



PIMA COUNTY

“Decriminalizing Mental Illness”

Conference

May 16 – May 17, 2017
Tucson, Arizona

Welcome

Ellen Wheeler, J.D.

Assistant County Administrator

Pima County



PIMA COUNTY

Hon. Kyle Bryson
Presiding Judge
Arizona Superior Court
in Pima County



PIMA COUNTY

Hon. Scott Bales
Chief Justice
Arizona Supreme Court



PIMA COUNTY

Keynote Speaker

Hon. Steven Leifman

Associate Administrative Judge

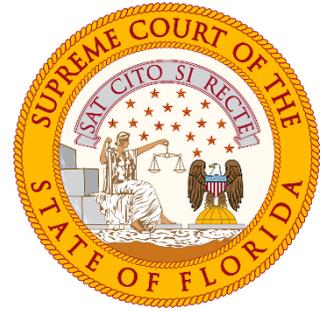
Miami-Dade County

Criminal Court Division



PIMA COUNTY

Leifman Video Here



JUDGE STEVEN LEIFMAN
Chair, Task Force on Substance Abuse and
Mental Health Issues in the Court
Supreme Court of Florida

Thank you very much for the opportunity to be here and for your interest in the intersection between criminal justice and mental health.

When I became a judge, I had no idea I would become the gatekeeper to the largest psychiatric facility in the State of Florida; the Miami-Dade County Jail.

While the United States has 5% of the world's population – we have 25% of the world's inmates! 1 in 4 of the world's inmates are in U.S. jails/prisons.

1 in 104 adults in the U.S. are behind bars today
1 in 33 adults in the U.S. are under correctional supervision

Since 1980 the number of people going to jail has tripled and time of sentences have increased by 166%.

As you drill deeper into these numbers what you find is that much of these increases are due to untreated mental illnesses and substance use.

In fact, people with mental illnesses in the U.S. are 9 times more likely to be incarcerated than hospitalized. They are 18 times more likely to find a bed in the criminal justice system than at a state civil hospital. Annually, 2 million people with SMI arrested, on any given day 360k in jail another 760K on probation/community control. 40% of all people with SMI's will come in to contact with the criminal justice system at some point in their life.

This is a shameful American Tragedy that must and can be reversed.

Drugs and Alcohol also account for a huge part of this problem. 65% of all inmates in jail and prison in the U.S. have a diagnosable substance addiction and 85% of all inmates in jail and prison meet criteria for substance abuse.

Counties spend approximately \$80 Billion annually on jails!

I. **The Forgotten Floor VIDEO – “Things do change” Last January the forgotten floor was closed...**

II. **My Journey into the MH World – Psychiatrist Story**

III. **3 Lessons**

i. MH Crisis in Miami-Dade

9.1% gen pop (192,000 adults/55,000 children – only 1% 24,000 receive services thru st funded community mntl hlth sys
35% of inmates (1,526 on psychotropic meds/4400 inmates)
\$400k per day - \$150 million annually
Until recently 3.5 floors out of 9
Since conditions NOT conducive to treatment -Stay in jail 4-8 x longer than no illness and Cost 4- 7 x higher than no illness
25 people died

ii Not local/State – But a national problem
SG Satcher – “Silent Epidemic of our times”

iii Community MH, Crisis System and laws– antiquated, fragmented – do not reflect modern science and medical research and practices and are in need of great reform.

After 17 years in this field, it has become quite evident to me that if we treated people with primary health needs the way we treated people with mental illnesses there would be massive lawsuits and criminal indictments for gross negligence.

IV. **If you would indulge me for one moment, I’d like to read from an article on Mental Health that I recently reviewed**

The past few years have seen an increasing amount of interest manifested in mental health and psychiatry.

The existing legal procedure treats a mentally ill person as a criminal instead of as a sick person [man]. Booking a mental patient at the police station is unnecessary and undesirable.

Police officers should be replaced by trained representatives of a hospital to affect the transfer of patients from their homes to the hospital or from one hospital to another.

All laws concerning mental hygiene should be integrated to eliminate inefficiency and duplication.

In the past, psychiatry has suffered because of its isolation from general medicine. Well-equipped psychiatric divisions in general hospitals are in keeping with modern ideas and principles of the

treatment of the person as well as of the disease, and they serve to foster the same general attitude towards mental illness as toward any other type of illness. Integrating psychiatry into the general practice of medicine is in line with modern trends of medical education and hospital practice.

COMMUNITY EDUCATION

While mental hygiene is everybody's job, the place of special training and experience must be tolerantly understood. Both lay interest and professional training are valuable, but only when they see their own limitations. Therefore, it is well for the mental hygienist, both lay and professional, to develop and preserve a sense of proportion in relation to his work and, above all, to cultivate that spirit of tolerance and cooperation which is the very essence of mental hygiene itself.

The article goes on and describes the importance of training;

1. **Parents** – that they may realize the full implications of their jobs as parents.
2. **Children** – that they may form the best habits, attitudes and character traits; that they may acquire self-understanding and self-control, together with the knowledge and insight necessary in handling internal conflicts and in adjusting to society.
3. **Teachers** – that they may live normal and efficient lives; understand their pupils, adapt themselves to the individual needs of the child and learn to lead and inspire rather than drive and thwart the children in their care.
4. **Physicians** – that they may have a greater understanding of the mental and emotional factors in the illnesses of their patients, recognize the beginning of mental illness and advise patients more wisely.
5. **Judges and jurists** – that they may have a better understanding of the mental, emotional and social factors underlying delinquency and crime and may develop understanding and a more tolerant attitude toward the services offered by psychiatric clinics and psychopathic hospitals.
6. **Clergymen** – that they may distinguish between sinfulness and illness, understand better the causes and conflicts of marital incompatibilities and become sensitive to the mental, emotional and social maladjustment of some of their flock.
7. **Employers and employees** – that they may learn greater understanding and become more tolerant of the needs of each other.
8. **The public in general** – that it may support wise measures for the promotion and preservation of mental health, take a more hopeful and less prejudiced attitude toward the mentally ill, and support the better study and care of mental patients and other poorly adjusted persons, such as the delinquent and the criminal.

These are just a few of the comments and Recommendations that were published in the American Journal of Psychiatry, in January of 1939 – 75 years ago.

It is so sad and tragic that when it comes to developing and funding an appropriate mental health system we have lost ground and frankly in many ways are worse off today than 75 years ago!

V HISTORY – Before we can fix the problem, we need to understand how we got here.

From the time our country was founded until the early 1800's we incarcerated people with mental illnesses – because we didn't know better. Around 1840, American Activist Dorothea Dix was visiting a Boston jail when she came across men freezing to death in a local jail – their crime – mental illness. She was so horrified by what she saw, she began a national movement in the US that started in France called Moral Treatment - to hospitalize people with mental illnesses rather than incarcerate.

By 1900, every state had a psychiatric hospital. However, there was no real treatment, no medication and really no psychiatry. These “hospitals grew rapidly – ignoring the idea of keeping them small – often housing thousands of individuals. They became houses of horror with human experimentation – insulin, electroshock therapy and even lobotomies become the norm.

In Florida, in the early 1800's we dealt with this problem by shipping people with SMI to GA and SC – where Florida paid these states \$250 per person per year to care for this individuals. We finally opened our first psychiatric state hospital in 1876 in Chattahoochee – a former Civil War Arsenal.

Early 1950 the 1st Psycho-tropic medication was developed – Thorazine.

In his last public bill signing, in 1963 President Kennedy signed a 3 billion dollar authorization to create a national network of community mental health facilities. The idea was to take people out of these horrible hospitals and return them to their communities and provide them with the newly created medications. Tragically, with the assassination of President Kennedy and the escalation of the Vietnam War not one penny of the 3 billion dollars was ever appropriated.

However, a whole slew of federal lawsuits was filed in the late 1960's against the states for operating these houses of horror – and in 1971 the 1st major case is decided in the federal court – Wyatt v Stickney which ultimately led to the “deinstitutionalization” of our state hospitals.

Ironically, the case initially had little to do with the conditions and treatment of the patients – it was about a tax cut and saving jobs!

Unfortunately, there was no national network of community mental health facilities to absorb these new patients.

And make matters worse, the closings continue today at an accelerated rate. In fact, since 1990 - twice as many state hospitals have closed than in the previous 20 years. And as predicted in 1972 by one of the leading experts on this issue – Abramson – we began the criminalization of mental illness.

VI The Impact is staggering

- 1955 - 560,000 in State Psyc. Hospitals around U.S./5,000 in custody
- Today, less than 40,000 in State Hospitals (if no change – today 1.5 million beds)
- However, last year 1.5 million people with mental illnesses were arrested.
- Approximately 360,000 people w/ Mental Illnesses in US Jail/prisons
- Another 760,000 people w/Mental Illnesses on Community Control/Probation
- For a total of 1.1 million people under correctional control
- Since 1955, the number of psychiatric hospital beds in US has decreased by more than 90 percent, while the number of people with mental illnesses incarcerated in our jails and prison has grown by more than 400 percent.
- In our own State of Florida, between 150k and 160k people with serious mental illnesses requiring immediate treatment are arrested and booked into Florida jails annually.
- **If you have a mental illness in Florida you are 30 times more likely to find a bed in the criminal justice system rather than a state civil hospital**
- Jails in the US ARE THE LARGEST PSYC Facilities (Warehouses).
- Approximately 25 percent of the homeless population has an SMI and over 50 percent of these individuals have spent time in a jail or prison.

VII TWO SAD AND HORRIBLE IRONIES:

1st - WE DID NOT DE-INSTITUTIONALIZE – WE ALLOWED FOR THE TRANSFER OF RESPONSIBILITY for people with mental illnesses from St. Psychiatric institutions to Correctional Institutions and in many cases put them in far worse conditions than the St. Hospitals they left, making it more difficult for recovery because a criminal record often leads to housing and employment restrictions.

2nd - The sadder and cruel irony is that in the US WE HAVE COME FULL CIRCLE - 200 years have passed and jails are again the primary warehouses for people with mental illnesses. It is the one area in civil rights in the US we have gone backwards. With all of the advances our society has made during the past 200 years, we have failed those with mental illnesses, miserably.

VIII Consequences

- Homelessness increased
- Police Injuries increased
- Police Shootings of people w/ mental illness increased
- Waste Critical Tax Dollars
- Mental Illness = Crime
 - In Florida the police actually initiate more Involuntary Examinations under our Baker Act Law than the total # of arrests for Robbery, Burglary and Grant Theft Auto – combined.

IX And if this wasn't disturbing enough - Just consider the fiscal impact our existing system is having on our local and state budgets and the projected impact over the next decade.

A. LOCAL (Miami-Dade) We recently looked at the “heavy users” of acute services with mental illness in our misdemeanor diversion program over a 5 year period. The results were breathtaking.

A subset of 97 participants (5 percent of all individuals), identified as “heavy users” and defined as people who have been referred to the CMHP for diversion on four or more occasions as the result of four or more separate arrests, have accounted for nearly 700 program referrals (22 percent of all referrals).

Individuals in the heavy users group have been referred for diversion services an average of 7.1 times each. By contrast, the remaining 1,711 individuals served by the CMHP have been referred for diversion an average of 1.9 times each. 85 individuals in the heavy users group have been diagnosed with a SMI, 75 of who were diagnosed with a schizophrenia spectrum disorder.

Event type	Total events	Average per individual over 5 years	Average per individual, per year	Estimated per diem cost	Estimated total cost
Arrests	2,172	22	4.4	-	-
Jail days	26,640	275	55	\$134	\$3.6 million
Baker Act initiations	710	8.6	-	-	-
Inpatient psychiatric days	7,000	72	-	\$291	\$2 million
State hospital days	3,200	33	-	\$331	\$1 million
Emergency room days	2,600	27	-	\$2,338	\$6 million
Total jail/inpt/hosp/ER days	39,440	407	81	-	\$12.6 million

Note: Number of events reported is based on information available in state and county archival databases. Due to incomplete reporting, actual utilization rates and costs are likely higher.

I guarantee everyone in this room lives in a community with 97 individuals just like the ones I described that are driving our acute care systems with little or no strategy to deal with these individuals.

B. Florida's Forensic Competency Restoration System (TRUEBLOOD DECISION – Washington State - April 2015)

When an individual who is charged with committing a felony and then found incompetent to proceed and unwilling to accept treatment – they are sent to a State Forensic Hospital for competency restoration.

The State of Florida currently spends 22% of its entire adult mental health budget – approximately \$135 million dollars annually for 1500 forensic beds serving approx. 2,500 individuals; most of whom are receiving services to restore competency so that they can stand trial on criminal charges and, in most cases, have their charges dropped or they are sentenced to time served or probation than released back to the community without any referral or access to appropriate mental health treatment.

