provide the mental health care system with the number of cases reviewed and accepted.



The methods for resolving charges differs based on the policies of the individual mental health court. Methods may include pre-adjudication suspension of charges, or post-plea strategies that suspend sentencing, and probation. The approach to disposition determines which agency is responsible for supervising the individual in the community. The court, probation, or parole staff may monitor, or the community mental health treatment providers may supervise while providing care, with reports back to the court in either case if there are problems.³²

Mental health courts typically allocate very little, if any, money toward collecting and analyzing outcome data. The Bureau of Justice Assistance's Guide to Collecting Mental Health Court Outcome Data emphasizes that before collecting any outcome data, mental health court

³²Griffin, P., Steadman, H., & Petrila, J.. The use of criminal charges and sanctions in mental health courts. *Psychiatric Services*, 53, 1285–1289 (2002).



Insight

Mental health courts are recognized as an effective treatment strategy for certain populations. Persons with the most severe or complex illnesses may not be included in that population; therefore, there may be few effective options to keep the public safe and provide treatment for those persons.

Nevertheless, it is critically important to know the prevalence of mental illness in jails at least at two levels of illness: non-severe levels of illness that can be diverted into the community and more severe levels of illness that require inpatient psychiatric treatment or treatment in jail.

administrators should have a clear target population and program goals.³³ The Guide identifies four main categories of person-level data that mental health courts should consider collecting on cases from participant characteristics through treatment and outcomes (See Table 1).

The Council of State Governments' Justice Center has developed a free database that can be used for mental health court operations and reporting to help programs with limited funding move beyond paper-based tracking of detainees.³⁴ The database was developed to allow a mental health court to track detainee demographics, referrals, and progress, as well as data related to detainee release.

Court disposition data show arrests that resulted in immediate release, pre- or post-trial diversion, pretrial detention, or other dispositions, along with the infraction codes. These documents also record if a defendant was taken in under civil commitment statutes. However, these documents—which constitute the final record of the charges and outcome—do not include a detailed level of information on the detainee or the case. In contrast, mental health courts frequently require that a potential participant provide permission to share information between criminal justice and behavioral healthcare providers as a condition of admission to the program, with mental health codes being made available to the specific collaborating agency but not to the public.

Court disposition data is organized for court efficiency purposes, from charge to disposition. It can be conceptualized as operational information, with a marker for the point in the adjudication process where a resolution was reached.



³³Steadman, Henry J. *A Guide to Collecting Mental Health Court Outcome Data*. New York: Council of State Governments (2005).

³⁴See <http://csgjusticecenter.org/mental-health/technical-assistance/tools/mental-health-court-data-collection-template/>.

Table 1: Suggested Data for Mental Health Courts

Participants	Services
<i>How many people did the courts serve and what are their characteristics?</i>	<i>What types of services did court participant receive? With what frequency? And for how long?</i>
Number of individuals screened	Assessment
Number of Individuals eligible (according to program criteria)	Case Management
Number of individuals accepted	Medication Appointments
Demographics of accepted individuals (including charges, prior criminal history, diagnoses)	Outpatient Treatments
Reasons not accepted	Intensive outpatient treatment
Relevant characteristics of eligible persons who declined to participate	Psychosocial rehabilitation
Reasons for declining to participate	Housing
Relevant characteristics of persons accepted into the court	Residential substance abuse treatment
Length of time between key decision points (e.g., screening to acceptance, acceptance to case termination)	Integrated treatment for co-occurring disorders
Reasons for termination	Supported Employment, other vocational training
	Education, GED
	Self-help groups
	Enrollment in Medicaid, SSI, SSDI
Criminal Justice Outcomes	Mental Health Outcomes
<i>What were the effects of these services on participants' criminal justice involvement?</i>	<i>What were the effects of the services on participants' mental health symptoms and overall functioning?</i>
Number of arrests during and after program	Number of inpatient hospitalizations and length of stay
Type of charge	Number of emergency room admissions and type of treatment received
Number of admissions to jail or prison during and after program participation	Changes in symptoms
Reason for admission (new charge, technical violation)	Number of days homeless
Number of days in jail or prison for new crimes	Number of victimizations
Number of days in jail due to sanctions for non-adherence to court conditions	Level of satisfaction with services offered
	Changes in quality of life
	Number of days clean/sober
	Number of days employed or in school during a specific period of time
	Level of compliance with psychotic medications
Source: Steadman, Henry J. <i>A Guide to Collecting Mental Health Court Outcome Data</i> . New York: Council of State Governments (2005).	

