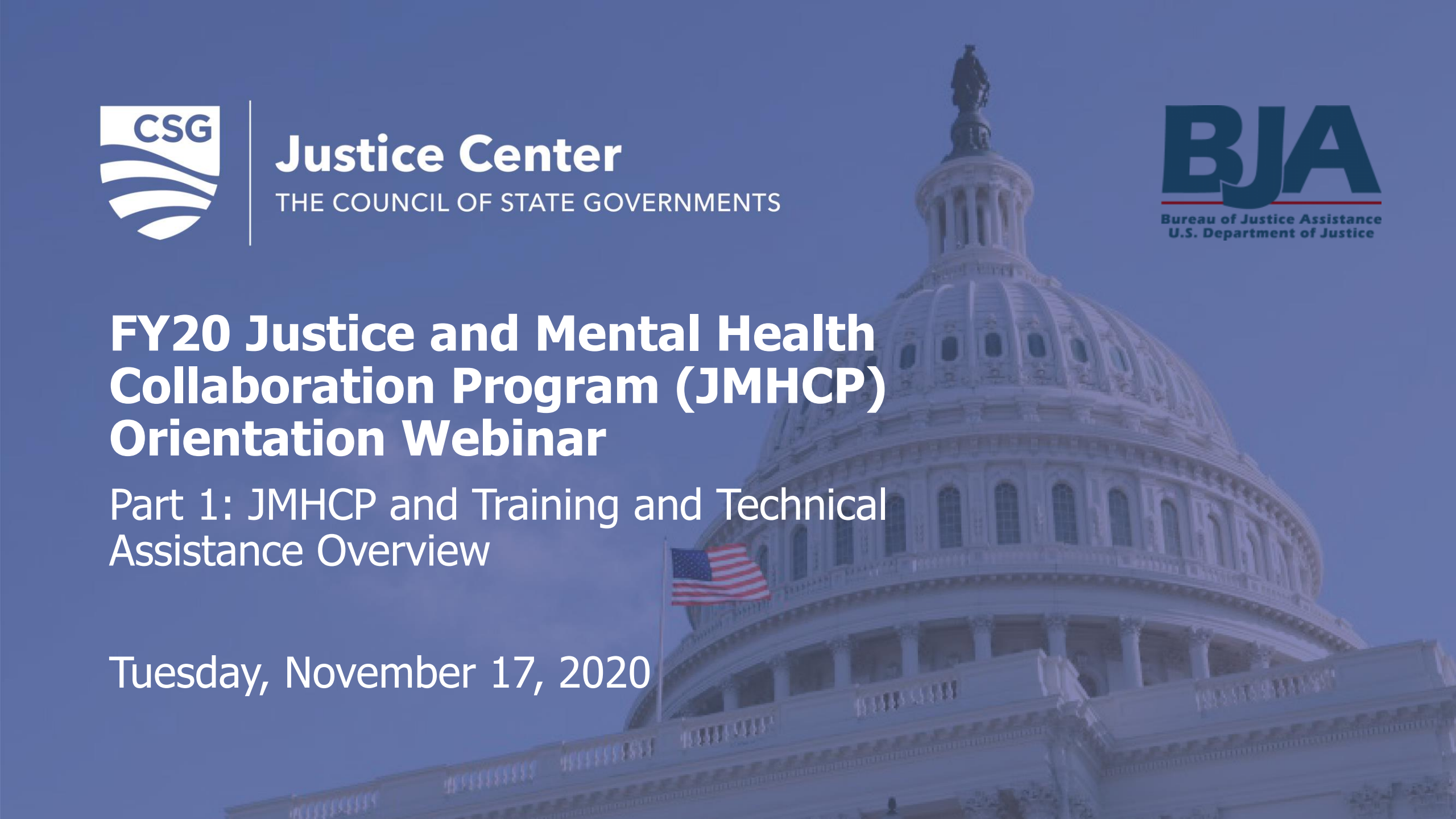


Justice Center
THE COUNCIL OF STATE GOVERNMENTS

Bureau of Justice Assistance
U.S. Department of Justice

FY20 Justice and Mental Health Collaboration Program (JMHCP) Orientation Webinar

Part 1: JMHCP and Training and Technical Assistance Overview

Tuesday, November 17, 2020

Agenda

I. Welcome and Introductions

II. Overview of Behavioral Health Diversion and Reentry Strategies

III. Overview of JMHCP

IV. Technical Assistance

V. Questions and Answers

Speakers

- Ayesha Delany-Brumsey, PhD, Director, Behavioral Health, The Council of State Governments Justice Center
- Maria Fryer, Justice Systems and Mental Health Policy Advisor, Bureau of Justice Assistance, U.S. Department of Justice
- Demetrius Thomas, Deputy Program Director, Behavioral Health, The Council of State Governments Justice Center
- Sarah Wurzburg, Program Director, Behavioral Health, The Council of State Governments Justice Center

The U.S. Department of Justice Bureau of Justice Assistance

Mission: BJA provides leadership and assistance to local criminal justice programs that improve and reinforce the nation's criminal justice system. BJA's goals are to reduce and prevent crime, violence, and drug abuse and to improve the way in which the criminal justice system functions. In order to achieve such goals, BJA programs illustrate the coordination and cooperation of local, state, and federal governments. BJA works closely with programs that bolster law enforcement operations, expand drug courts, and provide benefits to safety officers.

BJA
Bureau of Justice Assistance
U.S. Department of Justice

Visit the BJA website to learn more.

The Council of State Governments Justice Center

We are a national nonprofit, nonpartisan organization that combines the power of a membership association, representing state officials in all three branches of government, with policy and research expertise to develop strategies that increase public safety and strengthen communities.

How We Work

- We bring people together
- We drive the criminal justice field forward with original research
- We build momentum for policy change
- We provide expert assistance

Justice and Mental Health Collaboration Program Statutory Authority

- Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA), (Public Law 108-414)
- Authorized JMHCP: $50 million for criminal justice-mental health initiatives
- Reauthorized for 5 years -Mentally Ill Offender Treatment and Crime Reduction Act of 2008 (Public Law 108-416)
- Amended by the 21st Century Cures Act in 2016 (Public Law 114-255), which provided for JMHCP and mental health courts
- Additional authority is provided by the Consolidated Appropriations Act, 2020

Growing Awareness of a National Crisis

The Columbus Dispatch

Mentally-ill inmates at Franklin County jail stay longer

USA TODAY

Police departments struggle to get cops mental health training

rtv6 abc THE INDY CHANNEL

Sheriff: Mental health is number one problem

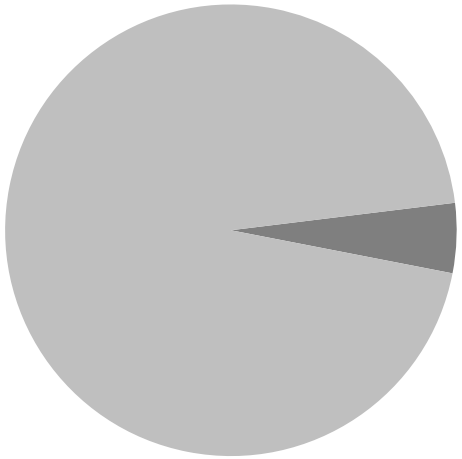
The Washington Post

Baltimore police cuffed, stunned and shot people in mental health crisis

People with Mental Illnesses are Overrepresented in Jails—Most Have Co-occurring Substance Use Disorder