The majority of individuals who currently enter the forensic treatment system do not go on to prison. Rather, approximately 70 percent return to court and either have their charges dismissed for lack of prosecution or the defendant takes a plea such as conviction with credit for time served or probation. Most individuals are then released to the community, often with little or no community supports and services in place. Many are subsequently rearrested and return to the justice and forensic mental health systems, either as the result of committing a new offense or failing to comply with the terms of probation or community control.

INSANITY – Doing the same thing over and over again and expecting a different outcome!

C. AND IF THIS WASN'T BAD ENOUGH, JUST CONSIDER THE IMPACT ON OUR PRISONS:

Historically the fastest growing subpopulation in Florida's prisons and in most American prisons are people with mental illnesses

Between 1996 and 2012 the overall inmate population in FL prisons grew by 56%.

In contrast, the number of inmate receiving ongoing mental health treatment increased by 153%. 7,000 – 17,000. Inmates experiencing moderate to severe mental illnesses increased by 170%

It is growing so fast, that the number of prison inmates is expected to almost double over the next 10 years from 17,000 to more than 30,000 requiring Florida to build 10 new prisons. The cost to build and operate 10 new prisons just for people with mental illnesses over a 10 year period is almost \$2.2 Billion. The average inmate with mental illness only spends between 2 and one half years and 4 years in prison.

There is something terribly wrong with a society that is willing to spend more on imprisoning people with mental illnesses than to treat them.

If we do nothing to change or re-design our mental health system – the US and many other countries will be looking at spending billions of additional dollars over the next ten years to deal with the increases in the forensic system, prison and the juvenile system.

X Where to Start The Miami-Dade Approach: It starts at the local level – **(80% solution)** – Cross System collaboration **(STEPPING UP – CNTY RESOLUTION)**

While more and more judges are becoming involved in this issue, the reality is that none of us can fix this problem alone. It is going to take a collaborative effort between the judiciary and all the non-traditional

stakeholders - such as law enforcement, St. Atty., Public Defender, Corrections, DCF, local AND county government, mental health providers, primary health providers, hospitals administrators, family members and consumers.

For many years there was recognition that our forensic mental health system was a disaster – in need of a total overhaul. We began this reform in June of 2000 by holding a 2 day Summit with the assistance of the GAINS Center – who provided us with three nationally recognized **experts** to help us analyze and reform our system. I personally invited all of the traditional and non-traditional stakeholders to this 2 day meeting – where no one was allowed to leave until we had some solutions. Everyone invited, attended.

I tried this 18 years earlier as an Assistant Public Defender – NO ONE CAME.

What was most impressive about the summit was that everyone in attendance agreed we had an enormous problem and the realization that the problem was not being addressed because we were all so busy doing our jobs – no one was looking at the system as a whole.

Judges-Judging, Police Policing, Prosecutor-Prosecuting, PD-Defending. No one was looking at the entire system when in fact this population was utilizing the resources of everyone in that room and then some. There is No other population of individuals who utilize so many different expensive resources.

As the story of the Psychiatrist illustrated, we also realized that our system was

Embarrassingly Dysfunctional!

Example – Jail Division

Arrest Possn of a dairy Cart

3 evals @ \$150 each

2-3 weeks in jail

St. v Onwu (692 So.2nd 881 Fla.1997) Now codified into law

An analysis of our mental health jail population showed us that 10% of the defendants with mental illnesses were making up 70% of the misdemeanor jail beds.

As a result of Summit:

1) Analyzed System (**MAPPING**)

2) Produced Goals (w/Seattle Experience in mind) Must develop a system that works for people w/ MI – not a 9-5 M-F Disease – ALSO, Understand that while this is a public safety issue – the vast majority of people with SMI’s are much more likely to be victims of violent crimes than perpetrators of violent crimes.

3) Produced Cooperative Agreement - Signing ceremony

4) Created 11th Judicial Circuit Criminal Mental Health Project

5) Gave tours of our jail mental health floors to all of our county commissioners, mayor and local state legislators.

6) Began to collect as much data as possible.

7) Looked at ways technology could be used to help identify inmates with mental illnesses and link treatment and services with existing providers.

After many task forces, including a Judicial Committee, Three Grand Jury Reports, and A Mayors task Force we have Developed program – with a simple goal that reads: *Diversion and Linkages to Comprehensive Care Makes Jail the Last Resort*

- Pre - Arrest Diversion/CIT – 5,100 Officers Trained 36/36 Agencies – 16,000-19,000 CIT calls Annually - **2010-2017-71,628 CIT Calls ONLY 138 Arrests**
LARGEST REDUCTION OF A JAIL AUDIT Over 7,300 – 4,000 **CLOSED A JAIL \$12 million dollar savings! Reg. Mtgs. CIT Coalition**
- All 911 Call Takers Trained/Executive Training Program
- Post - Arrest Diversion Misdemeanor/Felony
- ALF - Quality of Care Program
- Developed Staff – Project Coordinator, Court Case Mngt. Specialist, Peer specialist (funded by county, state and fed)
- Intensive Case Management/FACT Team
- Immigration Program - 7 Categories of Benefits/St. \$
- Computer Linkages- HMIS System
- Research - FIU/Health Foundation & DCF
- Transition & Housing Program/Homeless Trust – Receive approx 2 million developed low demand model w/ wrap around services
- Voluntary ID Card System
- Quarterly Newsletter

- Partnerships/Soc. Security, Homeless Trust, FL PIC
- Regular Meetings
- GAP Funding
- SOAR – Federal Expedited Benefits Program (SSI/SSDI Outreach Access and Recovery) (90% eligible 1st applic. – 30 days approval)
- New Jail Screening Tool (Osher & Steadman)
- \$1 Million SAMSHA Grant – Now funded by county
- Acquired new diversion forensic facility (\$22 million Bond Issue) Operational - 2016
- 2 - \$1 Million Dollar Florida Criminal Justice Mental Health Substance Abuse Reinvestment Grants (after CA) to Expand to Felony Cases and for re-entry
- \$1.7 Million Forensic Diversion Program (MDFAC)
- \$1.2 Million Grant from Bristol-Myers Squibb Foundation to test and evaluate the essential elements of a coordinated system of care for individuals with serious mental illnesses involved in the criminal justice system
- Coordinated Care through our Behavioral Health Managing Entity – which just began the implementation of an Electronic Utilization Management System.
- Using Advanced Technology to create a care coordination system of care - (Test site to test the use of Predictive Analytics for behavioral health)

XI OUTCOMES

- Since 2001, the post-booking jail diversion program is estimated to have served more than 4,000 individuals. Recidivism rates among misdemeanor program participants has decreased from roughly 75 percent to 20 percent

Felony Jail Diversion Program (FJDP) - Outcomes to date demonstrate:

- 75% reduction in number of bookings and days spent in the county jail, resulting in roughly 25,000 fewer days in jail (**nearly 68 years of jail bed days**).
- 70% of participants successfully complete all program requirements.
- 6% recidivism rate among individuals who successfully complete the program.
- 14 % rate of arrest for new offenses following program enrollment across all participants.
- SOAR more than 90% approval rate for federal entitlement benefits in approximately 40 days - compared to approval rates of less than 40% in 6 to 9 months prior to program implementation.

- Improved Public Safety
- Reduced Police Injuries
- Faster return to patrol
- Saved Critical Tax Dollars
- Saved Lives
- De-criminalized Mental Illness

And as good and successful this has been – limited – because our states mental health system is too fragmented and antiquated to provide adequate treatment and services for our most acute population. Diversion is great – but if the services are inadequate – it will fail. We need comprehensive seamless system of care.

XII So what we have learned after 17 years is that much of this is fixable at the county level (80% community solution) The 14 Essential Elements for an effective community system of care

- 1) Proper Diagnosis and Treatment
- 2) Move upstream – Typical or Troubled?
- 3) Intensive Case Mngt. Services
- 4) New approaches towards individuals w SMI – Open Dialogue
- 5) Trauma Related Services 92% of woman sexually assaulted 75% men
- 6) Meaningful Day Activities – like a CLUBHOUSE – Dr. Kandel – it actually has a physiological benefit that helps people recover. Every community mental health system should work to develop or link with a Clubhouse in their community. It should be standard practice and covered by Medicaid.
- 7) Treat long –term institutionalization (Snitch & Stitch Disorder) with program like (SPECTRUM)
- 8) Supportive Housing
- 9) Supportive Employment
- 10) Peer Specialists
- 11) SOAR (SSI/SSDI Outreach Access and Recovery)
- 12) Address the Clinical and Criminogenic factors with cognitive behavioral programs
- 13) Coordinated Criminal Justice Response – Pre/Post Arrest Diversion/Mental Health Courts & CIT
- 14) Use advanced technology to eliminate the fragmentation of the community mental health system, to better manage individuals with Serious Mental Illnesses and to develop evidence based treatment protocols for effective outcomes – Otsuka project

XIII The Remaining 20% solution

- i We need to Reform Involuntary Hospitalization Laws – Based on 1700 English law – dangerousness – Psychotic episodes are more like Congestive Heart Failure of the brain – toxicity. Heart attack – don't run to court first – particularly after all other efforts have failed.
- ii We must convince policy makers to fund the services that work – not just “medically necessary” services. By supporting some of the essential elements described above we would achieve much better outcomes. We have to develop treatment systems that are warm & welcoming – that encourage people to seek help not fear it. (Cancer Centers of America)
- iii. Dedicate additional resources – treat like any other illness

XIV The current shortcomings of the community mental health, criminal justice, and juvenile justice systems did not arise recently, nor did they arise as the result of any one stakeholder's actions or inactions. None of us created these problems alone and none of us will be able to solve these problems alone. We all must be a part of the solution.

If we are able to do this, we will finally begin to accomplish what the SC hoped would happen when they ordered the deinstitutionalization of our state hospitals.

Thank You.

SUPREME COURT RECOMMENDATIONS

1) The 1st Recommendation was the development of a competent/appropriate community mental health system that was capable of caring for this acute population – which most existing community mental health systems cannot do.

Under this new proposed system – providers would have to demonstrate the ability to deliver effective, high quality services incorporating best practices and communities would have to demonstrate ongoing, collaborative relationships with state and local criminal/juvenile justice and community stakeholders and also incorporate best practices. Including CIT/Judicial Diversion Programs

To ensure real system change or transformation in each community we suggest that the state require that all local providers and communities be certified before they can participate in new funding.

For instance, this new system of care would have to include Trauma Services, Case Management services, day activities, Diagnosis and Medication management, Housing, Employment.

This would allow the state to develop a competent community mental health system that was capable of caring for the most severe adults and children who are at the greatest risk of criminal justice or mental health institutional involvement.

The last thing we wanted to do was spend more money on an existing system that doesn't work. Under this scenario, we believe we can assure a new level and more effective system of care.

Fortunately, because this is a relatively small percentage of the mental health population – you can target services for this very well defined group of individuals who because of the severity of their illness are accessing the most expensive and ironically least effective services the state has to offer – making it difficult if not impossible to appropriately fund the rest of our mental health system.

So how do you pay for these enhanced services and sustain them once created?

Though some front end dollars will be needed for start up cost, the implementation of these proposals will save a great deal of general revenue funds. Just spending more money in the existing system of care will not fix this problem. We need to establish a new level of care for the most acute population that is currently utilizing our most expensive and least effective systems. To accomplish our goals we recommend phasing in our program over a six-year period.

2) 2nd recommendation – target the two or three counties that are over utilizing the state forensic system. As stated earlier, the legislature appropriated 48 million dollars to open 300 forensic beds to eliminate the backlog of people awaiting forensic hospitalization. DCF smartly contracted these beds with a clause in the contract allowing them to terminate with 30 days

notice. We recommend ways to pull 300 people out of the forensic system – allowing DCF to either cancel these contracts or shut down existing forensic facilities thereby freeing up 48 million dollars to be re-invested in the front end of the mental health system. (This should be coordinated with the Criminal Justice/Mental Health Substance Abuse Reinvestment Grant Program, which is helping communities develop the necessary infrastructure to keep people with mental illnesses out of the criminal justice system.)

3) We recommend establishing a multi-tiered level of care classification system that targets individuals with the highest risk of institutional involvement in the criminal justice, juvenile justice and state mental health systems to ensure adequate services in times of acute need.

4) We recommend the creation of a statewide limited enrollment Integrated Specialty Care Network under a newly authorized Medicaid State plan option – Specifically tailored to serve individuals with SMI/SED who are involved in or at risk of becoming involved in the justice system or other institutional levels of care. Thereby leveraging federal monies and greatly reducing state general revenues to these expensive – ineffective systems. Instead of spending 100% GR at DJJ, DCF and DOC only 40% in many cases would be needed to provide better and more effective treatment for the same population that is accessing the expensive and deep end programs.