National Data on Jails

The Bureau of Justice Statistics (BJS) maintains a comprehensive data collection on criminal victimization, law enforcement, prosecution, courts, and corrections. Data are collected at the inmate and jail levels. However, posted data are aggregated at the state, regional, and national levels. The data are collected through structured surveys of inmates and standardized forms to jails. Posted data are limited to reports and tables determined by BJS; not all data collected through surveys and reports are publicly available. The BJS data sources described in this document could address questions regarding the interface of the behavioral health and criminal justice systems.

The name of the data sources (survey/report) and a list of common elements are presented in Tables 2 & 3, which follow. A description of the data sources at the inmate level is presented first followed by a description of the data sources at the jail level.

Surveys at the Inmate Level

At the inmate level, there are at least four surveys identified that collect data on the mental health status of inmates. The **Survey of Inmates in Local Jails** provides information on: individual characteristics of jail inmates, current offenses, and detention status; characteristics of victims; criminal histories; family background; gun possession and use; prior drug and alcohol use and treatment; medical and mental health history and treatment; vocational programs and other services provided while in jails; and other personal characteristics. The survey provides a stratified sample of inmates representative of those detained in jails. The sample is stratified in a two-stage selection, in which jails are selected in the first stage and inmates to be interviewed are selected in the second stage. Data are collected through face-to-face interviews, with jail inmates using computer-assisted personal interviewing. Frequency of data collection varies. The most recent data collection is for 2002. There is no information on when the next cycle of interviews will take place.

Information about mental health history and treatment on the BJS Survey of Inmates in Local Jails is collected through screening questions related to the current and prior diagnosis of mental illness, services received for emotional or mental conditions such as medications, admission to a mental health hospital, unit or treatment program, and counseling or therapy from a trained professional. The survey also gathers information on the number of instances that an inmate has attempted suicide or has ever considered suicide.





Insight

*The 2002 **BJS Survey of Inmates in Local Jails** provides an historical context with which to begin dialogues between behavioral health and criminal justice systems. The acceptance of surveyors and the recognition that standardized protocols are used provides the foundation for common/standardized language and understanding between systems.*

*The **BJS National Inmate Survey** provides the current context for understanding prevalence of mental illness in jail settings, but is impacted by changes in survey methodology over the years. Public mental health authorities use extrapolation from sample surveys to develop an understanding of the size and severity of problems, and continue to use extrapolation in areas where records are rudimentary or non-existent.*

The **National Inmate Survey** gathers data similar to the *Survey of Inmates in Local Jails*, as well as mandated data on the incidence and prevalence of sexual assaults in correctional facilities. Data are collected directly from inmates in a private setting, using audio computer-assisted self-interview technology with a touchscreen laptop and an audio feed to maximize inmate confidentiality and minimize complications arising from the inmate's level of literacy. Data are collected through the voluntary participation of a 10 percent random sample of detainees in correctional facilities. The survey is administered in jails and prisons. Data collection occurs annually, subject to the availability of funds. The most recent data collection was for 2012.

The **Arrest-Related Death Report** and the **Deaths in Custody** Report collect inmate death records that include personal characteristics, criminal history, and information related to the death itself. Data are collected through a standardized form completed by jail personnel. The **Arrest-Related Death Report** focuses on questions related to the arrest, such as whether law enforcement used any type of force or device during the arrest, and the type of any weapon used during the deadly incident. Data collection occurs annually. The most recent data collection was for 2011. The **Deaths in Custody** Report collects further data on the inmate's legal status at time of death, emergency care provided, and pre-existing medical conditions. Data collection occurs annually. The most recent data collection was for 2014.

The Arrest-Related Death Report and the Deaths in Custody Report contain elements of mental health status completed by jail staff. Reports are completed and submitted to a State reporting coordinator on a quarterly basis.



Insight

Deaths in custody are a common liability for public mental health and criminal justice systems. There are insights from the Arrest-Related Death Report and the Deaths in Custody Report that can be shared across systems to improve the safety of each system. For example, medical conditions and medications are crucial pieces of information, as is the root cause of death (self-inflicted injury resulting in death, accident, or assault) in addressing issues of safety for the person and the environment, and complications resulting from complex medical conditions.