General Population

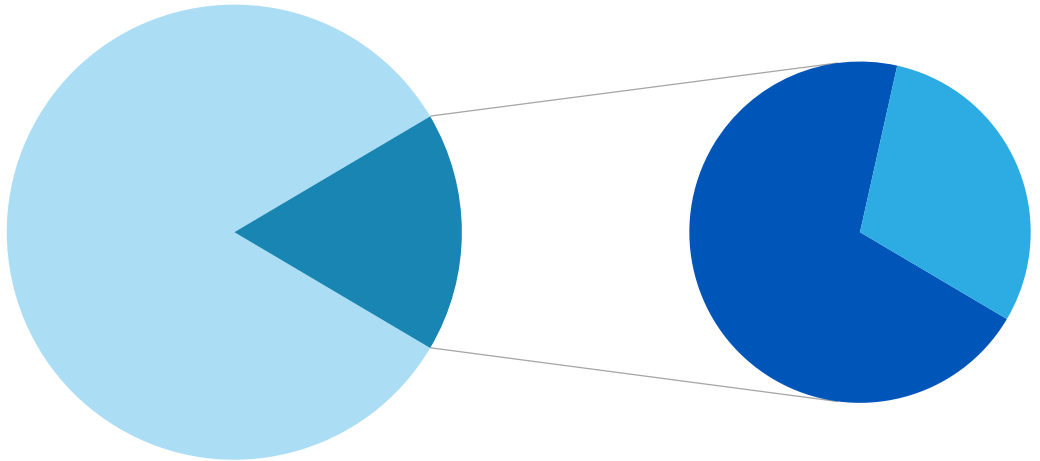
4% Serious Mental Illness



Jail Population

17% Serious Mental Illness

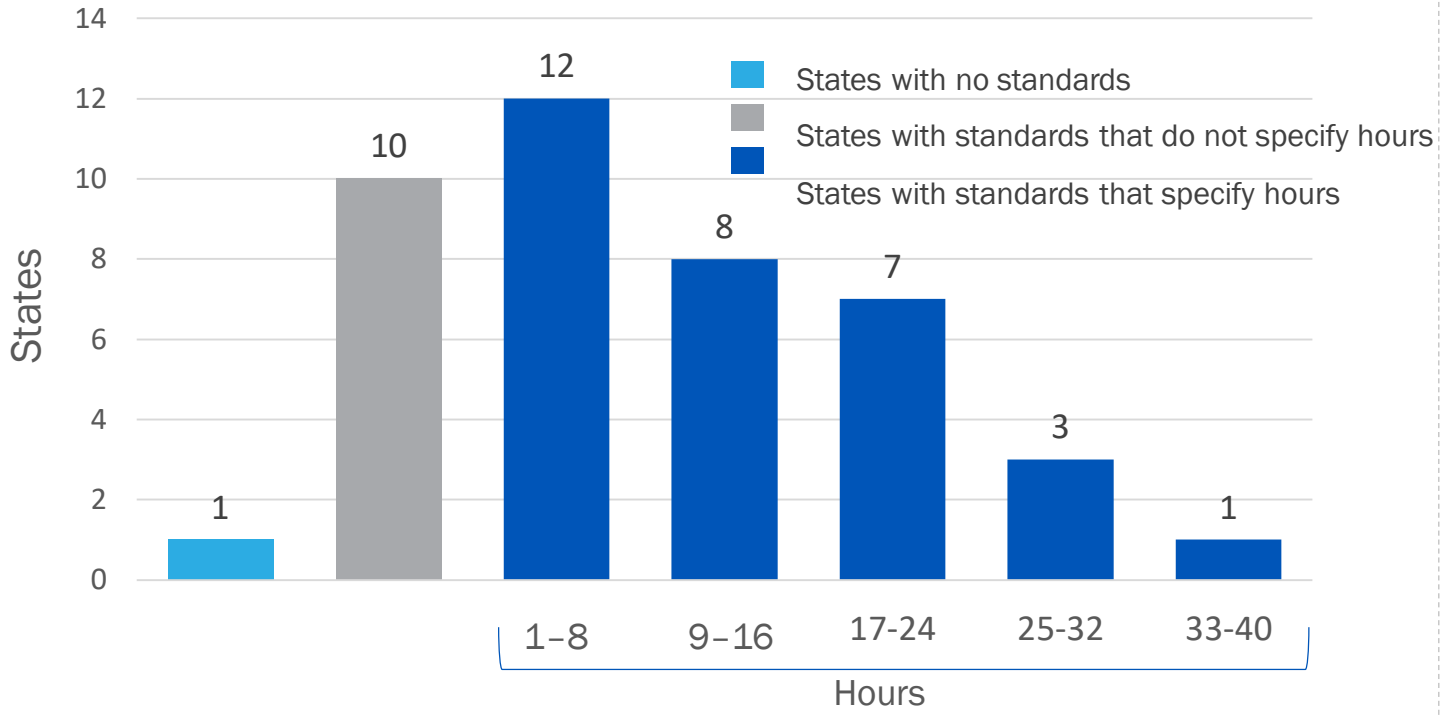
72% Co-occurring Substance Abuse



Source: H. J. Steadman, F. C. Osher, P. C. Robbins, B. Case, and S. Samuels, "Prevalence of Serious Mental Illness among Jail Inmates," *Psychiatric Services* 6 (60), 761–765, 2009; Center for Behavioral Health Statistics and Quality, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2015 National Survey on Drug Use and Hælth, 2016* (HHS Publication No. SMA 16-4984, NSDUH Series H-51), http://www.samhsa.gov/data/; Karen M. Abram and Linda A. Teplin, "Co-occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* 46, no. 10 (1991): 1036–1045.

Police Encounters for Service Involving People in Crisis

Across the country, there are inconsistent standards for mental health and de-escalation trainings



Source: Martha Plotkin and Talia Peckerman, The Variability in Law Enforcement State Standards: A 42-State Survey on Mental Health and Crisis De-escalation Training (New York: The Council of State Governments Justice Center, 2017).

In Gresham, OR when **CIT trained Officers** respond to mental health call, there are **significant less arrest**.

- When a **GSCT Clinician** responds, **even fewer are arrested** (only 2%)

Source: Justice & Mental Health Collaboration Program: Outcomes Associated with the Creation of the Gresham Service Coordination Team (October 2020).

In Madison, Wisconsin, **behavioral health calls** for service take **twice as long to resolve:**

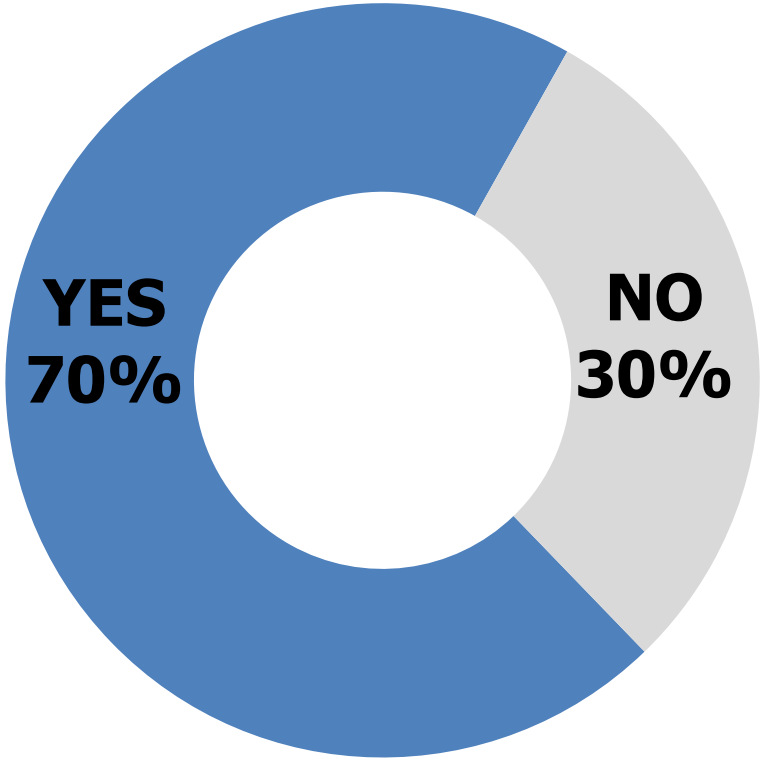
- All CFS = 1.5 hours
- BH = 3 hours

Source: Madison (Wisconsin) Police Department

Judicial Decision-Making Can Contribute to Higher Mental Illness Prevalence in Jails

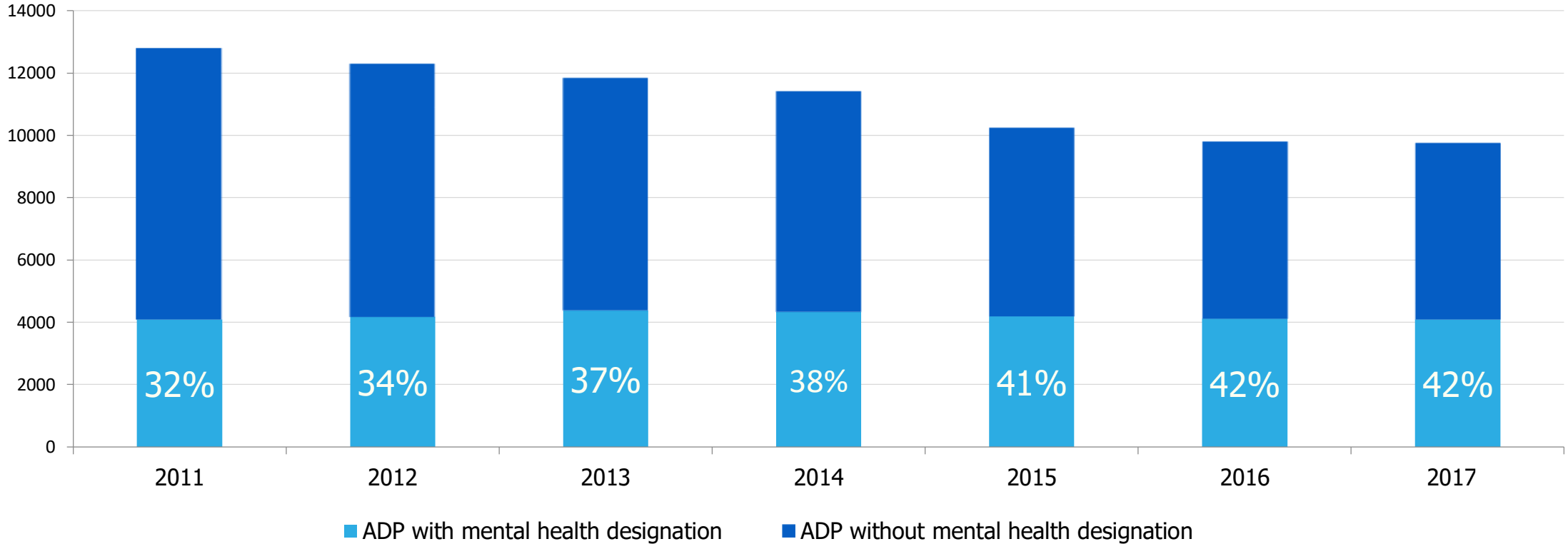
North Dakota judges were asked:

Have you ever sentenced someone to prison in order to connect him/her with needed mental health, alcohol or drug addiction programming, or other treatment even when he/she is not considered high risk?