5) We target both those at risk of criminal justice/juvenile justice and those already in those systems because we don't want to set up an incentive for people to get arrested to get this higher level of care.

6) To maximize funding streams with Medicaid dollars we recommend that a partnership be developed between these DCF and AHCA to better serve both individuals who are and are not covered by public benefits. What we found was that Medicaid is spent one way on individuals with mental illnesses – while DCF may spend mental health \$ entirely differently – resulting in the inefficient spending of these limited resources.

7) In addition, we recommend that all providers under this new Integrated Specialty Care Network have contracts that specifically require measurable outcomes to ensure appropriate treatment and outcomes.

8) We also took a hard look at the juvenile system and make several recommendations to help assure that our youngest and most vulnerable with mental health issues are better screened, and provided access to appropriate and competent care. These recommendations extend beyond the delinquency and juvenile justice system to include services targeting infants, children, and adolescents involved in the dependency and foster care system and child protective services. Among these specific recommendations are services and interventions targeting:

- Mental health screening and assessment in the juvenile justice and foster care systems.
- Use of evidence-based practices in the juvenile justice and foster care systems.
- Early childhood development and reactive attachment disorder among infants and young children involved in the foster care system. (EXPLAIN)

- Psychotherapeutic medication prescribing practices in the foster care system. Better info for Judges/Less reliance on meds)

9) Judicial Education

Available at: http://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf

Panel Discussion
Behavioral Health Court

Moderator

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Cochise County Administrator

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PIMA COUNTY



Amelia Craig Cramer, Chief Deputy Pima County Attorney

We have a problem.

More than half - indeed about 60% - of the people in our local Pima County Adult Detention Facility (more commonly known as the Jail) suffer from mental illness or a substance use disorder or both.

That means there are more than 1,000 individuals on any given day incarcerated in our jail who are in need of treatment for mental health and substance use disorders. It has been noted that our Jail is the largest mental health treatment provider in southern Arizona.

This is a problem because the Jail is not the most therapeutic environment for treatment of mental illness or addiction. Indeed, because many individuals suffering from mental illness and addiction are trauma survivors, and because residency in the Jail can be a traumatic experience, the Jail is, in fact, a non-therapeutic, contra-indicated environment for treatment.

Incarceration can make people suffering from mental health disorders worse, not better. Evidence-based research has demonstrated that incarceration of non-violent individuals for extended periods can actually increase their recidivism.

The National Association of Counties last week published an article regarding the Stepping Up initiative in which Pima County is participating, noting that there is a "revolving door of jailing the mentally ill," noting that this "is one of the foremost challenges faced by counties across the country, sucking up valuable budgets, time and space, not to mention the toll it takes on mentally ill residents and county employees."

In other words, the problem is the incarceration of those who suffer from these medical conditions, particularly those who are not violent nor dangerous.

We need to find a way to treat these mental health conditions with best medical practices to achieve better medical outcomes, to reduce recidivism, and to reduce decompensation and relapse.

We need to find a means by which to protect public safety, to protect and serve victims of crime, and at the same time to provide therapeutic treatment that works for those whose criminal activity is caused by their mental illness or addiction or both.

As a prosecutor, I often have to look at photos and other evidence and hear personal stories of crime victims recounting cruel and heinous acts of violence and abuse perpetrated against them. Some of it is truly horrifying.

My heart breaks for the men, women, and little children who have been tortured, sexually assaulted, even murdered by violent sociopaths. There is no excuse for such evil acts.

I am not troubled; in fact, I am comforted, by sending those who commit such horrific crimes to jail and prison to ensure they are off the streets where they cannot violate any more innocent victims. I believe that incarceration is an appropriate consequence for such crimes because it serves to protect public safety and to deter future criminal activity by the individual perpetrator, as well as by others. I make no apology for sending murderers, rapists, and child abusers to prison for extended sentences.

But, at the same time, as someone involved in the administration of the criminal justice system, I have seen many individuals who have committed non-violent criminal acts incarcerated while they await the disposition of their cases through a trial or a plea bargain. Some of these individuals have only committed misdemeanors - low level crimes. They do not pose a significant danger if released onto the streets. They are unlikely to hurt anyone. Moreover, if convicted, they are likely to be sentenced only to probation, not incarceration.

Some of these people are kept in the Jail during the *pretrial* phase of their criminal case because bail is imposed, and they cannot afford to pay bail. Sometimes, bail has been imposed by the court in order to assure the individual's appearance at future court dates because he or she has failed in the past to appear for court dates in other cases.

I witnessed this situation a couple of years ago when I visited the Mental Health Court in Justice Court. A woman was brought into court after spending 45 days in jail because she was unable to make bail after being arrested. During her incarceration in the jail, she was treated for mental illness and restored to competency. She had been arrested on a failure to appear warrant. The warrant had been issued for her failure to appear two years prior in a misdemeanor case. That case involved her stealing a candy bar. At her court hearing, the woman pled guilty and was sentenced to probation, with the only condition being that she make contact with a mental health service provider. She spent 45 days in jail *pretrial*, even though her ultimate sentence did not involve any jail term.

Some have said they suspect that criminal defendants are defiant, disrespectful of the court and the law and that this is why they have failed to appear for court dates. Yet, upon inquiry, we find time and time again that the failure of a significant number of individuals to appear for scheduled court hearings is not the result of willful defiance, not fleeing or absconding from the jurisdiction in an effort to evade justice, but rather it is a passive result of their disability - either mental illness or addiction or both.

We are doing nothing to protect the public by incarcerating these non-violent individuals who suffer from mental illness and addiction.

While they need to be held accountable for their criminal acts and to make restitution to any victims whose property they took or damaged, incarceration often is not the appropriate consequence, especially during the pretrial phase.

For this reason, the Pima County Attorney's Office is proud to be partnering with the Court's Pretrial Services Division and County Administration in the Safety + Justice Challenge to provide the court with alternatives to bail for non-violent, non-dangerous individuals, especially those charged with misdemeanors.

We need to invest in a much broader range of pretrial options and consequences to give those for whom incarceration is not the solution. And we need those options to include the availability of treatment and recovery.

We know these types of alternatives to incarceration can work. The Drug Treatment Alternative to Prison Program (known as DTAP) was developed by Pima County Attorney Barbara LaWall as an alternative sentencing option for those who have committed non-violent, non-dangerous felonies due to their drug addiction. The DTAP Program has a rolling success rate of 65-70%, and the recidivism rate for those who participate in DTAP is less than half that for those who go to prison. Meanwhile, the DTAP Program costs far less than prison. This DTAP Program is a collaboration among prosecution, public defense, the courts, probation, health care authorities, and community based treatment agencies. It is a proven solution that saves lives and saves money at the same time.

Likewise, Pima County Superior Court's standard specialty Drug Court for those convicted the first or second time of felony narcotic drug possession has been a success at reducing recidivism through coordination among the court, probation, and community based service providers to help participants succeed. The Superior Court's felony Mental Health Court is another success. The Pima County Attorney is proud to have sought and obtained federal grant funding to enhance the services available to defendants in both of these felony specialty court programs.

We also have additional Mental Health Courts for those charged and convicted of misdemeanors in our Tucson City Court and our Consolidated Pima County Justice Courts. We have a very successful Consolidated Municipal Veteran's Treatment Court as well as a Justice Court Veteran's Treatment Court. These are very successful operations.

But, more needs to be done. We have no misdemeanor drug court, not in any of the Justice Courts, nor in any of the city or town misdemeanor courts. We need to add a drug court component to our misdemeanor problem solving courts.

And, some poor defendants who suffer mental illness and have been arrested on multiple misdemeanors may have cases pending in different courts. They might have one case pending in Tucson City Court, another in South Tucson City Court, and yet a third in Pima County Justice Court. It is difficult enough to keep track of one court date, much less three, particularly for someone suffering from addiction and mental illness.

And, the judicial consequences imposed by the different courts can sometimes be conflicting. So, we need a Consolidated Misdemeanor Problem Solving Court for non-veterans like we have for veterans.

The Pima County Attorney's Office is leading a team working to put together this Consolidated Misdemeanor Problem Solving Court and to find grant funding for it. We hope to have it operational by 2018. This is part of our work under the multi-year, federal Behavioral Health Treatment Court Collaborative grant obtained by the County Attorney, which helped fund our recent Sequential Intercept Modeling project here in Pima County through which we identified how those with mental illness interact with the criminal justice system at each intercept where interventions can be made – from pre-booking crisis intervention, to post-booking diversion, jail treatment and specialty courts, re-entry, and community corrections ongoing support.

One of the gaps identified through the Safety + Justice Challenge and confirmed through the Sequential Intercept Modeling project is that we need more diversion options.

We have robust diversion programs for juveniles and for adults who commit misdemeanors, but only a tiny diversion program for adults who commit felonies.

The Pima County Attorney, with the help of the new Community Bridges facility that recently opened downtown, is working to lead a team to institute a Felony Drug Diversion Program that we hope may serve as many as 50 arrestees each month.

Development of a Consolidated Misdemeanor Problem Solving Court with a drug court component and Felony Drug Diversion are just two of the solutions we in the Pima County Attorney's Office are working to put into place along with our partners in Public Defense Services, the Courts, Pretrial Services, Probation, Law Enforcement, Community Bridges, other community based agencies, and City and County Administration.

It is important that we complete these projects and more to ensure that we achieve both safety and justice in dealing with those who suffer from mental illness and addiction.

Thank you for being here to demonstrate your commitment to working with us to decriminalize mental illness and addiction.

Sheriff Mark Napier

Pima County



PIMA COUNTY

Sheriff Mark D. Napier



Since as far back as the 1950's our country has struggled with how to best address the mentally ill. In the 1970's the United States engaged in the well-intentioned deinstitutionalization movement which started with the noble aim of treating and rehabilitating mentally ill patients in the community itself, so to reduce human rights violations and mitigate their sufferings. In 1975, the film One Flew Over the Cuckoo's Nest hit theaters. Jack Nicholson's Oscar-winning portrayal of a mistreated patient further turned public opinion against mental hospitals. Human rights violations, which did occur behind impregnable walls of mental hospitals, now instead occur right in front of the opened eyes of society, as a result of mentally ill patients suffering in jails, prisons, and on the streets of our communities.

Deinstitutionalization has helped create the mental illness crisis by discharging people from public psychiatric hospitals without ensuring that they received the medication and rehabilitation services necessary for them to live successfully in the community. Deinstitutionalization further exacerbated the situation because, once the public psychiatric beds had been closed, they were not available for people who later became mentally ill, and this situation continues today.

About 2.2 million of the severely mentally ill do not receive any psychiatric treatment at all. About 200,000 of those who suffer from schizophrenia or bipolar disorder are homeless. That's an estimated one-third of the total homeless population in the United States. The streets of our communities have become holding areas for the seriously mentally ill. This is a sad commentary on our commitment to our fellow man. Ten percent of homeless are veterans who suffer from Post-Traumatic Stress Disorder or other war-related injuries. Our veterans often feel alone and unappreciated. The rate of suicide and substance abuse is staggering. We are not keeping our commitment to those who have served and sacrificed for our Country.

In many communities, the County Jail is now the largest mental health facility in the County. Most jails are neither well equipped nor particularly adept at providing healthcare services to the mentally ill. In fact, incarceration, separation from family and familiar surroundings can compound the effects of mental illness. The judicial process eventually ends with the person being released back into the community. We are surprised when mental illness once again appears acute and once again the person is incarcerated. This becomes a terrible, vicious and never ending cycle that with each cyclical rotation degenerates. A recent Department of Justice Report indicated that at midyear 2005 more than half of all prison and jail inmates had a mental health problem, including 705,000 inmates in State prisons, 78,000 in Federal prisons, and 480,000 in local jails. These estimates represented 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates. The findings in this report were based on data from personal interviews with State and Federal prisoners in 2004 and local jail inmates in 2002. At the Cook County Jail, an estimated one in three inmates has some form of mental illness.

At least 400,000 inmates currently behind bars in the United States suffer from some type of mental illness—a population similar to that of the cities of Cleveland, New Orleans, or St. Louis—according to the National Alliance on Mental Illness. NAMI estimates that between 25 and 40 percent of all mentally ill Americans will be jailed or incarcerated at some point in their lives.

Could deinstitutionalization contribute to the rise of mass shootings? Since 1976, there have been 20 mass murders a year on average. J. Reid Meloy, Ph.D., is a forensic psychologist who has studied them. He found that mass murderers suffer mental illnesses that range from chronic psychotic disturbances, schizophrenia, and paranoid disorders. They have the paranoid, narcissistic, and schizoid traits of personality disorders.

These were not otherwise normal people who simply "snapped." Instead, they suffered for years from untreated or poorly treated mental illness. Most had planned the shooting for years. Meloy argues that behavioral threat assessments are available that are our best hope of prevention. Still, we have failed to act or fully recognize the causal relationship between these horrific acts and mental illness. We seemingly wait for another tragedy to hit the media and once again search for answers. The news cycle turns and our attentions are once again directed elsewhere.