Table 2. Common data elements* for data sources at the inmate level

	Survey of Inmates in Local Jails	National Inmate Survey	Arrest-Related Death Report	Deaths in Custody
Last data collection:	2002	2012	2012	2014
Gender	X	X	X	X
Date of birth	X	X	X	X
Age	X	X		
Race	X	X	X	X
Hispanic origin	X	X	X	X
Marital status	X	X		
Education	X	X		
Employment status	X			
Living status	X			
Homeless status	X			
History of sexual abuse	X	X		
History of physical abuse	X			
History of alcohol use	X	X		
History of drug use	X	X		
Current mental health screening	X	X		
History of mental health and treatment	X	X		
Previous mental health treatment or counseling		X		
Current mental health treatment or counseling		X		
Offense/charges	X	X	X	X
Property offender	X	X		
Drug possession	X	X		
Stolen property	X	X		
Prior probation	X			
Prior incarceration	X	X		
Date of death			X	X
Manner of death			X	
Cause of death			X	X
Arrest-related injuries			X	
During arrest, exhibit mental health problems?			X	
At the time of entry into jail, exhibit mental health problems?			X	
Mental health observation				X

*The name of the data elements might not be exactly the same as the name in the data sources.



Insight

The BJS **Annual Survey of Jails** has a broad scope and highlights the complexity of the criminal justice system and the need for dialogue with mutual respect between complex systems.

The BJS **Census of Jails** provides organizational data, type of structure, capacity, utilization, and major attributes. This has the potential to provide contextual information for making interpretations, but more importantly for learning about the structures in a state and how jurisdictions may vary.

Surveys at the Jail Level

Common data elements for the data sources available at the local jail level are summarized in Table 3. The **Annual Survey of Jails** collects data from a nationally representative sample of local jails on inmate populations, jail capacity, staff, and security. The survey targets confinement facilities usually administered by a local law enforcement agency, intended for adults but sometimes holding juveniles. Confinement facilities include jails and city/county correctional centers, special jail facilities, and temporary holding or lockup facilities not part of the jail's combined function from which inmates are not held beyond arraignment and so usually transferred within 72 hours.³⁵ The survey has collected data annually starting in 1982, excluding years 1983, 1988, 1993, 1999, and 2005. The most recent data collection was for 2014.

Trend data are available from the BJS Annual Survey of Jails on census and capacity of jails to highlight changes. This data can help project change in the impact of persons with mental illness on the jail system and the rolling effect on the behavioral health system of jail inmates.



The **Census of Jail Facilities: Jurisdiction Form** collects information on each facility aggregated by jurisdiction, including admissions and releases, court orders, programs that offer alternatives to incarceration, counts of inmates on hold for other jurisdictions, use of space and crowding, staffing, inmate work assignments, and education and counseling programs. In contrast, the **Census of Jail Facilities: Facility Form** gathers data at the facility level on population, function, rated capacity, year of construction, and major facility renovations. The most updated information for both forms is for 2006.

³⁵ Some jurisdictions include facilities in jail jurisdictions that held juvenile inmates at the time of the 2005 Census of Jail Inmates and had an average daily population of 500 or more inmates during the 12 months ending June 30, 2005. The survey also includes facilities in jail jurisdictions that held only adult inmates and had an average population of 750 or more at the time of the 2005 Census of Jail Inmates.



Insight

*As with the inmate-level death data, mental health and criminal justice can potentially learn from each other's experiences in addressing system liability through the BJS **Deaths in Custody: Annual Summary**.*

*Given the completeness of this data, studying this data in combination with the *Death in Custody* and *Census of Jail Facilities* surveys is likely to provide valuable insights.*

The BJS Census of Jail Facilities provides a complete enumeration for every jail, although posted in summary format. The “availability of psychiatric services” is a beginning point for dialogue between the criminal justice and behavioral health systems.



The **Deaths in Custody: Annual Summary** gathers data on inmate deaths, supervised population, costs of incarceration, and staffing levels. The report collects data from confinement facilities usually administered by a local or regional law enforcement agency, intended for adults but sometimes holding juveniles. It also includes jails and city/county correctional centers, special jails, private facilities operated under contract to local, regional, or federal correctional authorities, and facilities that hold inmates for other jurisdictions—including federal authorities, state prison authorities, and other local jail jurisdictions. The most updated information is for 2013.