Source: The Council of State Governments Justice Center electronic survey of North Dakota judges, March 2016.

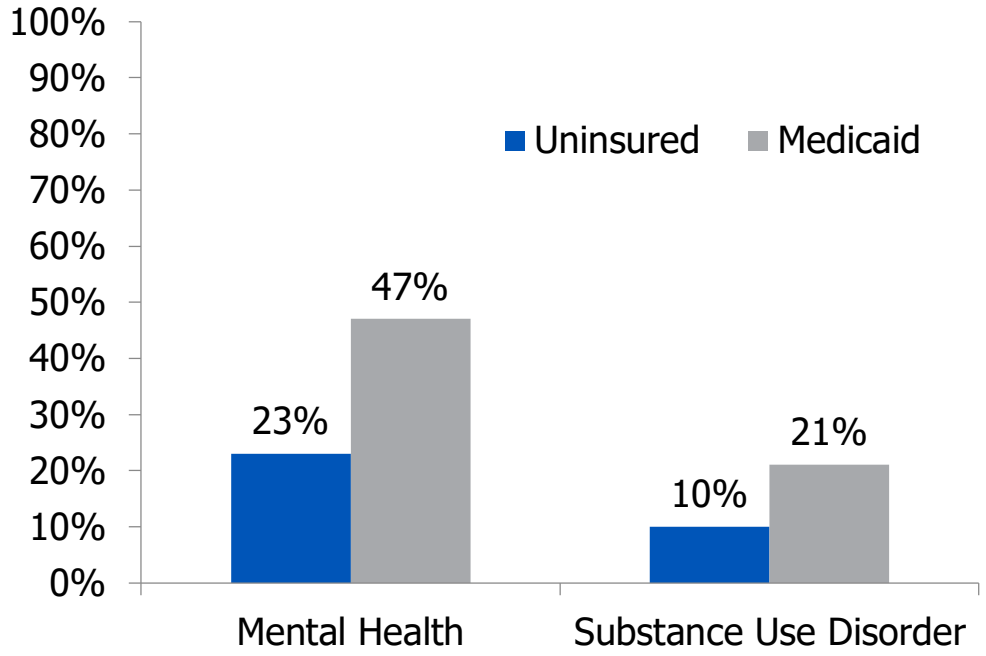
Proportion of NYC Department of Corrections Average Daily Population (ADP) with Identified Mental Health Need

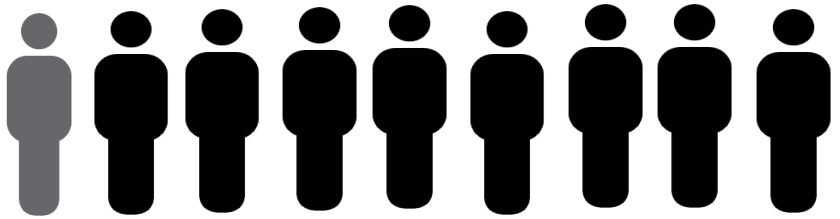


Source: New York City Department of Corrections, Mayor's Management Report, 2017.

Community-Based Treatment Capacity is Limited

Americans with Behavioral Health Disorders Face Significant Treatment Gap (2015)





1 in 10 people who needed substance use disorder (SUD) treatment received it in a specialty SUD facility

Source: (Left) Kaiser Family Foundation, *Medicaid's Role in Behavioral Health* (Menlo Park, CA: Kaiser Family Foundation, 2017). (Right): *Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017), https://www. samhsa.gov/data/.

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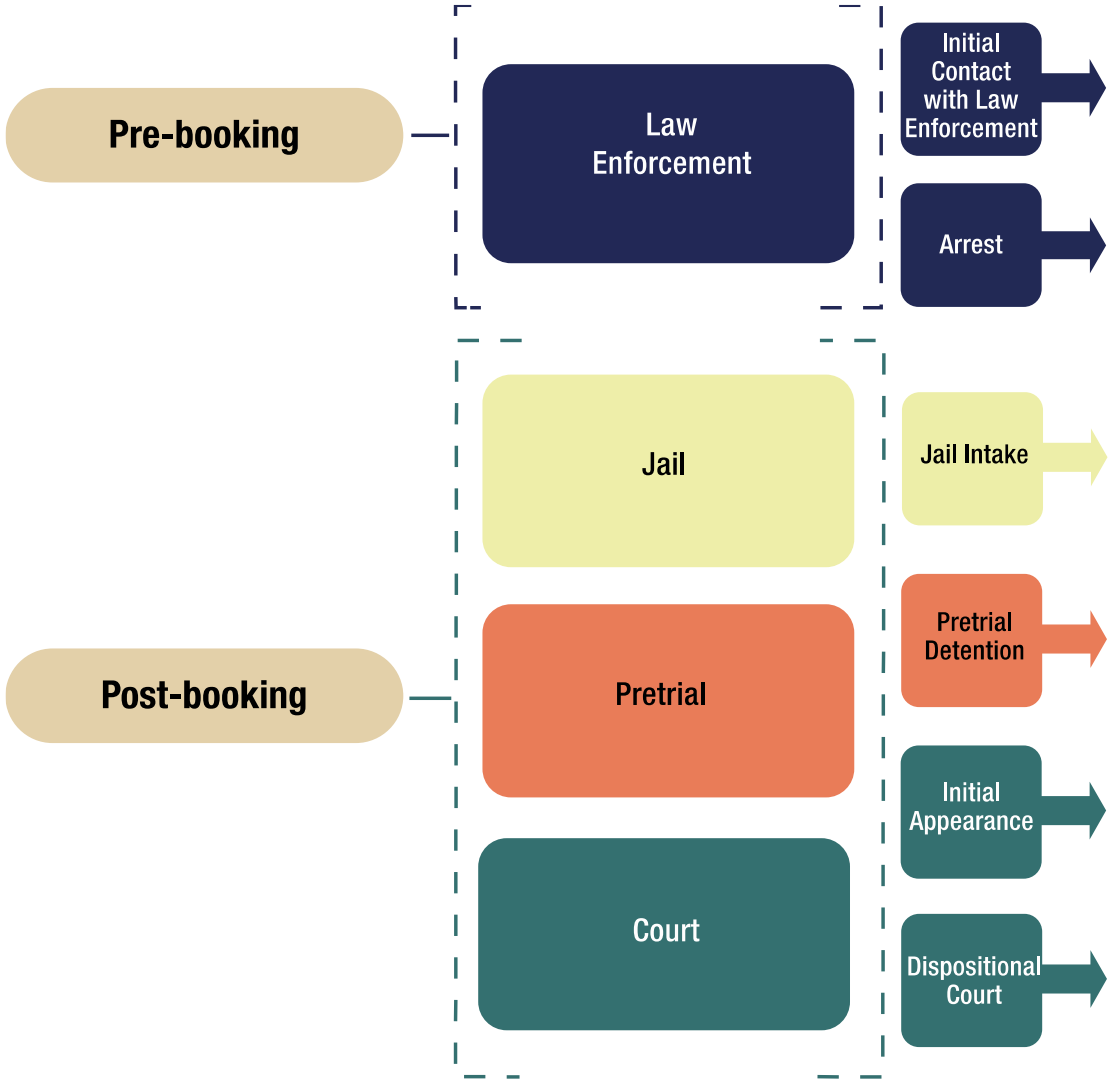
Why Is it Important?

- What has JMHCP taught us so far?
- What law enforcement approach should we adopt?
- What tools can help us identify people?
- How do we build a better crisis system?
- What do we do to support "high utilizers"?