Degenerative behavior and the failure of the system to properly address mental illness can lead to other tragedies. Officers confronted with a person acting out violently due to an acute episode of mental illness may have little option other than the use of force. Unfortunately, this is sometimes deadly force. The deinstitutionalizing of the severely mentally ill prompted increased interactions with law enforcement officers. Law enforcement officers traditionally have not been well trained or equipped to address these persons effectively. We know that it takes a special skill set to effectively interact with the severely mentally ill. Over the past few years, we have recognized the use of force and its potential outcomes is very often tragically unnecessary. We have started providing better training to law enforcement officers. This training helps them to recognize the signs of mental illness and develop more effective intervention strategies. Still tragedies occur.

Mental illness is not something people elect to be afflicted with any more than any other medical condition. Yet, it is probably the only medical condition that will often lead the person suffering to be labeled a criminal and incarcerated. Mental illness is not a crime, it is a healthcare issue. However, our jails and prisons are full of people whose real crime is being mentally ill.

Since the deinstitutionalization of the mentally ill in the 1970's community based alternatives have been slow to develop and keep pace with the demands. Additionally, jails have been slow to evolve in their approach to addressing this inmate population and their special needs.

We are fortunate in Pima County to have a robust array of community based alternatives. We have excellent strategic partners in the addressing of the mentally ill when they become intertwined in the criminal justice system. At the Pima County Jail, we have begun to see our role differently with respect to these inmates. We have moved from temporarily warehousing them to providing effective screening, housing and to better understanding treatment needs.

We work with our community partners to ensure that an inmate is not simply dumped back into the community, but is rather led toward resources. We ensure bridge medication is provided to offer a stable post-release period so that the person can pursue treatment and other support options.

When an officer encountered a person suffering mental illness, who was breaking the law or behaving dangerously, there used to be few options available. Officers often, by default, would find a reason to incarcerate the person as an expedient solution to the problem. This served to further the problem of criminalizing the mentally ill. Officers did not do this out of malice, but rather because there used to be few options available to them. Now we have provided an alternative drop off location for officers who may have previously taken a mentally ill person to jail. An officer can now take a person to the Crisis Response Center (CRC) and quickly release a person to care, rather than incarceration. This is a much needed community resource that law enforcement officers praise consistently. This has helped to significantly reduce the incidence of the mentally ill being taken to jail unnecessarily.

I am very proud of the work Pima County is doing to address decriminalizing the mentally ill. Our approach combines thoughtful use of resources, strategic partnerships and an enlightened commitment to solving the problem. That being said, there is more work to be done. We have to commit ourselves to a steadfast refusal to address a health problem like a crime. Incarceration is not an answer, it is rather a part of the problem. Incarceration is not a humane alternative in addressing this special population. It aggravates mental illness and has shown no promise in addressing the real issues confronting us. We still need a greater understanding that being mentally ill is not a crime.

Conferences like this provide the opportunity to recharge our commitment and share ideas. I am honored to be the Sheriff of Pima County and to work alongside such wonderful people pursuing such a noble undertaking.

Thank you.

Chief Chris Magnus

Tucson Police Department



PIMA COUNTY

CHANGING THE PARADIGM CHANGING LIVES

The Police-Mental Health Model in Tucson, AZ
and our efforts to move away from incarceration as the only public
safety solution

Includes slides, data, and other information provided by

Dr. Margie Balfour, ConnectionsAZ CRC

1 out of every 8 calls for police service . . .

"Some people have
absolutely nobody"



. . . in Tucson are for people in
emotional or mental health
crisis

Tucson police shoot, kill armed man in mental-health call; officers not hurt

Carmen Duarte Arizona Daily Star Jul 8, 2016

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[VIDEO: Man Threatens to Explode RV at Tucson Police Station, Standoff in Progress](#)

Many in mental crisis call Tucson police

Health agency to help TPD prioritize queries starting this summer

Darren DaRonco and Carli Brosseau Arizona Daily Star Apr 14, 2013

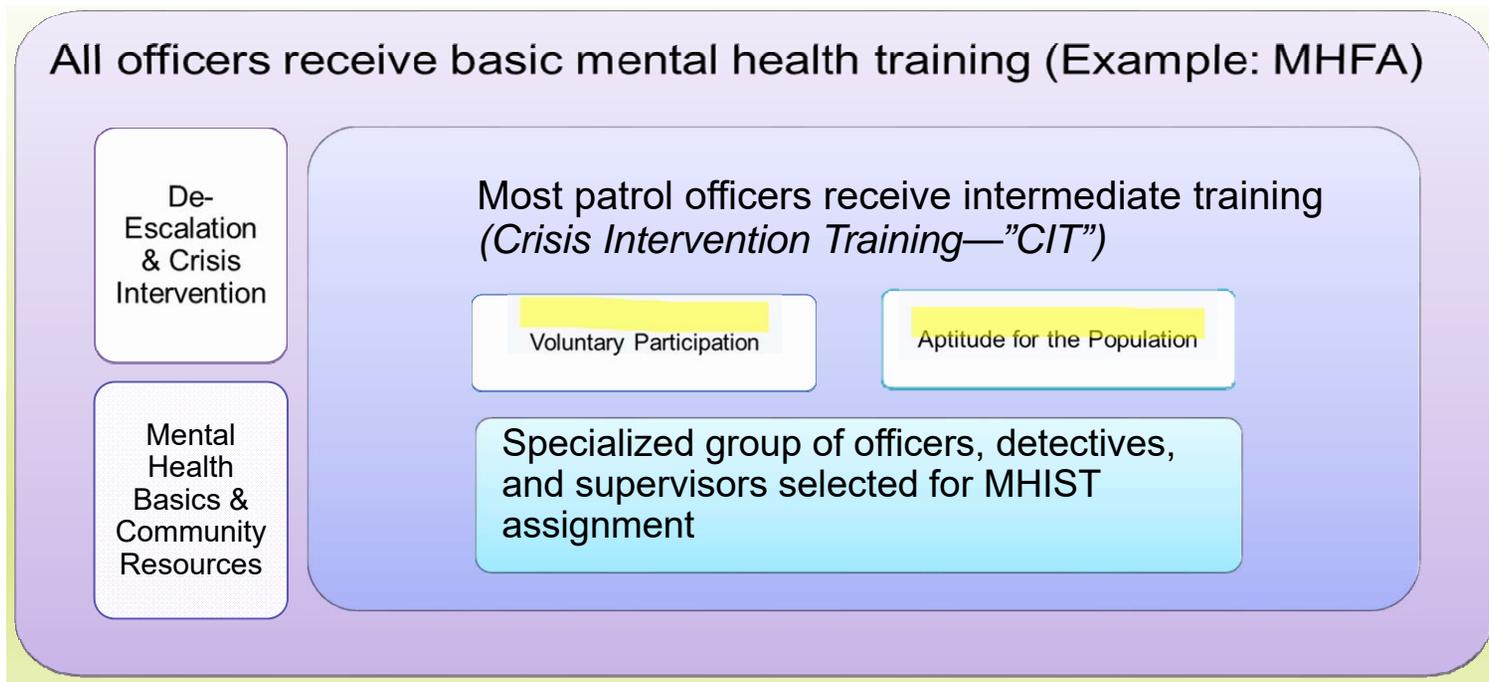
Respond: Write a letter to the editor | Write a guest opinion

f t e p b

Tucson Police Department receives more calls about mental illness than about burglaries or stolen cars....



MHIST and the TPD mental health response model



Drawing national attention for innovation



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Gathering Perspectives: Police Leaders Share Their Experiences



Tucson's Mental Health Investigative Support Team – a New Approach for Responding to Mental Health Calls for Service

Posted on August 30, 2016

The President's Task Force on 21st Century Improving police interactions with people

- adopting preferences for seeking
- embracing a guardian mindset
- engaging in multidisciplinary collaboration implementing, and responding to

Embedded with TPD's mental health unit

Published: Tuesday, July 26th 2016, 4:09 pm PDT
Updated: Tuesday, July 26th 2016, 6:07 pm PDT



The Tucson Police Department's Mental Health Investigative Team (MHIST) offers calls, the associated risks, and how it works to prevent a violent situation.



Tucson Police Department's Mental Health Investigative Team. (Source: Tucson News Now)

TUCSON, AZ (Tucson News Now) - The Tucson Police Department's Mental Health Investigative Team (MHIST) offered *Tucson News Now* an exclusive look at how the group handles calls, the associated risks, and how it works to prevent a violent situation.

Earlier this month, a tense confrontation between Tucson police officers and someone suffering mental illness ended with one man dead after police say he lunged at officers with a knife. The shooting, according to MHIST Sgt. Jason Winsky, was one of only a handful of cases resulting in someone getting hurt with the special unit on scene.

MHIST allowed *Tucson News Now* to cover an assignment Tuesday where the unit was tasked with taking someone to the hospital for court-ordered treatment. The unit handles many calls like this, but this one was especially high-risk because the man was believed to own guns and may have been taking drugs that could aggravate his symptoms of paranoia.

One officer approached the apartment to make contact, knocking, identifying himself, and letting the man know he's not facing charges. Officers communicated with the man via text message and coordinated with his family. It's all part of an attempt to put the person in crisis at ease.

At one point the unit swapped officers at the door. According to Det. Todd Schladweiler, the unit will have different officers make contact in case the person inside somehow finds that officer less threatening.

"If need be, we can go in and get the individual, but our goal is to talk him out," said Schladweiler.

Half an hour went by without a reply. Officers believed they heard someone inside, so they backed off to give the man some space. The officers moved downstairs. Eventually the man

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Previous Article Volume 68, Issue 2, February 01, 2017, pp. 211-212

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Frontline Reports

The Tucson Mental Health Investigative Support Team (MHIST) Model: A Preventive Approach to Crisis and Public Safety

Margaret E. Balfour, M.D., Ph.D., Jason M. Winsky, B.A., and Jill M. Isely, B.A.

Published online: February 01, 2017 | <http://dx.doi.org/10.1176/appi.ps.68203>

Citation Full Text Cited by PDF PDF Plus

"The Tucson Mental Health Investigative Support Team (MHIST) Model: A Preventive Approach to Crisis and Public Safety." *Psychiatric Services*, 68(2), pp. 211-212

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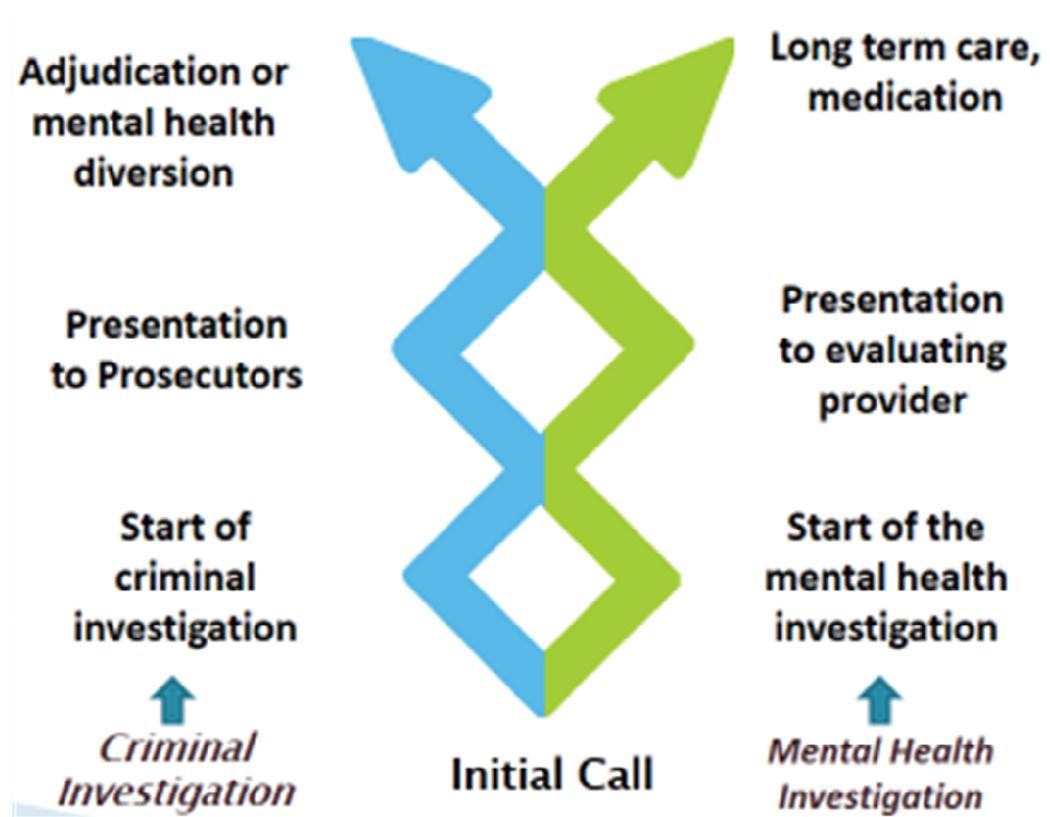