Table 3. Common data elements* for data sources at the local jail level

	Annual Survey of Jails: Certainty Jurisdictions	Census of Jail Facilities: Jurisdiction Form	Census of Jail Facilities: Facility Form	Deaths in Custody: Annual Summary
Last data collection:	2014	2006	2006	2013
Number of confined inmates	X	X		X
Number of confined adult males	X		X	X
Number of confined adult females	X		X	X
Number of White inmates	X			X
Number of Black inmates	X			X
Number of Hispanic inmates	X			X
Number of other races (American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, other)	X			X
Average daily population confined in the jail	X	X		X
Average daily male population confined in the jail				X
Average daily female population confined in the jail				X
Total jail rated capacity (number of beds)	X		X	
Total jail operational capacity (total max of inmates)	X	X		
Total number of staff	X	X		X
Number of physical or sexual assaults on jail staff	X	X		
Number of deaths as a result of assaults by inmates	X	X		
Number of inmates found guilty of assault on another inmate	X			
Number of inmates found guilty of drug violation	X			
Number of inmates found guilty of alcohol violation	X			

	Annual Survey of Jails: Certainty Jurisdictions	Census of Jail Facilities: Jurisdiction Form	Census of Jail Facilities: Facility Form	Deaths in Custody: Annual Summary
Last data collection:	2014	2006	2006	2013
Number of inmates found guilty of possession of a weapon	X			
Number of inmates found guilty of possession of stolen property	X			
Number of inmates found guilty of escape or attempted escape	X			
Number of inmates found guilty of any other major violation	X			
Psychological/psychiatric counseling available to inmates?		X		
Number of inmate deaths				X
Number of male deaths				X
Number of female deaths				X
Offense type				X

*The name of the data elements might not be exactly the same as the name in the data sources.



Insight

Inmate and jail structural data are in some ways congruent to patient/consumer and provider data. Inmate/detainee-level data can provide a wealth of information about the people in the system, their common and unique needs, service levels (amount and variety of services, offense history), and outcomes. Organization-level data can provide a wealth of information about the context of services (staffing, relationships with other providers, and types of services). These are the fundamental building blocks for assessing need and defining gaps across systems.

Benefits and Limitation of National Data

Nationally reported data provide a hint of the extent to which data may exist at a local level. As in other reporting environments, data transmitted from one organization to another may be “translated” from local coding into the required coding of the receiving organization and aggregated for the purposes of reporting to the receiving organization. A full understanding of local data can only be achieved by asking the local entity directly or accessing a report published by the local entity.

A significant problem with data that are collected by survey is that they may only exist in the survey. However, as most surveys conducted by state and federal agencies are often repeated over time, local information is likely to be maintained from the prior survey, and mechanisms to store and extract these data locally are likely to improve over time.

Surveys that provide a “representative sample” must define the qualities they represent. For instance a sample of jails may be representative of jails based on size of jails plus population base. A sample of inmates may be a completely random proportionate representation of inmates, or it may be stratified by offense or sample of jails. Finally, individual survey administrators may vary each year, raising questions about data integrity over time.

In addition, the inmate surveys are collected through structured interview and self-administered computer-assisted tools. While these techniques add to the credibility of the information because of standardized and repeatable protocols, the data are collected only for survey purposes and therefore not available at the jail in its record management systems. This suggests that a validation technique that compares jail record management summaries to survey results would be beneficial.

The overall limitations of the data from the BJS data sources are:

1. Variation in time for data collection of common data elements. Similarities across surveys are hampered by the disparate collection timeframes.

2. Timeliness. Survey data may be subject to many months or years of analysis before they become available in report or other format. Due to this limitation, survey data often provide only an historical context.
3. Publicly posted raw data from sources are presented in a pre-designed format. However, not all raw data collected from sources are posted or presented in the pre-designed format.
4. Publicly posted data are often aggregated at the state, regional, and national levels. While aggregate data provide a snapshot of information, extrapolation and individual participant interviews are critical sources of information to understand the needs of the system.
5. Data sources can change from one year to the next. Source identification may not be available in the reported results, rendering comparisons to historical information compromised.
6. Mental health screenings are self-reported and may lack clinical validation. In addition, the reliability of self-reported data differs by instrument and survey method.
7. Staff data are often aggregated by classification, with data pertaining to mental health professionals such as psychiatrists and psychologist classified under a general category of professional and technical staff, which may also include counselors, classification officers, social workers, doctors, nurses, and chaplains.