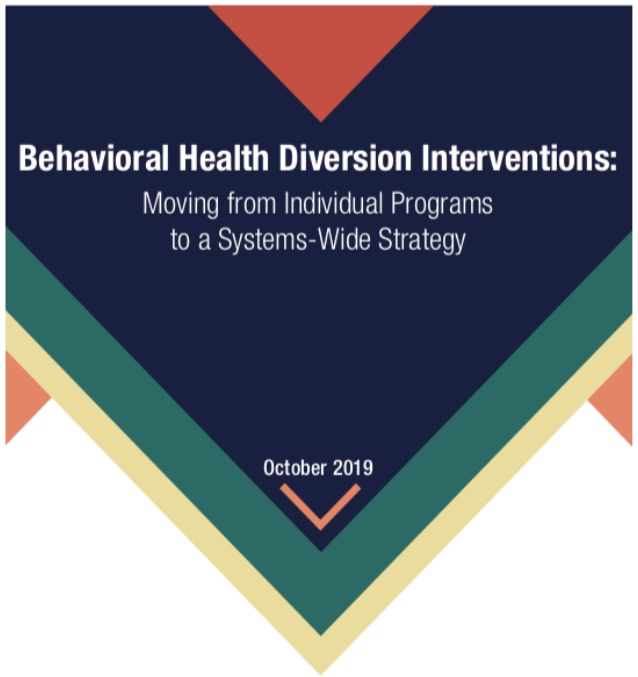
Behavioral Health Diversion and Reentry Strategies

- Diversion strategies that address system enhancements
- Opportunities for diversion at multiple intercept points
- For people who are not eligible for diversion, providing reentry services that include connection to behavioral health services in the community

Continuum of Diversion Interventions



Behavioral Health Diversion Interventions



- Leaders are seeking opportunities to build bridges across systems to create community-wide strategies that have the greatest impact
- Outlines overarching elements needed to create a holistic and effective diversion response strategy

Read more at https://csgjusticecenter.org/mental-health/publications/behavioral-health-diversion-interventions-moving-from-individual-programs-to-a-systems-wide-strategy/

Police-Mental Health Collaboration (PMHC) Framework

APRIL 2019

Police-Mental Health Collaborations

A Framework for Implementing Effective Law Enforcement Responses for People Who Have Mental Health Needs

Introduction

Law enforcement agencies across the country are being challenged by a growing number of calls for service involving people who have mental health needs. Increasingly, officers are called on to be the first—and often the only—responders to calls involving people experiencing a mental health crisis. These calls can be among the most complex and time-consuming for officers to resolve, redirecting them from addressing other public safety concerns and violent crime. They can also draw intense public scrutiny and can be potentially dangerous for officers and people who have mental health needs. When these calls come into 911/ dispatch, the appropriate community-based resources are often lacking to make referrals, and more understanding is needed to relay accurate information to officers. As such, there is increasing urgency to ensure that officers and 911 dispatchers have the training, tools, and support to safely connect people to needed mental health services.[1]

To respond to these challenges, police departments are increasingly seeking help from the behavioral health system.[2] This trend is promising, as historically, law enforcement and the behavioral health system have not always closely collaborated. Absent these collaborations, officers often lack awareness of, or do not know how to access, a community's array of available services and alternatives to arrest, such as crisis stabilization services, mental health hotlines, and other community-based resources. And even when officers are fully informed, service capacity is typically insufficient to meet the community's need. As a result, officers experience frustration and trauma as they encounter the same familiar faces over and over again, only to witness the health of these individuals deteriorate over time.

Police Departments Can't Do it Alone

Many communities continue to face pervasive gaps in mental health services, especially crisis services, placing a heavy burden on law enforcement agencies and, in particular, officers. Without access to appropriate alternatives, officers are often left with a set of poor choices: leave people in potentially harmful situations, bring them to hospital emergency departments, or arrest them.

Understanding a need for greater collaboration, many law enforcement and behavioral health agencies have begun taking important steps to improve responses to people who have mental health needs. These efforts have led to improvements in practices, such as providing mental health training to law enforcement workforces and including mental health, crisis intervention, and stabilization training as part of some states' law enforcement training standards. (Stabilization training refers to tactics used to defuse and minimize any harmful or potentially dangerous behavior an individual might exhibit during a call for service.) Some of these communities also designate officers to serve as part of specialized teams to respond to mental health-related calls for service. But while these steps are commendable and signify widespread

BJA | Justice Center

- Draws upon experience of most advanced PMHCs in the nation
- Articulates the core components of a comprehensive and robust PMHC that produce improvements in community-wide outcomes
- Shifts the focus away from stand-alone training or small-scale programs/teams toward agency-wide collaborative responses and metrics-driven performance management

Read more at https://csgjusticecenter.org/law-enforcement/publications/police-mental-health-collaborations-a-framework-for-implementing-effective-law-enforcement-responses-for-people-who-have-mental-health-needs/.

A Common Framework for 18,000+ Law Enforcement Agencies

Written for **law enforcement executives**, with the expectation that they can manage

- ↑ up to elected/appointed leaders
- ↔ horizontally to behavioral health partners
- ↓ down to program-level staff and all agency personnel

Six Questions for Law Enforcement Leaders

1. Is our **leadership** committed?

2. Do we have **clear policies and procedures** to respond to people who have mental health needs?

3. Do we provide staff with quality mental health and stabilization **training**?

4. Does the community have a full array of **mental health services and supports** for people who have mental health needs?

5. Do we **collect and analyze data** to measure our progress?

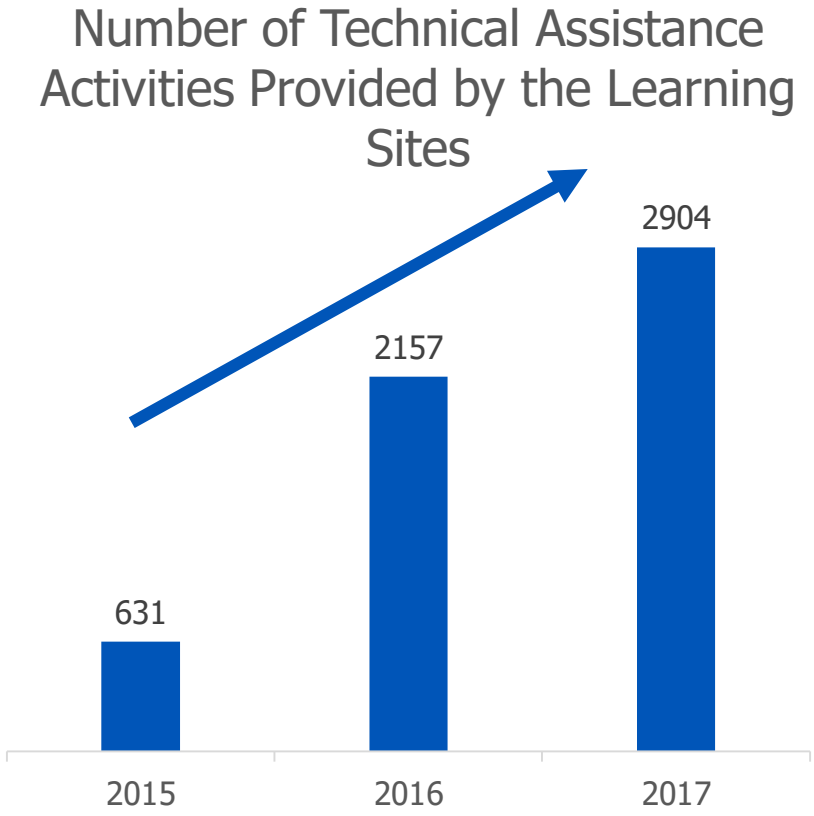
6. Do we have a formalized process for reviewing and **improving performance?**