MHIST officers and detectives

- Focus on people already in the civil commitment system (Title 36)
- Address the needs of these people through centralized tracking and specialized training
- Prevent people in crisis or with a history of mental health who pose a risk to others or themselves from falling through the cracks
- Recognize patterns and connect people to services



MHIST investigation *(possible criminal nexus)*



Collaboration with the mental health system is key to success

- MHST had to make a concerted effort to engage and form partnerships with the mental health system
- Initial response from mental health providers was suspicion
 - *"I'm not going to help you get my patient arrested."*

Words that matter	Actions that mean even more
<ul style="list-style-type: none">• <i>"We're sorry that we have been missing before now."</i>• <i>"We want to be helpful."</i>• <i>"We want to share data with you, not just receive it."</i>	<ul style="list-style-type: none">• Showing up• Developing a dedicated team to devote attention and resources to this population• Investment in training

The Crisis Response Center (CRC)

- Built with county bond funds in 2011 to serve the community
 - 12,000 adults + 2,400 youth each year
- Alternative to jail, ED, hospitals
- **Serves as the law enforcement receiving center**
- Co-located crisis call center
- Space for community clinic staff and other partners



ConnectionsAZ/Banner University Medical Center Crisis Response Center in Tucson, AZ

Why the CRC “works” for law enforcement

- “No wrong door”
- The CRC does their best to take *everyone*:
 - No such thing as “too agitated”
 - Can be highly intoxicated
 - Can be voluntary or involuntary
- Fewer medical exclusionary criteria than many inpatient psych hospitals
- Law enforcement is never turned away



Otherwise, where would these patients go?

The CRC provides safe environment where people can be under **continuous observation** in a place where they **lack the means** to hurt themselves or others, in a setting as comfortable and welcoming as possible.



Crisis Response Center, Tucson AZ



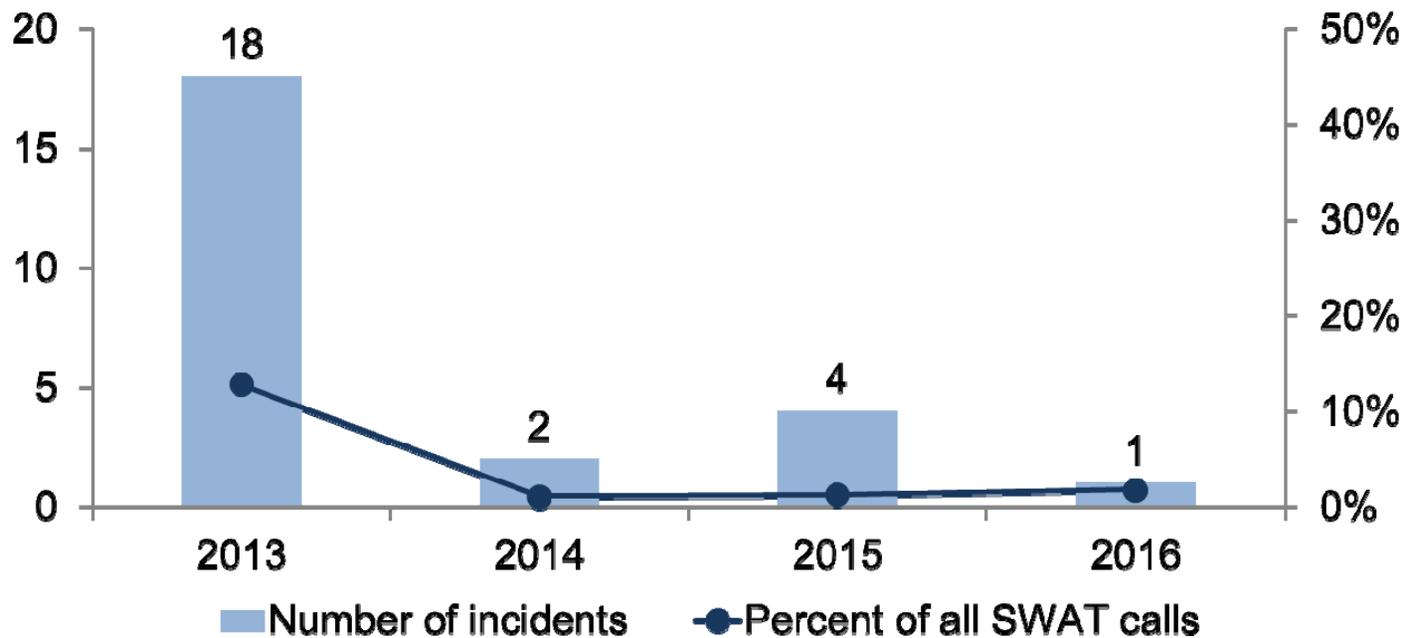
Tucson: 15 sworn personnel per 10K pop. Comparable cities: 23.7 officers per 10K

Jurisdiction	Average Total Personnel Per 10k Population	Average Officers Per 10k Population	Number of Agencies
50,000-100,000	20.4		
100,000-200,000	21.0	15.9	
200,000-500,000	24.4	16.1	419
500,000+	29.8	18.6	165
All Departments	21.4	23.7	73
		16.6	33
			690

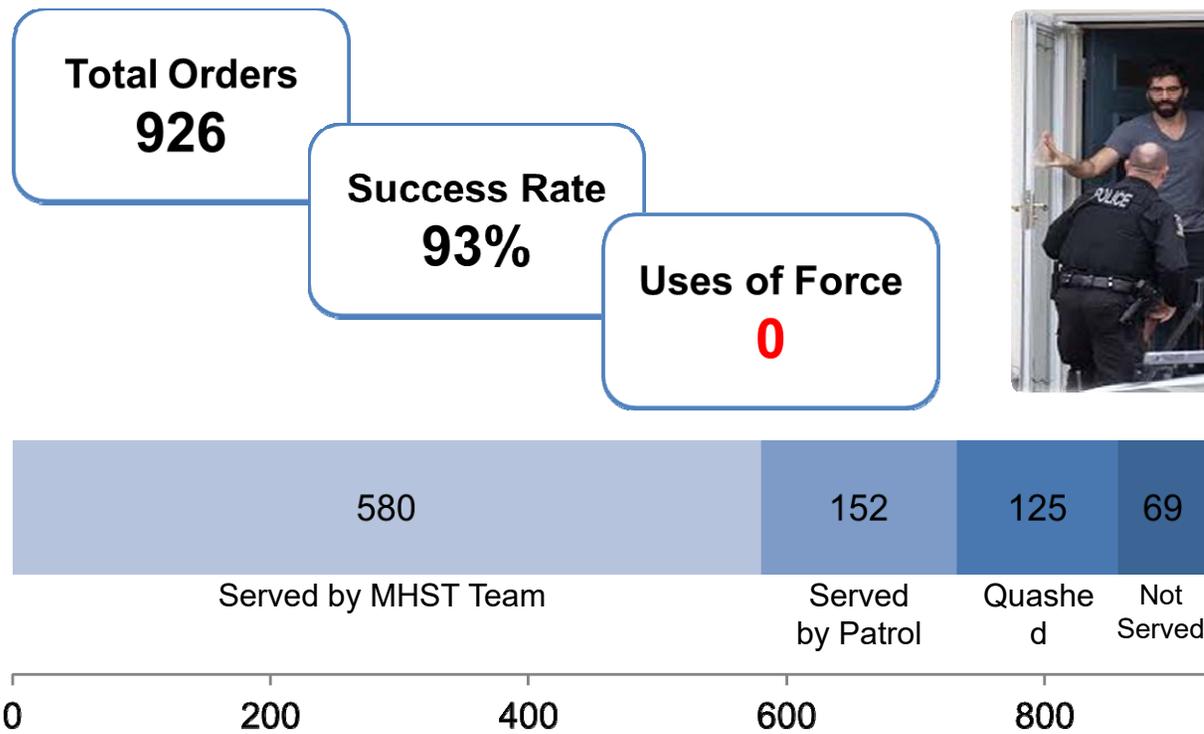
SOURCE: Governing calculations of 2015 FBI UCR data for cities of populations exceeding 50,000.

Scarce resources require smarter use of personnel

MHIST is better for the police: SWAT calls for suicidal/barricaded subjects



Civil Commitment Pick-up Orders 2014-2016



The “Jail Paradox”

- Police officers recognize many people “acting out” need treatment—not incarceration;
- . . . but they don’t know where to take them except the Emergency Room . . .
- where they know they’ll have to wait.
- So because they’re busy and calls are waiting,
- they take these people to jail instead.

- There are over **2 million** jail bookings of people with serious mental illness (SMI) each year.¹
- Nearly **half** of people with SMI have been arrested at least once.²

Prevalence of Mental Illness		
	Jail	US Adults ⁵
SMI ³		4%
-Men	17.1%	
-Women	34.3%	
Any mental disorder ⁴	76%	18%
+ Co-occurring substance use ⁴	49%	3.3% ⁶

JAIL: *the "non-solution"*

- Jails and prisons frequently lack the policies and trained staff to deal with this population
- Offenders with mental illness are incarcerated twice as long
- The mentally ill are three times more likely to be sexually assaulted while incarcerated
- They are more likely to be in solitary confinement which exacerbates psychiatric symptoms
- Jail is at least 2x the cost of community treatment



JAIL: But
wait,
there's
more . . .



**AT TWICE
THE COST!**



- Interrupts Medicaid and other benefits
- Hinders finding/keeping employment
- Make the incarcerated more likely to become homeless
- They're more likely to lose family ties
- They're more likely to be rearrested



PIMA COUNTY

Pragmatism over ideology

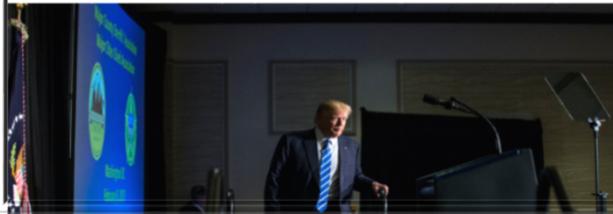
Republicans And Democrats Are Blasting The "Dumb On Crime" Sessions Order For Tougher Sentencing

Former federal prosecutors are also speaking out against a new order from Attorney General Jeff Sessions to pursue the most serious sentence possible against those suspected of crimes, calling it a return to the failed "War On Drugs."

Originally posted on May 12, 2017, at 9:27 a.m.
Updated on May 12, 2017, at 11:30 a.m.

Justice Chiefs Say Trump's Law Enforcement Priorities Are Out of Step

By TIMOTHY WILLIAMS and RICHARD A. OPPEL, Jr. FEB. 12, 2017



LAW ENFORCEMENT LEADERS

To Reduce Crime & Incarceration

FOR IMMEDIATE RELEASE: May 12, 2016

Media Contact: Mark Ro Beyersdorf, mark@berlinrosen.com, (646) 200-5295
Experts available for comment

Prosecutors & Police: Justice Department's Shift on Criminal Charging Policy is Misguided

Sessions New Policy Will Lead to Shifting Resources Away From Violent Crime Prevention

Washington, D.C. – Attorney General Sessions released a memo today reversing criminal charging policy reforms implemented by the Obama administration, which directed federal prosecutors to concentrate law enforcement efforts on the most serious criminals, rather than low-level drug crimes. Law Enforcement Leaders issued the following statement from **Law Enforcement Leaders member and former United States Attorney for Utah Brett Tolman**:

"To maintain law and order, we need effective policing and prosecution. The Justice Department's shift to prosecuting and incarcerating more offenders, including low-level and drug offenders, is an ineffective way to protect public safety. Decades of experience shows we cannot arrest and incarcerate our way out of America's drug problem. Instead, we must direct resources to treatment and to specifically... This will help law enforcement do our jobs better."

is available for interviews. Walsh served as the chair of the from 2015-2016, where he coordinated Justice Department initiative. He also served as U.S. Attorney of Colorado from

The Trump White House

The historic moments, head-spinning developments and White House intrigue.

The Election Is Over, but Trump Can't Seem to Get Past It

Richard Burr Leads Russia Inquiry, Whether He Likes It or Not

A Look at the Candidates Trump Is Considering to Head the F.B.I.