Suggestions to Improve National Data

Several additional considerations could improve the quality and utility of data collected for the criminal justice system and for any dialogue with the behavioral health system.

1. Development of a standard form for inmates and a standard form for jails, from which common pieces of information could be combined.
2. Standardization of the frequency of data collection to allow for more meaningful longitudinal analysis.
3. Making data accessible at the inmate and jail levels, with the necessary HIPAA-and 42 CFR Part 2-related patient-level data protections, for the development of more significant research.
4. Broadening data collection beyond mental health services offerings to include the type and volume of those services as well as the mental health diagnosis.
5. Evolving the data collection process beyond the use of collection forms to the development of standardized performance measures.

Interdepartmental Information Sharing

There are jurisdictions across the U.S. that are demonstrating the successful connection between criminal justice and health data. The discussion begins with the national dialogue and development of standardized frameworks, and then proceeds to explore examples of state accomplishments.

Each individual jurisdiction will approach information sharing in its own way. The following examples foreshadow a future of interoperability and connectedness of criminal justice and behavioral health data. As this movement has begun, it is an opportune time to develop a standardized methodology to assess the effectiveness of various interventions for justice-involved individuals with mental illnesses.

Not all systems have progressed to a level of seamless information-sharing using health information technology. Setting aside the shortage of funding for advance technology infrastructure, most systems still struggle with issues of privacy, consent, and information security when beginning interdepartmental discussions of information-sharing.³⁶

National Dialogue

1. National Info Exchange Model: Global Standards Council's Justice-to-Health Services Task Team

In 2014, the Global Standards Council's Justice-to-Health Services Task Team reported on the alignment of justice-to-health priority exchanges under the assumptions that high-priority justice-to-health exchange opportunities would be beneficial for the justice and health communities.³⁷ The main report provided two recommendations to the Global Standards Council: (1) place a high priority on defining the business exchange requirements, service identification, and adoption of services to support justice-to-health information sharing field implementations, and (2) steps that should be considered when deciding how best to initiate alignment of the justice-to-health data.

Prior to the global efforts on justice-to-health information sharing exchanges, the health

³⁶ The Justice and Health Connect website aims to increase the ability of government agencies and community organizations to share information across health and justice systems: <http://www.jhconnect.org/>

³⁷ Aligning Justice-to-Health Priority Exchanges Task Team: Final Report. (2014, August). Global Justice Information Sharing Initiative.

domain community embarked on a similar effort known as the Direct Project. The Direct Project was established to specify a simple, secure, scalable, standards-based way for participants to send authenticated, encrypted health information directly to known, trusted recipients over the internet. It was developed to guide and direct the Meaningful Use requirements as well as the funding that was being provided via the Affordable Care Act for states to implement priority exchanges within the Health Information Exchange environment. Concurrent with the work in the health domain, a group of experts identified ten priority justice-to-health business exchanges that were then analyzed, aligned, and mapped, as well as primary cross-business alignments with health data.

This effort of the Global Justice Information Sharing Initiative reflects both the highest-priority justice business/information exchange needs and the technology architecture requirements to deliver cross-business domain value between justice and health.

2. Justice & Health Connect Website

The Justice and Health Connect is a project of the Substance Use and Mental Health Program at the Vera Institute of Justice, supported by the Department of Justice Bureau of Justice Assistance. It aims to increase the ability to share justice-health information between agencies and organizations. It recognizes that careful information-sharing is a way of improving collaboration between agencies. Sample Memorandums of Understanding are provided to help states establish a governance framework for health and justice agencies for sharing confidential substance use, mental health, and primary health care information. Sharing information can help to address health disparities, reduce costs, increase access to treatment and reduce crime. The project has prepared a tool kit³⁸ that provides a framework for planning, implementing, and sustaining interagency collaboration between justice and health systems including mental health systems.