Law Enforcement-Mental Health Learning Sites

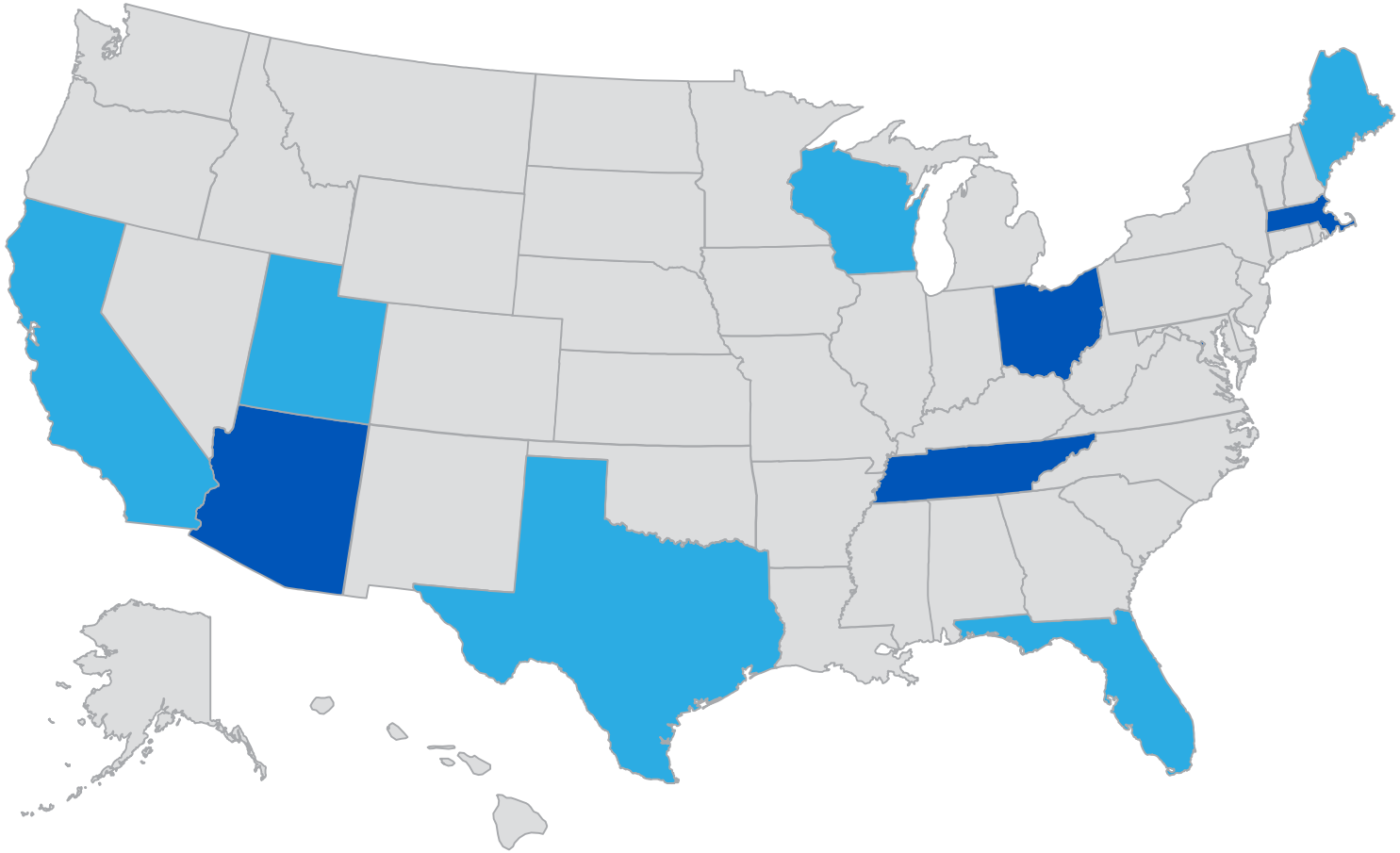
A peer-to-peer learning program supported by BJA and the CSG Justice Center

Since 2010, 6 learning sites have supported jurisdictions across the nation in exploring strategies to improve law enforcement responses to people who have mental health needs.

In 2017, 4 additional sites were added to meet demands from the field and increase the range of strategies and agency features.



Law Enforcement-Mental Health Learning Sites



2010 Cohort:

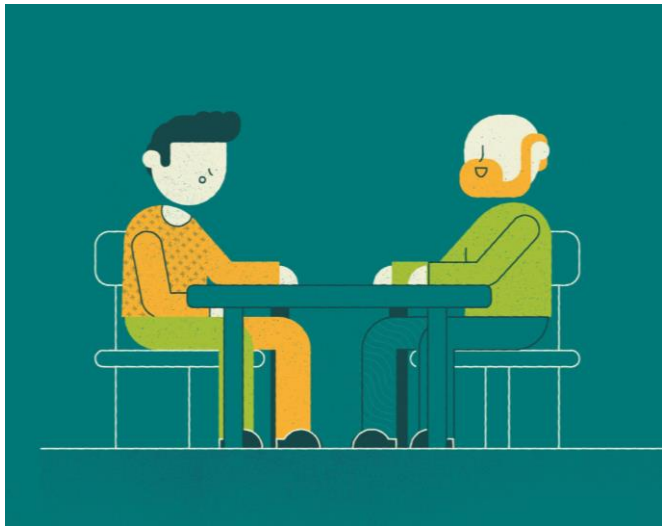
1. Houston (TX) Police Department
2. Los Angeles (CA) Police Department
3. Madison (WI) Police Department
4. Portland (ME) Police Department
5. Salt Lake City (UT) Police Department
6. University of Florida Police Department

2017 Cohort:

1. Arlington (MA) Police Department
2. Jackson County (OH) Sheriff's Office
3. Madison County (TN) Sheriff's Office
4. Tucson (AZ) Police Department

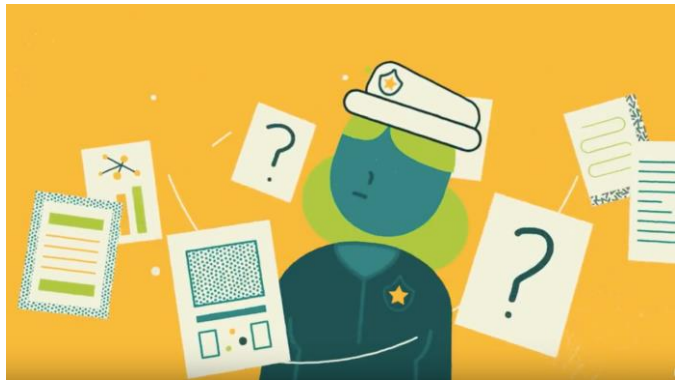
The Stepping Up Initiative

Stepping Up is a national movement to provide counties with tools to develop cross-systems, data-driven strategies to measurably reduce the number of people with mental illnesses in jails.



THE STEPPING UP INITIATIVE

- Calls for a paradigm shift:
  - Move beyond programs and pilots to scaled impact and measurable reductions in prevalence
- No-nonsense, data-driven public management:
  - Systematic identification of mental illnesses in jails
  - Quantification of the problem
  - Scaled implementation of strategies proven to produce results
  - Tracking progress and adjusting efforts based on a core set of outcomes



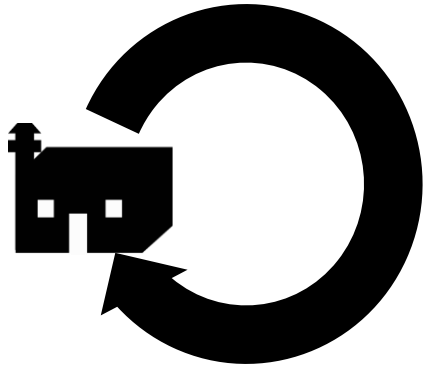
THE STEPPING UP INITIATIVE

Systems-Level, Data-Driven Changes Should Focus on **Four Key Measures**

1. Reduce the number of people who have mental illnesses booked into jails

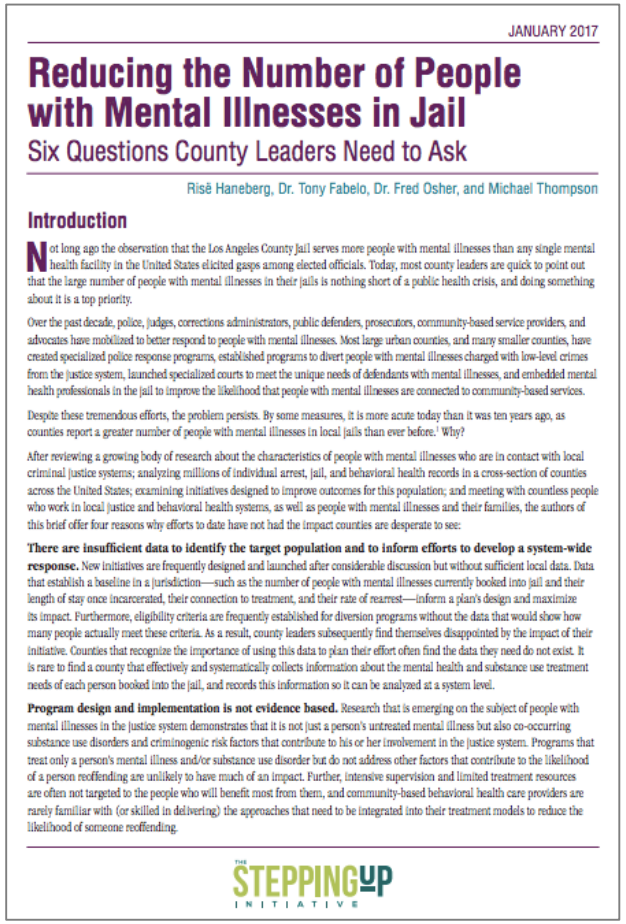
2. Shorten the length of stay in jails for people who have mental illnesses

3. Increase connection to treatment for people who have mental illnesses



4. Reduce recidivism rates for people who have mental illnesses

THE STEPPING UP INITIATIVE



JANUARY 2017

Reducing the Number of People with Mental Illnesses in Jail

Six Questions County Leaders Need to Ask

Risë Haneberg, Dr. Tony Fabelo, Dr. Fred Osher, and Michael Thompson

Introduction

Not long ago the observation that the Los Angeles County Jail serves more people with mental illnesses than any single mental health facility in the United States elicited gasps among elected officials. Today, most county leaders are quick to point out that the large number of people with mental illnesses in their jails is nothing short of a public health crisis, and doing something about it is a top priority.