PIMA COUNTY

Law Enforcement Leaders

- Art Acevedo, **Houston** Police Chief
- Steve Anderson, **Nashville** Police Chief
- Charlie Beck, **Los Angeles** Police Chief
- Bill Bratton, former **NYC** Police Comm.
- David Brown, former **Dallas** Police Chief
- Bonnie Dumanis, **San Diego** D.A.
- Paul Fitzgerald, past Pres. **Nat'l Sheriffs**
- Sean Smoot, Dir. **Illinois Police PBA**
- Darrel Stephens, Dir. **Major Cities Chiefs**
- Cy Vance, **New York County** DA . . . and more than 175 others

To Reduce Crime and
Incarceration

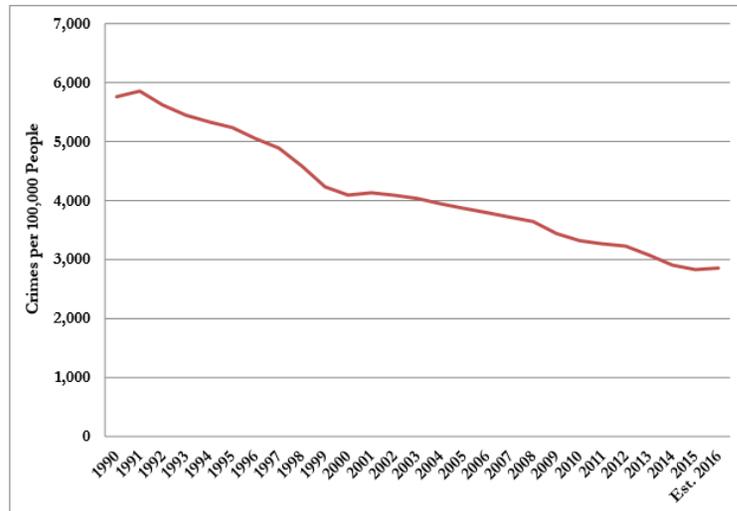


No justification to move backwards

CRIME

Figure 1 shows the national crime rate from 1990 to 2016. This graph includes Part I index crimes tracked by the FBI: aggravated assault, murder, and robbery (collectively, “violent crime”); and burglary, larceny, and motor vehicle theft (“property crime”).¹

Figure 1: Crime Rate in the United States (1990-2016)



Source: FBI Uniform Crime Reports (1990-2015) and Brennan Center Analysis (2016).²

BRENNAN CENTER FOR JUSTICE

CONCLUSION

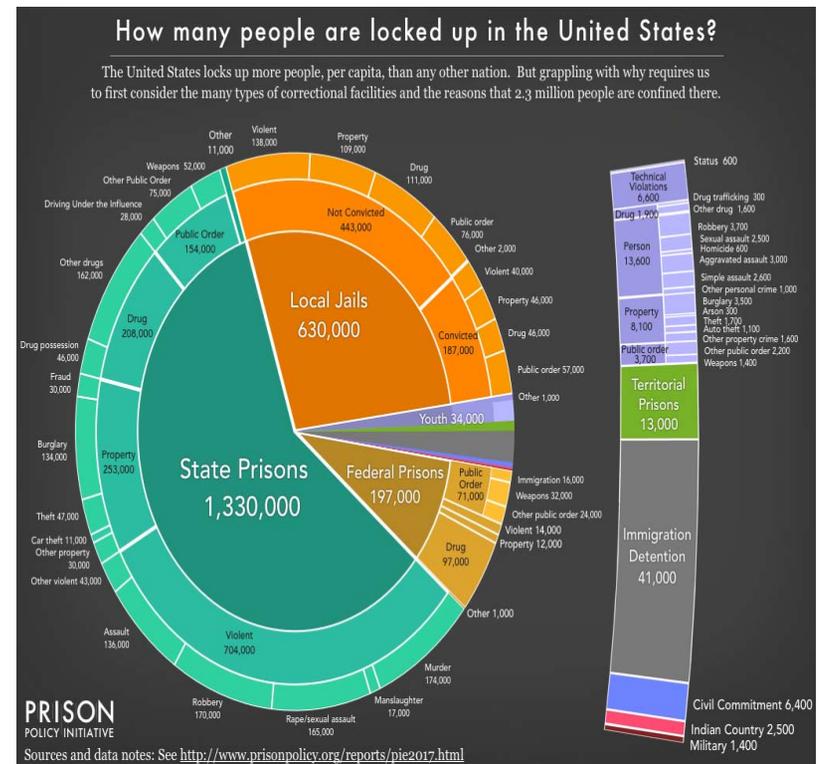
Americans today are safer than they have been at almost any time in the past 25 years. Since 2014, some cities have seen increases in murder, causing increases in national rates of murder and violence. These spikes in urban violence are a serious cause for concern. But history shows these trends do not necessarily signal the start of a new nationwide crime wave, and even with these increases, crime and murder rates remain near historic lows. There is no evidence of a national crime wave.



PIMA COUNTY

Lock-up Extended Stay = FAIL

- Reliance on prison as a punishment doesn't keep us safe. **Imprisoning people at today's high levels has little crime control benefit, especially for nonviolent offenders and the mentally ill.**
- Research shows incarceration can increase future crime in some cases, as prison often acts as a "crime school." **Laws that require prison for low-level offenses take time and vital resources away from us preventing serious and violent crimes.**



“The arc of the moral universe is long but it bends towards justice.”



"When we talk about the criminal justice system, we must talk about reentry... We must talk about the crippling effects a criminal record has on a person and their families."



- Our current system is tremendously expensive. Government spending on jails and prisons has grown almost **400 percent** over the past 30 years. Today, our vast system of prisons costs \$80 billion a year.

- These dollars could be better spent on **what we know works to keep down crime – smart law enforcement policies, reentry services, and mental health and drug treatment** for those who need it.

Alternatives to “no” . . .



Jason Winsky added 2 new photos — with Corey Doggett and 4 others.

21 mins · 📷

I don't often post about my job, but I can't resist sharing this story. Yesterday, my team received a judge's order to transport a 67 year old woman to a local mental health facility. We discovered that the woman was living in her car (which doesn't run) in a church parking lot for the last ten years. Every day, she works in the church garden and is generally self sufficient. When we met with her, my team was somewhat confused as to why this woman needed to be transported to a mental hospital, but with a judge's order, our hands were tied.

When we told the woman she had to go with us, she became very upset. Pointing to her car, she told us "my whole life is in that car." She just wouldn't leave her car, and we didn't blame her. We knew that she would likely stay in the hospital overnight, leaving her car vulnerable. After trying many other options, suddenly I realized: let's just bring her car with her to the hospital. Easier said than done, since the car didn't run and she had no money for a tow.

With a few phone calls, the Tucson community I love so much rallied to support this woman. **Andrew Cooper** and **Shaun McClusky** pointed me to Barnett's towing, who referred me to Gavin Mehrhoff, owner and operator of East Side towing. I talked to Gavin,

and he quickly agreed, at NO cost, to tow the woman's car to the hospital, and when she's done there, tow it back to the church.

But the kindness didn't stop there. Working with the always awesome Doctor **Margaret Balfour** and the folks at **ConnectionsAZ** was amazing, not only did their hospital security team agree to watch the woman's car, they even promised to help find a room at the hospital where she could SEE her car.

When the woman saw what we had done, the relief in her face was obvious and she agreed to go with us to the hospital. I want to thank my team, especially **Darrell Hussman** and **Todd** for being so patient and compassionate, **Margaret Balfour** who runs the best crisis center in the country, and **Gavin** at East Side towing for making a small but critical difference in this woman's life. I love my job!



PIMA COUNTY

Take aways . . .



- Especially with scarce resources, it makes sense to build to build stronger collaborations between police and mental health service providers.
- There are probably many more calls involving police/fire that have a mental health nexus than you think. This requires new approaches, better training, and creative assignments.
- Locking people up, even over short time periods, for low-level non-violent crimes is a high cost, low yield proposition. Especially at the local level, it's time to explore more effective alternatives.



Questions? Want more information?



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Panel Discussion

From Pretrial to Probation

Moderator

Hon. Danelle Liwski
Superior Court in Pima County

Panelists

Susan Lehman

Supervisor

Pima County Pretrial Services

Kelly Pesano

Lead Probation Officer

Pima County Adult Probation

ARIZONA SUPERIOR COURT IN PIMA COUNTY

Mental Health Court

The History: 13 years of MHC

- 2004 – Hon. Nanette Warner consolidates the Mental Health bench to include CST proceedings and a post conviction MHC
- 2008 - Hon. Howard Fell (pictured) takes over the MH bench. He refines application process, adds a peer support element. The first comprehensive data analysis is done on the program.
- 2011- Hon. Deborah Bernini becomes MH Presiding. She adds options for Veterans to participate, and installs a level system.
- 2015 – Hon. Danelle Liwski is named MH Presiding. Level system is refined, certificate system is improved, graduation is made more personal and significant for the defendant.



MHC Level System

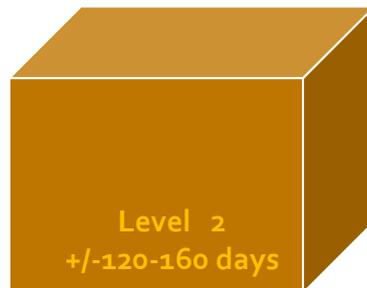
Focus on *STABILITY*

- Write Acceptance Assignment
- Turn in Acceptance Assignment
- Keep PO and case manager appointments
- Keep doctor/therapist appointments
- Attend all groups
- Clean, no missed drops
- Fully compliant to probation
- Take all meds as directed



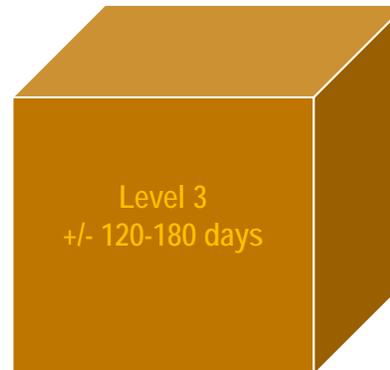
Focus on *SUPPORT*

- Keep all appointments
- Attend all groups
- Clean, no missed drops
- Take all meds as directed
- Fully compliant to probation
- Build stronger support network of family, friends & ties to community
- Engage in Job search, Community service, or work



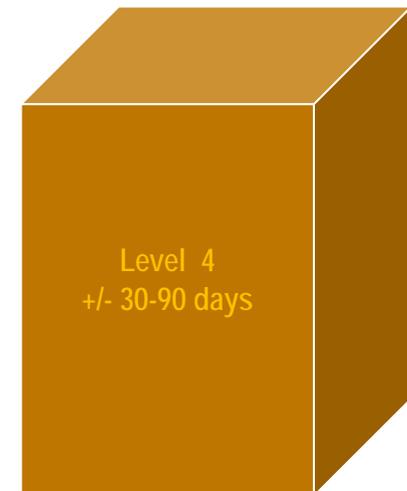
Focus on *PLANNING*

- Keep all appointments
- Attend all groups
- Clean, no missed drops
- Take all meds as directed
- Fully compliant with probation
- Engage in work, job search or community service
- Write Names and phone numbers of people in your support network
- Write a list of 3 coping techniques for stressful situations now and in future
- Write an emergency plan with telephone numbers and treatment contacts



Focus on *ACHIEVEMENT*

- Keep all appointments
- Attend all groups
- Clean, no missed drops
- Take all meds as directed
- Fully compliant with probation
- Engage in work, job search or community service
- Write graduation assignment & turn it in to court
- Fines and fees paid or plan to pay them
- Able to describe coping skills and emergency plan



What we have learned

- Schizophrenia sufferers graduate at the highest rate > 54%
- Schizoaffectives with chemical dependence issues have lowest success rates with only 1 in every 3 to reach graduation (33%)
- Length of program most helpful to defendants when 18 months rather than 12 months long
- Most frequent convictions are assault, theft and drug charges. No defendant has ever been refused admission due to nature of charges. Sex offenders are part of the graduate cadre



WHAT WE HAVE ACHIEVED



- Over 300 participants (currently 40)
- 120 graduates (40% overall grad rate)
- 60% men and 40% women
- Maintained operation through 4 Judges, 2 RBHA's & established partnerships with all major behavioral health providers (thank you!)
- **ZERO** Pima County dollars spent on this model in over 13 years of operation.