3. Center for Integrated Health Solutions at SAMHSA

The Center for Integrated Health Solutions at SAMHSA provides behavioral health organizations with training and technical assistance in implementing electronic health records and resources and posting those resources and data to health information exchanges. The paper *Jails and Health Information Technology: A Framework for Creating Connectivity*,³⁹ shares insights from

³⁸ Justice and Health Connect Toolkit: <http://www.jhconnect.org/toolkit>

³⁹ Butler, B., *Jails And Health Information Technology: A Framework For Creating Connectivity*, Community-Oriented Correctional Health Services (COCHS), http://www.cochs.org/files/HIT-paper/cochs_health_it_case_study.pdf (August 15, 2013).

the experiences of five jurisdictions (Florida, Oregon, New York, Massachusetts and Kentucky) working to implement different forms of health information technology connectivity. The author found that there are many ways to approach information technology connectivity in jail environments. Establishing such connectivity takes into consideration the unique circumstances and environment in which each jurisdiction operates. An additional consideration in these connections is the extent to which behavioral health data are carved out from the information exchange.

4. Legal Framework for Sharing Health Information

In 2010, the Council of State Governments' Justice Center prepared the report "Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws,"⁴⁰ which was funded by BJA. The report provides an understanding of the legal framework for information-sharing when attempting criminal justice-mental health collaborations. It describes the federal legal framework for sharing health information, but encourages those interested in the criminal justice-mental health collaborations to be aware of state laws that may establish additional criteria.

The report contains a detailed legal analysis of when behavioral health care providers, law enforcement officers, courts, and jail staff are covered by HIPAA, and when they can disclose and receive protected health information. HIPAA requires that external organizations not providing health care that may want to access protected health information either from inmates in the criminal justice system or from individuals receiving services in mental health institutions have in place business associates agreements or qualified service organization agreements. Overall, HIPAA's restrictions on sharing health information are often misunderstood, which has resulted in health care practitioners misapplying the law in a far more restrictive manner than the actual regulatory language requires. The report makes the point that the legal framework governing information-sharing should not be seen as an impossible obstacle to criminal justice-mental health collaborations.

As the International Association of Chiefs of Police (IACP) wrote in the June 2010 summary of a national policy summit on improving police response to persons with mental illness:

"Maintaining confidentiality of consumers' mental health records is an important priority for treatment agencies, and most state statutes require patients' written consent for clinicians to share information with others. Local mental health advisory groups should develop internal protocols to obtain such consent as appropriate, and establish Memoranda of Understanding

⁴⁰ Padriola, J. and Fader-Towe, H., *Information Sharing in Criminal Justice-Mental Collaborations: Working with HIPAA and Other Privacy Laws*, (2010), https://www.bja.gov/Publications/CSG_CJMH_Info_Sharing.pdf.

(MOUs) that define the types of information that can be shared, and when, how and with whom the information will be shared. Family members may also be able to provide information in the event of a crisis involving their loved one. One local advocacy group suggests preparing a crisis file of materials that can easily be shared with treatment or law enforcement professionals who respond to a call for service. The central goal of information-sharing is to ensure that law enforcement officers and/or their crisis intervention partners have knowledge that can help them to avoid injury or death and achieve a positive resolution when responding to a crisis call for service.”⁴¹

Examples of State Accomplishments

Nebraska

The Nebraska Behavioral Health and Criminal Justice Joint Project (joint project) formally began in 2009 when the Nebraska Department of Health and Human Services Division of Behavioral Health formed electronic data transfer interagency agreements with the Nebraska Commission on Law Enforcement and Criminal Justice and the Nebraska Department of Correctional Services to permit their mutual use of data from their respective systems. Data from these agencies were transferred to the University of Nebraska Medical Center College of Public Health for analysis and reporting of the Uniform Reporting System Table 19A, a requirement for receipt of the Substance Abuse & Mental Health Services Administration (SAMHSA) Mental Health Block Grant. Data were analyzed after a rigorous matching of the behavioral health and criminal justice data, and after data confidentiality was guaranteed. The Nebraska Behavioral Health and Criminal Justice Report found that 41 percent of the consumers of behavioral health in the state were housed in jails and 20 percent of all individuals housed in jails in the state received behavioral health services during 2005-2009.⁴²

In an updated brief report from 2011, the joint project found that 23 percent of the individuals admitted to jail also received a state-funded behavioral health service in the community setting at least once during the 2005-2009 time period.⁴³ The prevalence increased when the focus of analysis changed; it was found that 48 percent of the individuals receiving behavioral services

⁴¹ International Association of Chiefs of Police, *Building Safer Communities: Improving Police Response to People with Mental Illness: Recommendations from the IACP National Policy Summit* (June 2010).