Over the past decade, police, judges, corrections administrators, public defenders, prosecutors, community-based service providers, and advocates have mobilized to better respond to people with mental illnesses. Most large urban counties, and many smaller counties, have created specialized police response programs, established programs to divert people with mental illnesses charged with low-level crimes from the justice system, launched specialized courts to meet the unique needs of defendants with mental illnesses, and embedded mental health professionals in the jail to improve the likelihood that people with mental illnesses are connected to community-based services.

Despite these tremendous efforts, the problem persists. By some measures, it is more acute today than it was ten years ago, as counties report a greater number of people with mental illnesses in local jails than ever before.[1] Why?

After reviewing a growing body of research about the characteristics of people with mental illnesses who are in contact with local criminal justice systems; analyzing millions of individual arrest, jail, and behavioral health records in a cross-section of counties across the United States; examining initiatives designed to improve outcomes for this population; and meeting with countless people who work in local justice and behavioral health systems, as well as people with mental illnesses and their families, the authors of this brief offer four reasons why efforts to date have not had the impact counties are desperate to see:

There are insufficient data to identify the target population and to inform efforts to develop a system-wide response. New initiatives are frequently designed and launched after considerable discussion but without sufficient local data. Data that establish a baseline in a jurisdiction—such as the number of people with mental illnesses currently booked into jail and their length of stay once incarcerated, their connection to treatment, and their rate of rearrest—inform a plan's design and maximize its impact. Furthermore, eligibility criteria are frequently established for diversion programs without the data that would show how many people actually meet these criteria. As a result, county leaders subsequently find themselves disappointed by the impact of their initiative. Counties that recognize the importance of using this data to plan their effort often find the data they need do not exist. It is rare to find a county that effectively and systematically collects information about the mental health and substance use treatment needs of each person booked into the jail, and records this information so it can be analyzed at a system level.

Program design and implementation is not evidence based. Research that is emerging on the subject of people with mental illnesses in the justice system demonstrates that it is not just a person's untreated mental illness but also co-occurring substance use disorders and criminogenic risk factors that contribute to his or her involvement in the justice system. Programs that treat only a person's mental illness and/or substance use disorder but do not address other factors that contribute to the likelihood of a person reoffending are unlikely to have much of an impact. Further, intensive supervision and limited treatment resources are often not targeted to the people who will benefit most from them, and community-based behavioral health care providers are rarely familiar with (or skilled in delivering) the approaches that need to be integrated into their treatment models to reduce the likelihood of someone reoffending.

THE STEPPING UP INITIATIVE

1. Is our leadership committed?
2. Do we conduct timely screening and assessments?
3. Do we have baseline data?
4. Have we conducted a comprehensive process analysis & inventory of services?
5. Have we prioritized policy, practice, and funding improvements?
6. Do we track progress?

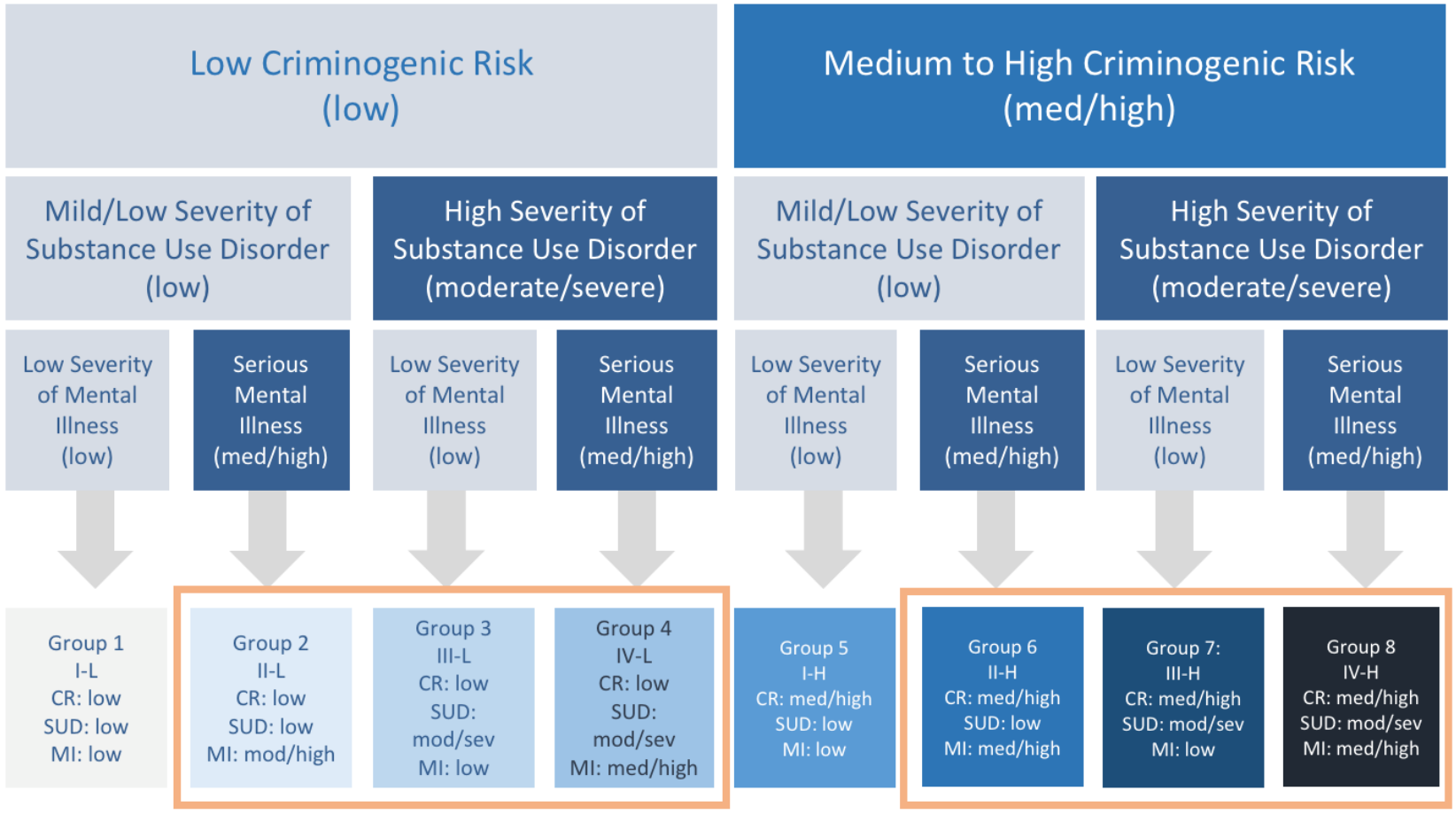
Primary Systems-Level Challenges

- Quantifying needs using data
  - Systematic identification of people with behavioral health needs using validated tools and standard definitions of mental illness and substance abuse
- Identifying system improvements and treatment gaps using data
  - Specifying gaps in community-based services and treatment based on data on connections to care
- Developing multiple diversion opportunities and a community-based crisis response system
- Working to identify "high utilizers" of multiple systems and support targeted interventions across systems