**PRETRIAL SERVICES
ARIZONA SUPERIOR COURT
IN PIMA COUNTY**

Screening and Supervision Strategies

History of Pretrial Services



- Started as Correctional Volunteer Center (CVC) in 1972 due to funding from a Law Enforcement Assistance Administration (L.E.A.A) grant
- In 1979, expanded to include supervised release services and created a misdemeanor pre-booking release program
- In 1996, through a partnership with the University of Arizona, the agency developed an objective risk instrument



Safety and Justice Challenge Initiatives



Pretrial Services

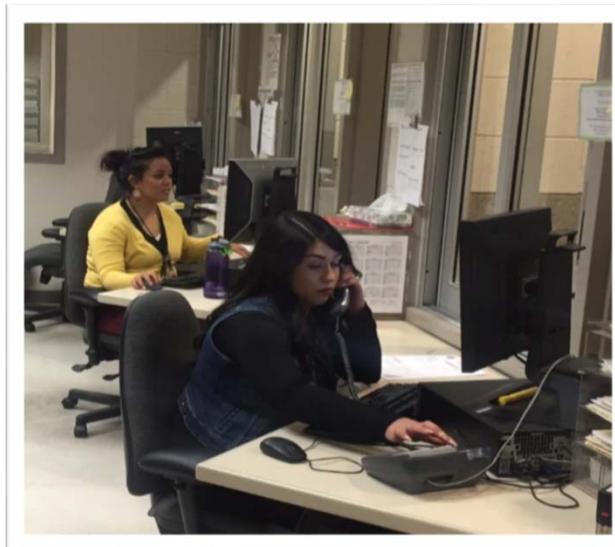
- Increased screening at the Pima County Adult Jail
- Behavioral health screening and expedited referral to treatment
- Enhanced pretrial supervision

Increased Screening 4 Case Analysts 2 Lead Case Analysts



Implementation Initiated October 2016

- Screening of all Tucson Municipal Court cases
- Post-booking, Pre IA release screening



Enhanced Supervision & Behavioral Health Screen



Implementation Date, April 27

- BH screening
- Screening to identify defendants suitable for referrals
 - *Initial Target population:* High Risk, Class 4-6 Felonies
- Supervision caseloads, low caseload levels
 - Assist with connections, appointment reminders

Enhanced Supervision & Behavioral Health Screen



Implementation Update

-Week 2

13 defendants screened into the program

-Process working as intended



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PIMA COUNTY

BEHAVIORAL HEALTH SERVICES IN SOUTHERN ARIZONA

Cenpatico Integrated Care

Presentation

Behavioral Health Services in Southern Arizona

**Cenpatico Integrated Care
Crisis Justice Team**

Presenters

Sarah Darrah

Director of Justice Systems

Polly Knape, M.S., LAC

Supervisor of First Responder Services

Terry Randolph, M.A., LPS

Director of Crisis Services



PIMA COUNTY



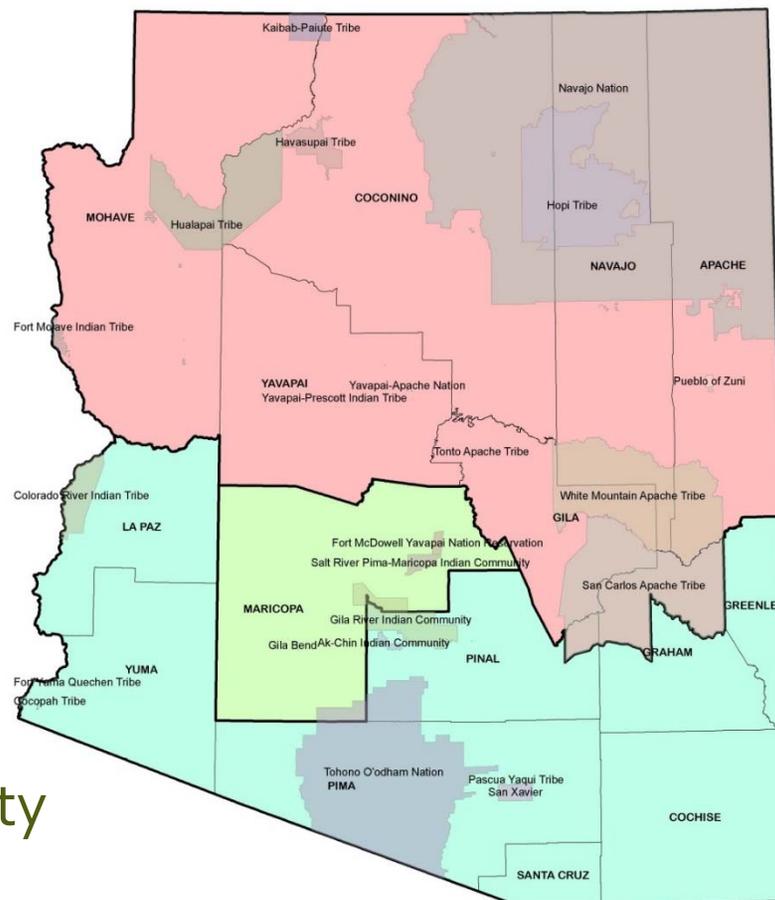
Overview of Counties Served

Covered Lives: 355K – 455K

8 Southern AZ Counties:

- Cochise
- Graham
- Greenlee
- La Paz
- Pinal
- Pima
- Santa Cruz
- Yuma

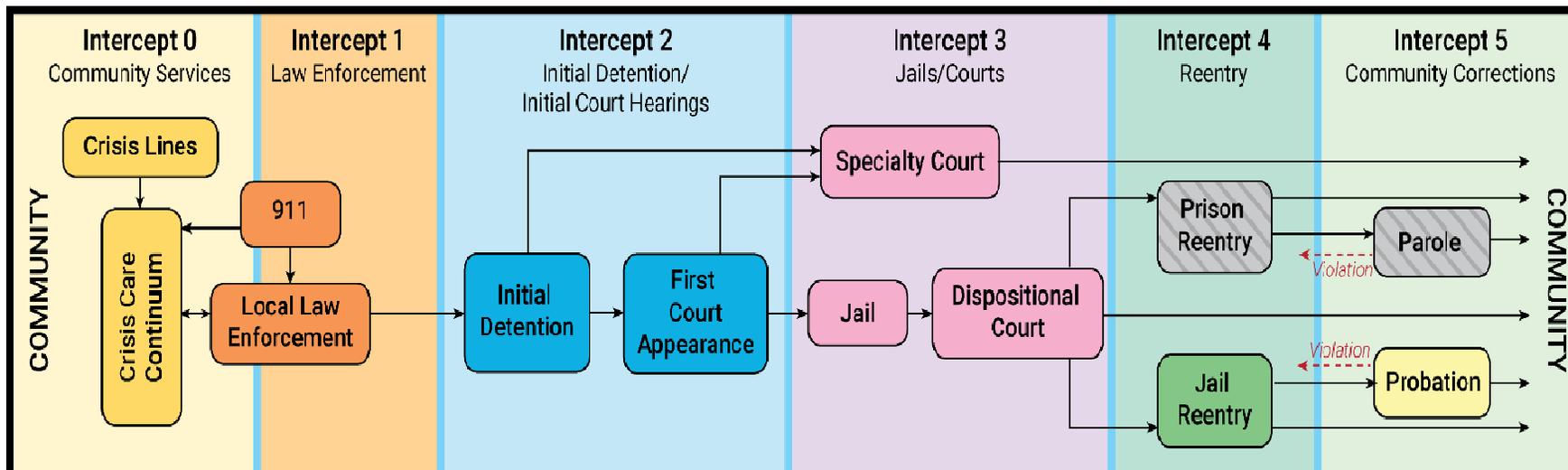
The San Carlos Indian Community in Gila County is also covered by Cenpatico Integrated Care



PIMA COUNTY



Sequential Intercept Model



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The SIM identifies six key points for “intercepting” individuals with behavioral health issues, linking them to services and preventing further penetration into the criminal justice system



Intercept o The Crisis System Goal

- Cenpatico is committed to providing crisis services in collaboration with the community, law enforcement and first responders to avoid:
 - Unnecessary detentions
 - Use of hospital emergency departments
 - Involuntary psychiatric commitments under Title 36
 - Unnecessary psychiatric inpatient hospitalization
 - Revolving door usage of Crisis Centers and 911
- **All individuals are eligible for crisis services regardless of insurance status**





Intercept O Crisis Services Available

- NurseWise Crisis Line
- Crisis Mobile Teams
- Urgent Engagements
- Community Stabilization Centers
- Brief Intervention Program
- Engagement Specialists
- My Health Direct Appointments





Intercept 0

NurseWise Crisis Line

- The crisis line numbers is **1-866-495-6735**
- Dispatch Crisis Mobile Teams
- Coordinate My Health Direct Appointments
- Dispatch Urgent Enrollment, Rapid Response, and Urgent SMI assessors
- Coordinate placement of involuntary members
- Partner with 911 dispatch to determine the protocols and timeline for implementation of a “CMT-only” response to 911 calls
- Coordinate with Health Homes to assure they are aware of crisis episodes
- Triage and resolve crisis calls over the phone
- Complete Crisis Follow up calls and Telephone welfare checks after a crisis event



Intercept 0 Crisis Mobile Teams



- Call NurseWise for CMT dispatch
- 30 minute responses time goals to Law Enforcement in City Limits
- Assistance and coordination of T-36, Requests for Involuntary Evaluation (emergent and non-emergent)
- CMT's assess and coordinate expanded crisis services
 - Community Stabilization
 - Coordination of care with local hospitals, Health Homes and out patient providers
 - Onsite resolution, treatment planning, and placement services including Behavioral Health Inpatient facilities
 - Connection to Health Homes
 - Evaluations in Emergency Departments and Detention Complexes



Intercept 0

Urgent Engagements



- Urgent Engagement is the process of engaging people into care who have experienced a crisis or have been admitted to an inpatient facility
- The process includes:
 - ensuring effective coordination of care
 - engagement
 - discharge planning
 - an SMI screening when appropriate
 - screening for eligibility
 - referral as appropriate for prevention of future crisis events
- Once the Health Home completes the Urgent Engagement process, the Health Home is the entity that is responsible for coordination of necessary service and discharge planning
- Urgent Engagements are required to be started within one hour (at a Community Observation Center) or 24 hours (at a Behavioral Health Inpatient Facility)



Intercept O



Community Observation Centers

- To provide crisis intervention services to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior
- These intensive and time limited services are designed to prevent, reduce, or eliminate a crisis situation and are provided 24 hours a day, 7 days a week, 365 days a year
- The Services to be provided include:
 - Health risk and acuity assessments for triage
 - Comprehensive screening and assessment
 - Crisis intervention services
 - Title 36 Emergency petition for facilities licensed to provide court ordered evaluations



Intercept o

Brief Intervention Programs



- It is a time-limited, intensive crisis intervention program that delivers services in an ADHS-licensed Behavioral Health Residential Facility (BHRF) to help persons live successfully in the community
- The program includes:
 - Crisis, supportive and treatment services
 - Maximum length of stay is ten (10) days per episode of care
 - No prior authorization is needed
 - The member cannot be readmitted within 72 hours of discharge from any BIP
- In order to be admitted a member must have had a crisis episode or an inpatient admission, and the following criteria must be met:
 - Significant recent risk of harm as evidenced by:
 - Suicidal/homicidal ideation that does not require a level 1 admission and the inability to carry out a safety plan
 - A sudden onset of anxiety, depression or psychotic symptoms considered likely to lead to an inability to maintain safety unless the person is supervised 24/7
 - Functional impairment that has led to a crisis episode that requires short term stabilization and monitoring of medications in a facility with 24/7 supervision
 - There is a safety risk due to a serious functional impairment due to psychiatric symptoms not outlined above
- The need for further stabilization following an inpatient stay that can be managed at this lower level of care



Intercept o My Health Direct Urgent Appointments



- Call NurseWise to Coordinate appointment
- All Appointments are scheduled with in 72 hours
- Intake and Enrollment:
 - For non enrolled persons who are in need of services
- Medication Management:
 - Enrolled persons who are in need of urgent medication services
- Post-Crisis Follow up:
 - Enrolled persons, who need to touch base after a crisis





Intercept 1

Goals:

- Increase diversion from the justice system
- Increase community stabilization
- Decrease transfers between levels of care

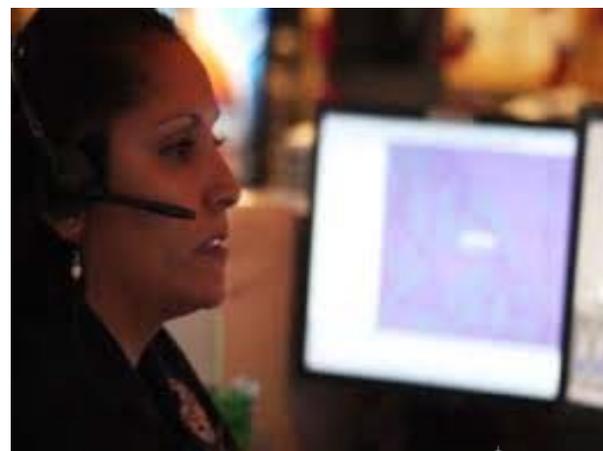




Intercept 1

911 to Crisis Line direct call transfer

- No safety risk
- No need for Law Enforcement
- No need for fire/ Emergency Medical Services
- Triage over the phone
- Arrange expedited appointments
- Dispatch Crisis Mobile Team