⁴² Nebraska Department of Health and Human Services. Nebraska Department of Correctional Services. Nebraska Behavioral Health and Criminal Justice Report (Dec 2009).

⁴³ Nebraska Department of Health and Human Services. Nebraska Department of Correctional Services. (2011, April). Nebraska Behavioral Health & Criminal Justice Joint Statistics Brief: April 2011.

were also admitted to the jail system at least once during the 5-year period. Of those admitted to jail, 32 percent were admitted before receiving services from community-based behavioral health providers and 25 percent were admitted after receiving such services. There was a slight decrease in jail admissions after receiving behavioral health services. The findings in 2011 do not significantly differ from the findings in 2009. There is no description of the methodology used in the 2011 brief report, but it spanned the same study years as the 2009 report.

Maryland

The Maryland DataLink initiative began in 2006 when the Mental Health Hygiene Administration, the Maryland Department of Public Safety and Correctional Services, and the State's Care Service Agencies developed and implemented the data-sharing initiative. The main goal of Maryland DataLink is to promote the continuity of treatment for individuals with serious mental illness who are detained in local detention centers.⁴⁴ The Mental Health Hygiene Administration receives a daily file from the Maryland Department of Public Safety and Correctional Services of all individuals who have been detained and processed at local detention centers, have been incarcerated in one of the state's correctional facilities, or have been remanded to the Department of Parole and Probation. Data received from the justice system is compared to Medicaid eligibility data. If a match is found for a person in a local detention center, an automated process seeks mental health service authorizations, then sends the information to the electronic health record at the detention center for the medical staff to access.

Oregon

Benton County, Oregon is the focus of a study of the prevalence of contacts between police and individuals with mental illness. In the study, the authors examined some of the potential causes and consequences of the change in prevalence and provided policy suggestions, based on research, for more efficiently and successfully addressing contacts between individuals with mental illness and the police.⁴⁵

The overall number of contacts, measured by quantifying the use of "Peace Officer Custody" (POCS) which is an arrest that occurs because an individual is believed to be a danger to himself or others due to mental illness, dramatically increased between 2007 and 2011, and continued

⁴⁴ Maryland Department of Health and Mental Hygiene. Maryland Department of Public Safety and Correctional Services. Project Brief: Maryland DataLink.

⁴⁵ Butler B. Jails and Health Information Technology: A Framework for Creating Connectivity. Issue Paper. Community Oriented Correctional Health Services, 2013.

to rise through 2012. Between 2009 and 2012, the number of POCs increased more than 60 percent.

Among the recommendations for targeting and reducing the contacts between Benton County police and individuals with mental illness, was the formal establishment of inter-agency collaborations. To achieve such collaborations, the authors recommended:

- the development of memoranda of understanding between law enforcement and mental health agencies;
- legal consultation regarding HIPAA thresholds for personal health information disclosure;
- creation of a mental health court;
- providing CIT training;
- creating an on-site co-response team housed with law enforcement; and
- pursuing grant funding to develop the infrastructure to better manage the problem, empirically assess any policy change, and monitor the number of POC and mental health calls.⁴⁶

Summary of Opportunities

Public behavioral health agency administrators are asked to address the continuum of the issue from prevalence of mental health illness in jail detainees to effective diversion programs and effective treatment while maintaining safety. Much of this information, however, depends on the data capability of the criminal justice system. Based on the literature and advancements to date, there are a number of actions that can be taken to improve criminal justice system data (information) systems to develop a better mutual understanding of justice-involved persons with mental illness. As described throughout this paper, there are several intervention points in the criminal justice system that can be seen as opportunities for information exchange among systems. These intervention points can be conceptualized as part of the continuum of care, both for safety and treatment.