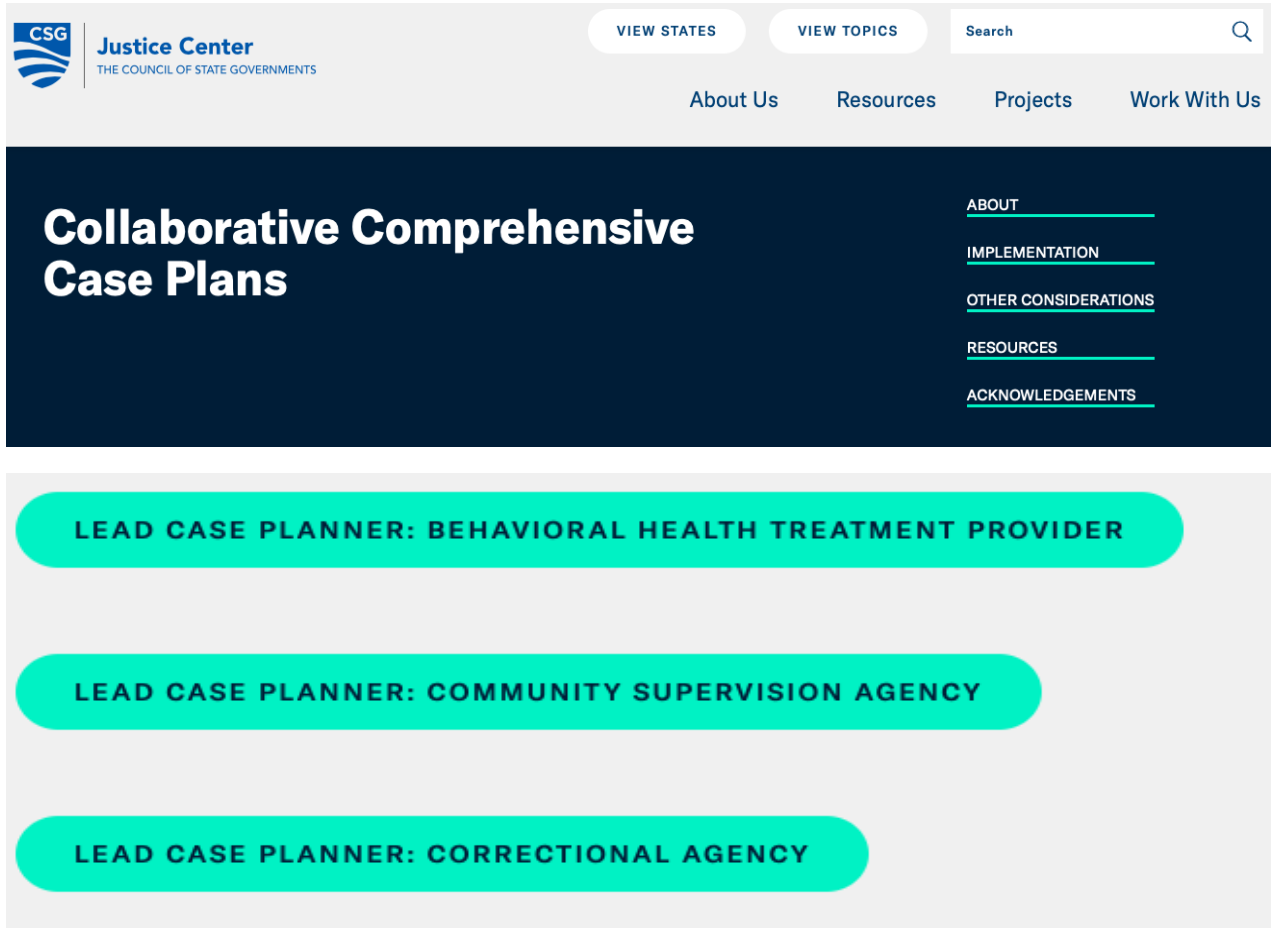
Primary Practice-Level Challenges

- Targeting interventions based on behavioral health needs and criminogenic risk
  - Assessing serious mental illnesses, substance abuse, and criminogenic risk factors in courts and correctional facilities
- Incorporating assessment information into case plans
  - Utilizing the assessment information for BOTH behavioral health and criminogenic risk in case plans
- Implementing evidence-based practices (EBPs)
  - Developing quality assurance for screening, assessment, and EBPs
- Using Data to Support Changes in Practices

Criminogenic Risk/Behavioral Health Needs Framework



Web-Based Tool to Support Case Planning



- Online tool that helps behavioral health and criminal justice professionals integrate the risk/needs information gathered from assessments into case plans that engage the person reentering the community.
- "Collaborative Comprehensive Case Plans," the CSG Justice Center, accessed May 7, 2020, https://csgjusticecenter.org/publications/collaborative-comprehensive-case-plans/.

Example of Lead Case Planner

Lead Case Planners:

- Are any agency or provider who takes the lead in case planning and management, such as a probation or parole agency, behavioral health treatment provider, or correctional agency
- Oversee the case planning process and engage the appropriate people from each partnering agency, as well as each participant and their support system

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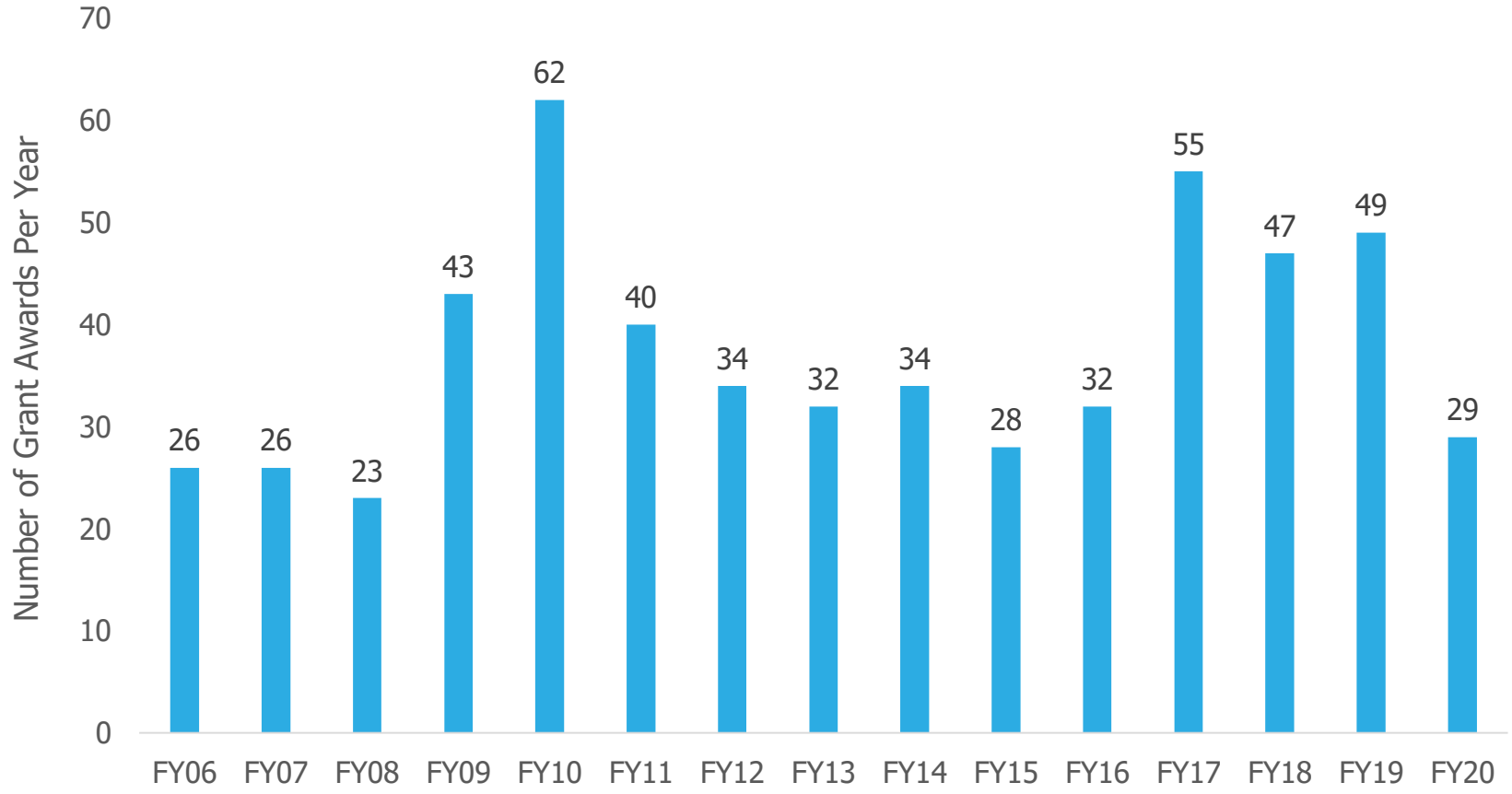
Overview of JMHCP

The Justice and Mental Health Collaboration Program (JMHCP)

- Supports cross-system collaboration to improve public safety responses and outcomes for individuals with mental illnesses (MI) or co-occurring mental illness and substance abuse (CMISA) who come into contact with the justice system; and
- This program supports public safety efforts through partnerships with social services and other organizations that will enhance responses to people with MI and CMISA.