Intercept 1

Mental Health First Aid Training

- Provides Fire, Emergency Medical Services, and Law Enforcement with training to:
 - Identify
 - Understand
 - Respond
- Mental Health and Substance Abuse Disorders



Intercept 1



Crisis Intervention Team

- Training for officers, dispatchers, and other first responders
- 2-3 classes a year of 50 persons each
- Facilitated by:
 - Pima County Attorneys Office
 - Tucson Police Department
 - Cenpatico Integrated Care
 - Pima County Sheriff's Department





Intercept 1

Fire / EMS Response

- Alternative Outcomes to Emergency Department drop off
- Hand off to Crisis Mobile Team in the Field
- Treat and Refer
 - Urgent Care
 - Primary Care offices
 - Community Observation Centers
 - Detoxification facilities



Intercept 1

Co-Responder Program

- Pilot Project:
 - Tucson Police Department
 - Community Bridges
 - Cenpatico Integrated Care
- Clinicians riding along side Officers as a team
- Increase community stabilization
- Increase diversion from jail
- Increase diversion from emergency departments
- Saves Officer and clinician time
- Efficient utilization of resources

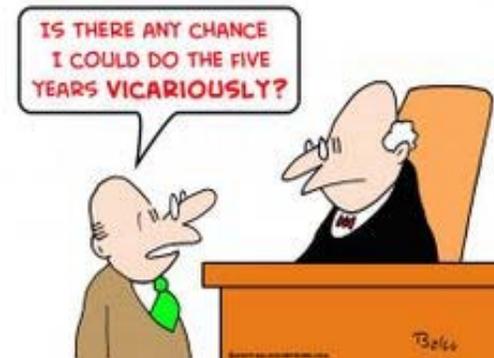


Intercept 2

Initial Appearance



- First Court Appearance with a Judge upon entering a Detention Center
- Judge reviews case and determines if an individual will be released or housed in Detention Center
- Cenpatico Data Sharing with Initial Appearance Judges
 - In Pima, notify IA Judge if eligible with Cenpatico
 - Hope, Inc. Jail Liaisons
- Collaboration with Pretrial Services
 - Strategy 1 of Safety & Justice Challenge
 - Enhanced Supervision Caseload



Intercept 3 Jail/Detention



- Coordination of care for our members from community to detention and detention back to community
 - Collaboration with Detention Staff & Treating Provider
 - Data Sharing – Booking Files & JHIDE
 - Co-location of Jail Liaisons in 5 Counties (CHA/Hope, Inc.)
 - Commitment from our Health Homes
 - Community Re-entry (CRE) Referrals
 - **Reducing Recidivism**



Intercept 3

Courts/Specialty Courts



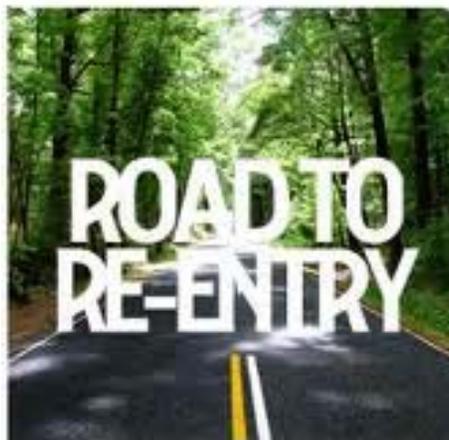
- The Justice Team collaborates with multiple Specialty Courts throughout the Southern Region
- We work to notify the Judges when a member may be eligible for Specialty Court
 - Focus on treatment versus punishment, designed to address the root cause of criminal behavior
 - Mental Health Court, Drug Court, Veterans Court, CARECourt
- Collaboration and commitment from our Health Homes to participate in staffings and provide treatment compliance information
- Coordination with rural courts to share treatment compliance information





Intercept 4 Re-Entry

- Community Re-Entry (CRE) Process
- Criminal Justice Reach-In Care Coordination Program
- AHCCCS Pre-Release Application Process





Intercept 4 Re-Entry

Community Re-Entry Process

- Community Re-Entry Protocols
 - Federal and State Prison System
 - County Adult and Juvenile Detention Centers
- Referrals can be generated by any System Partner
- Health Homes engage member or potential member while incarcerated
 - Obtain a release of information, conduct an initial assessment to begin discharge planning, complete an SMI evaluation if applicable
 - Schedule an appointment post release
 - Arrange transportation to treatment if needed
 - Collaborate with Detention Officers and Treating Provider



Intercept 4 Re-Entry



Criminal Justice Reach-In Care Coordination Program

- The goal of the Reach-In program is to identify eligible members 30-45 days prior to release, meet with and educate members on resources and services available, engage members into services and coordinate both behavioral and physical health care
- The target population are eligible members (those enrolled in AHCCCS) who are sentenced and have a known release date, to include Arizona Department of Corrections and County Detention Centers
- The Reach-In program is in addition to existing initiatives such as Community Re-entry and provides an additional opportunity to assist members involved in the justice system
- Current Facilities participating in Reach-In include:
 - Cochise, Pima, Pinal and Yuma Detention Centers
 - Arizona Department of Corrections



Intercept 4 Re-Entry



- Reach-In Program includes:
 - Appointment scheduled to occur within 7 days post release
 - Members with a designation of SMI and/or with high needs/high cost in the Reach-In program will be assigned a Cenpatico Care Coordinator
 - Referral to PEER support services
 - Adult Recovery Team meeting within specified time period post release
- Outcomes to date:
 - From October 2016 through March 2017, 768 members initiated for Reach-In services
 - 68% opted to participate
 - Claims data shows those that participated in the program have less crisis events, fewer ED visits, fewer re-arrests and overall reduced average cost per member compared to those who did not participate



Intercept 4 Re-Entry



AHCCCS Pre-Release Application Process

- Partnership between Cenpatico, AHCCCS, DES and CHA Jail Liaisons
- Ability to submit AHCCCS applications from the Detention Center prior to release or upon release
- Implemented paper application process in Yuma & Pima County Adult Detention Centers
 - **317** applications submitted in 15 months
- Implemented HEAPlus application process in Pima County Adult Detention Center
 - **80** applications submitted from September 2016 – April 2017
- Most recently implemented in Cochise, Graham and Pinal County Detention Centers





Intercept 5

Community Corrections

- Collaboration with Probation and Parole to assist members in successful completion
- Bridge the gap between Community Corrections and Health Homes
- Integrate Risk, Need & Responsivity with Treatment





Intercept 5

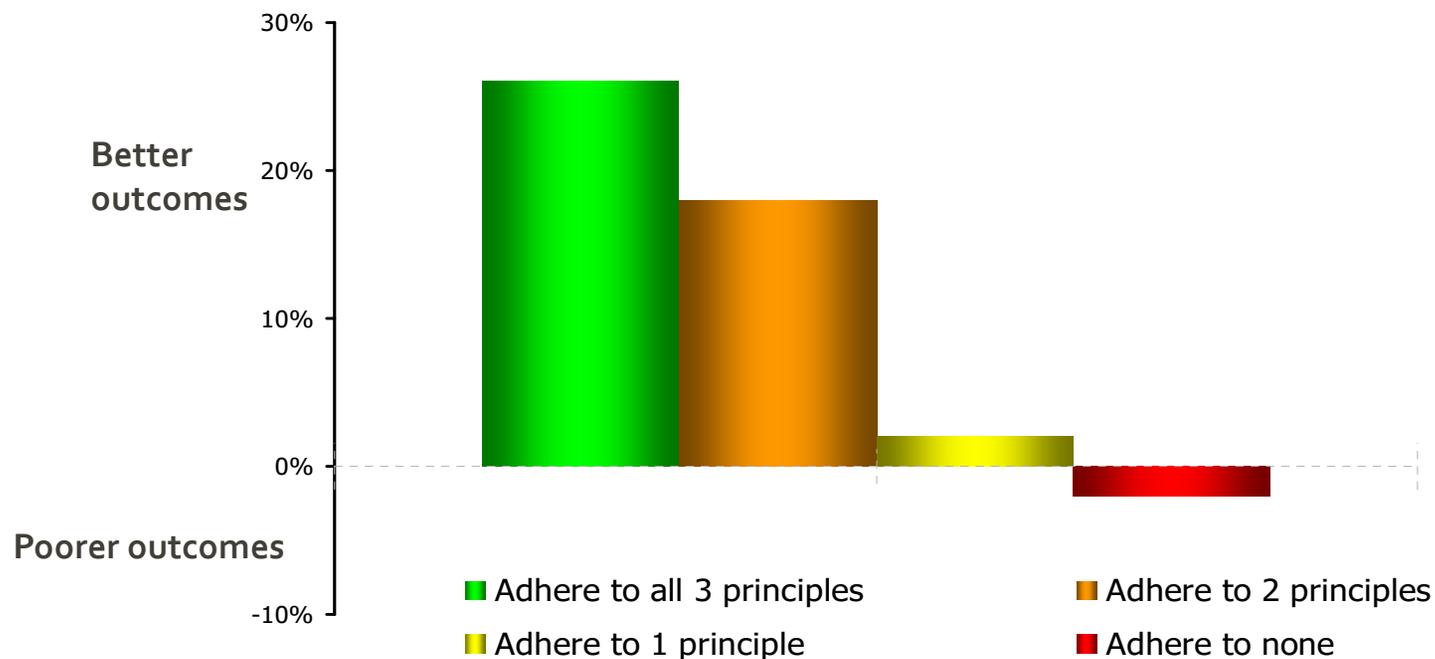
The Eight Evidence-Based Principles to Reduce Risk of Reoffending

1. Assess Actuarial Risk/Needs
2. Enhance Intrinsic Motivation
3. Target Interventions
 - **Risk Principle:** Prioritize supervision and treatment resources for higher risk offenders
 - **Criminogenic Need Principle:** Target interventions to criminogenic needs
 - **Responsivity Principle:** Be responsive to temperament, learning style, motivation, culture, and gender when assigning programs
 - **Dosage/Intensity:** Structure 40-70% of high-risk offender's time for 3-9 months
 - **Treatment Principle:** Integrate treatment into the full sentence/sanction requirements
4. Skill train with directed practice (Use cognitive behavioral treatment methods)
5. Increase positive reinforcement
6. Engage ongoing support in natural communities
7. Measure relevant processes and practices
8. Provide measurement feedback





Impact of Adhering to the Core Principles of Effective Intervention: Risk, Needs, and Responsivity*



* meta-analysis of 230 studies (Andrews et al., 1999)

Top 4 Criminogenic Factors



FACTOR	RISK	DYNAMIC NEED
History of Anti-social Behavior	Early and continued involvement in a number of anti-social acts	Build non-criminal alternative behaviors in risky situations
Anti-social Personality	Adventurous, pleasure seeking, weak self control, restlessly aggressive	Build problem-solving, self-management, anger management and coping skills
Anti-social Cognition	Attitudes, values, beliefs and rationalizations supportive of crime, cognitive emotion states of anger, resentment and defiance	Reduce anti-social cognition, recognize risky thinking and feelings, build up alternative less risky thinking and feelings. Adopt a reform and/or anti-criminal identity.
Anti-social Associates	Close association with criminals and relative isolation from prosocial people	Reduce association with criminals, enhance associate with prosocial people.

Source: Ed Latessa, Ph.D.



PIMA COUNTY

The Next 4 Criminogenic Factors



FACTOR	RISK	DYNAMIC NEED
Family/Marital	Two key elements are nurturance and/or caring. Better monitoring and supervision.	Reduce conflict, build positive relationships, communication, enhance monitoring and supervision
School/Work	Low levels of performance and satisfaction	Enhance performance rewards and satisfaction
Leisure/recreation	Low levels of involvement and satisfaction in anti-criminal leisure activities	Enhancement involvements and satisfaction in prosocial activities
Substance Abuse	Abuse of Alcohol or drugs	Reduce substance abuse, reduce the personal and interpersonal supports for substance abuse behavior, enhance alternative to substance use

Source: Ed Latessa, Ph.D.



PIMA COUNTY



QUESTIONS



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Workshops

Nuts and Bolts of Creating a Diversion Program

Grand Ballroom

Law Enforcement Diversion

Boojum Room

Harnessing the Power of Data for Change

Bonsai Room



Planning Committee

Pima County Administration
Pima County Attorney's Office
Pima County Behavioral Health
Pima County Communications
Pima County Grants and Data Office
Pima County Public Defense Services
Pima County Sheriff's Office
Pima County Superior Court
Pretrial Services
Tucson Police Department
Cenpatico Integrated Care
NAMI Southern Arizona

Event Sponsors



PIMA COUNTY

BEHAVIORAL HEALTH



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