An initial consideration should be how to standardize the screening to identify mental illness. Screening must differentiate levels of mental illness to inform the most appropriate level and type of diversion program and the impact of diversion programs on the overall prevalence of mental illness in jail populations, as well as help identify the characteristics of persons not eligible for diversion. This report has identified at least two screening tools that can serve as the

⁴⁶ Akins, S. MD et al., *Law Enforcement Response to People with Mental Illnesses in Benton County: Executive Summary* (February 28, 2014), <http://liberalarts.oregonstate.edu/files/economics/akinsburkhardt28feb2014.pdf>.

basis for a standardized protocol across settings and over time. Public behavioral health agency administrators must consider their level of responsibility for the training of professionals for screening and evaluation, the standardization of documentation, and the minimum data sharing necessary to ensure continuity of care for persons with mental illness.

The prevalence of mental illness must be quantified to the satisfaction of both systems as prevalence rates are necessary to determine staffing and resource needs. Change in the prevalence rate can be interpreted in terms of both changes in the accuracy of screenings and in the characteristics of the population.

While it appears that courts prefer inpatient mental health evaluations, this may be a reflection of the perceived quality of the evaluation tools used to this point and the documentation produced. In order for the public behavioral health agency administrator to influence this flow, the competencies of community level evaluators and readability of their reports should be addressed.

Crisis intervention teams and jail diversion programs can be assessed using program evaluation models which specify the measures of effectiveness, cost considerations, and cost-offset implications. Diversion programs should identify the qualities that make them effective, for what type of person, and how that effectiveness has impacted recidivism. Evaluation results will be useful to the behavioral health agency in its dialogue with the criminal justice system in identifying effective programs for persons with mental illness and effective supports for staff of criminal justice programs.

The treatment of mental illness within jail settings has an impact on the continuum of care for the individual being served. Given that many local jails must collaborate with community behavioral health experts, the public behavioral health agency administrator's relationship to community providers must be strengthened on all levels to streamline collaborations across multiple mental health providers that serve persons before, during and after criminal justice involvement. The public behavioral health agency authority has a wealth of experience and clinical expertise, using contracted clinicians and employees, treatment modalities, and medications. Sharing this knowledge with criminal justice system administrators can reduce the burden on the criminal justice system, while demonstrating the value of collaboration for a common goal.

Effective treatment within criminal justice should consider the level of services reasonable to expect from jail personnel and level of contracting to community mental health or state psychiatric hospitals to assist jails in providing consistent treatment. For the public behavioral health systems, mental health treatment staff competencies in dealing with the complex issues of justice-involved persons should be evaluated. For criminal justice systems, competencies and

contracting for mental health services, staff safety, and medication formulary needs are important components of such an evaluation.

Effective custody and restoration of competency within the behavioral health system should also help to inform the most effective treatment for use in the jail/corrections setting after the patient/detainee is returned to corrections. This evaluation should also highlight patients deemed not to have a mental illness, focusing attention on any potential flaws in the referral process to understand how these patients get mandated for evaluation. The behavioral health system can educate the criminal justice system on resources needed to address maintenance of mental status and continued movement toward recovery.

Interagency collaboration on understanding and improving the continuum of mental health services to justice-involved persons with mental illness will allow both the behavioral health system administrators and the criminal justice system administrators to begin to address more complex questions such as:

1. Understanding the trajectory of individuals across systems and through the criminal justice system, identifying the points of contact with multiple agencies, and which interventions have a positive impact on outcomes.
2. Identifying the cause of the increase in forensic evaluations.
3. Identifying improvements to community crisis services, specialized police responses, and post-booking programs that lower the number of persons with mental illnesses entering jails.
4. Adapting specialized response models that can be effective in communities with limited access to mental health resources.

Public behavioral health agency administrators have developed more sophisticated data systems over the past several years to address their own systems and outcomes issues and to more effectively report to federal funders using common platforms. Public behavioral health has been using a continuity of care model to improve information flow coincident to patient movement. Defining the critical information for entry, service, and exit has benefited from a collaborative approach involving all entities to ensure each provider's role within the individual's care continuum are understood. This model can be applied to justice-involve persons with mental illness. Addressing the complex needs of persons with mental illness in the criminal justice system should be the next step in the evolution of sophisticated data systems, resulting in a collaboration of the behavioral health and criminal justice systems to benefit inmates and detainees with mental illness through shared decision-making and the efficient and appropriate allocation of limited fiscal resources.