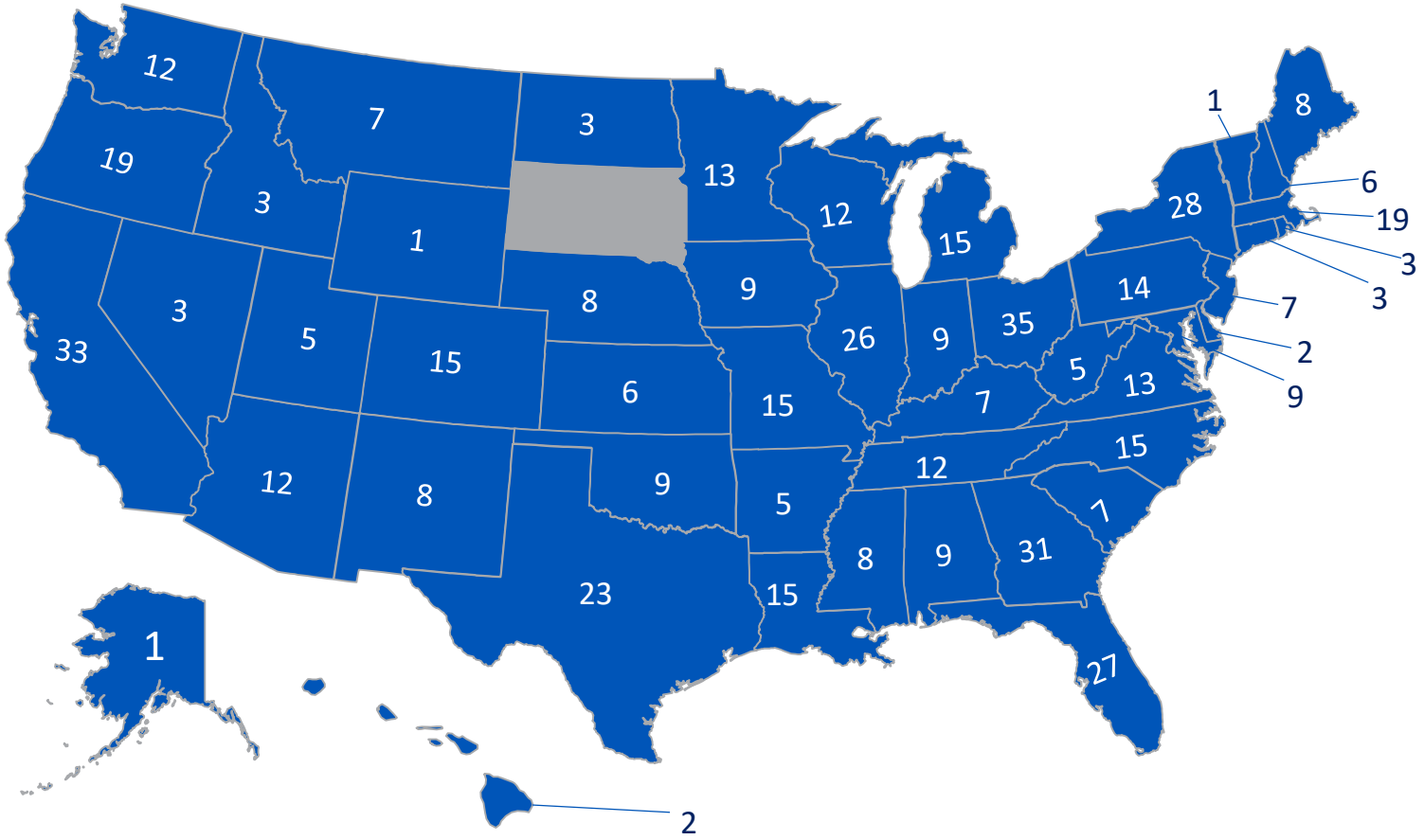
JMHCP Grant Program: $164.3 Million Awarded



FY06	FY07	FY08	FY09	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17	FY18	FY19	FY20
$4.9M	$4.9M	$6.5M	$10M	$12M	$9.9M	$9M	$8.4M	$8.3M	$8.5M	$7.25M	$8.7M	$23.52 M	$23.83 M	18.6M

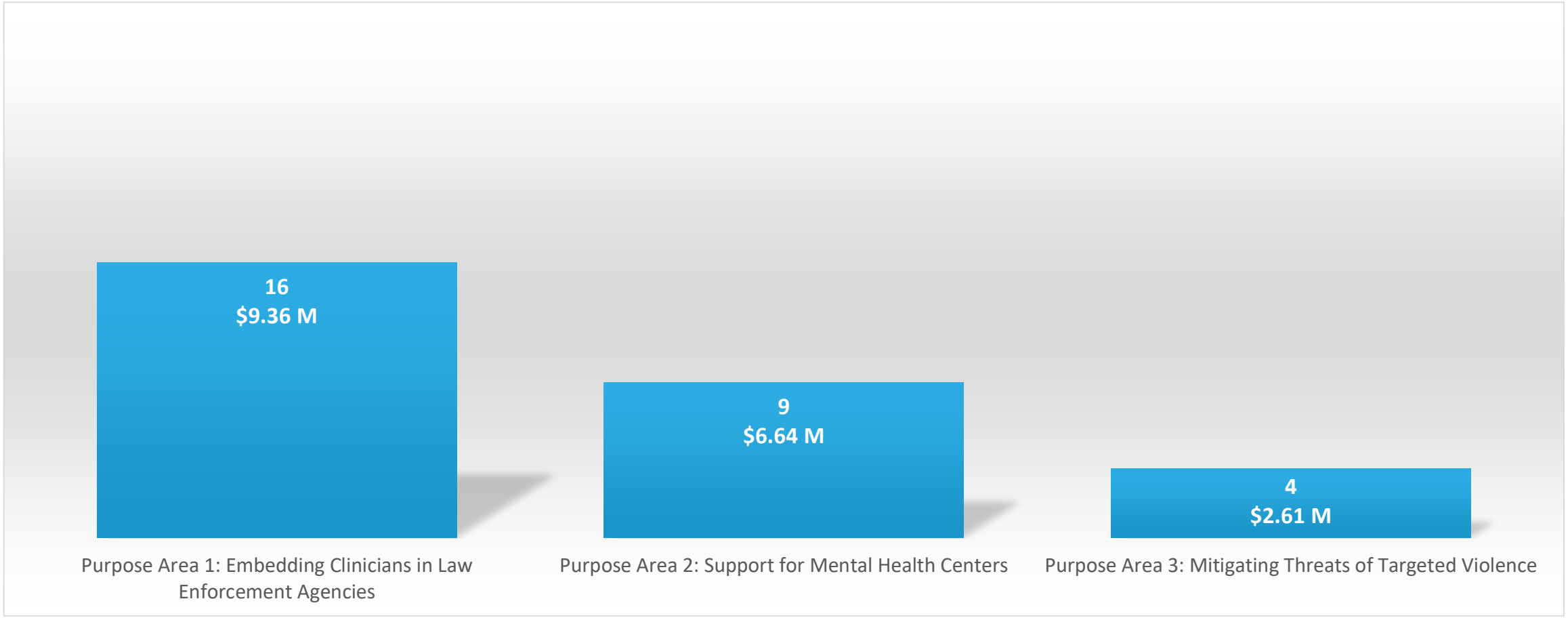
568 Awardees across the Nation

- Representing 49 states and two U.S. territories
- **$164.3 million** awarded



CSG Justice Center

FY20 JMHCP Awardees



Objectives and Deliverables

- Through a two-phase process consisting of planning and implementation activities during with grantees will develop a systemwide coordinated approach to safely reduce the prevalence of low-risk individuals with MI and CMISA in local jails.
- The planning phase can be for up to 12 months and the implementation phase will begin once the grantee has met the requirements of the planning phase and will continue for the remining time of the grant.

Objectives and Deliverables

- Grantees should structure their budgets to allocate a portion of the budget (up to $100,000 of the total grant award) to complete Phase 1: Planning within 12 months of receiving final OJP approval of the projected budget.
- Program budget approval is after BJA and CSG's Justice Center's technical assistance coach has approved the Planning and Implementation Guide.
- Period of performance duration: Up to 36 months

Grant Purpose Areas

Purpose Area 1: Embedding Clinicians in Law Enforcement Agencies

- Allows for social workers and/or mental health professionals to be place (embedded) in the law enforcement agencies to assist officers during encounters with people in mental health crisis. Grantees under this purpose area can use funding to pay for salaries as well as other expenses such as training and other coordination activities to ensure implementation of the collaborative program.

Grant Purpose Areas

Purpose Area 2: Support for Mental Health Centers

- Funds operational expenses for centers that provide assistance to those with severe mental health needs who are at risk of recidivism. These mental health centers can provide, but are not limited to, the following services: crisis care, residential treatment, outpatient mental health and primary care services, and community reentry supports.

Grant Purpose Areas

Purpose Area 3: Mitigating Threats of Targeted Violence

- Supports law enforcement and prosecutors to respond to and mitigate threats of targeted violence. Funds under this purpose area can be used by state and local prosecutors and investigators to seek assistance from mental health professionals and threat assessment experts to identify and disrupt individuals who are mobilizing toward violence.

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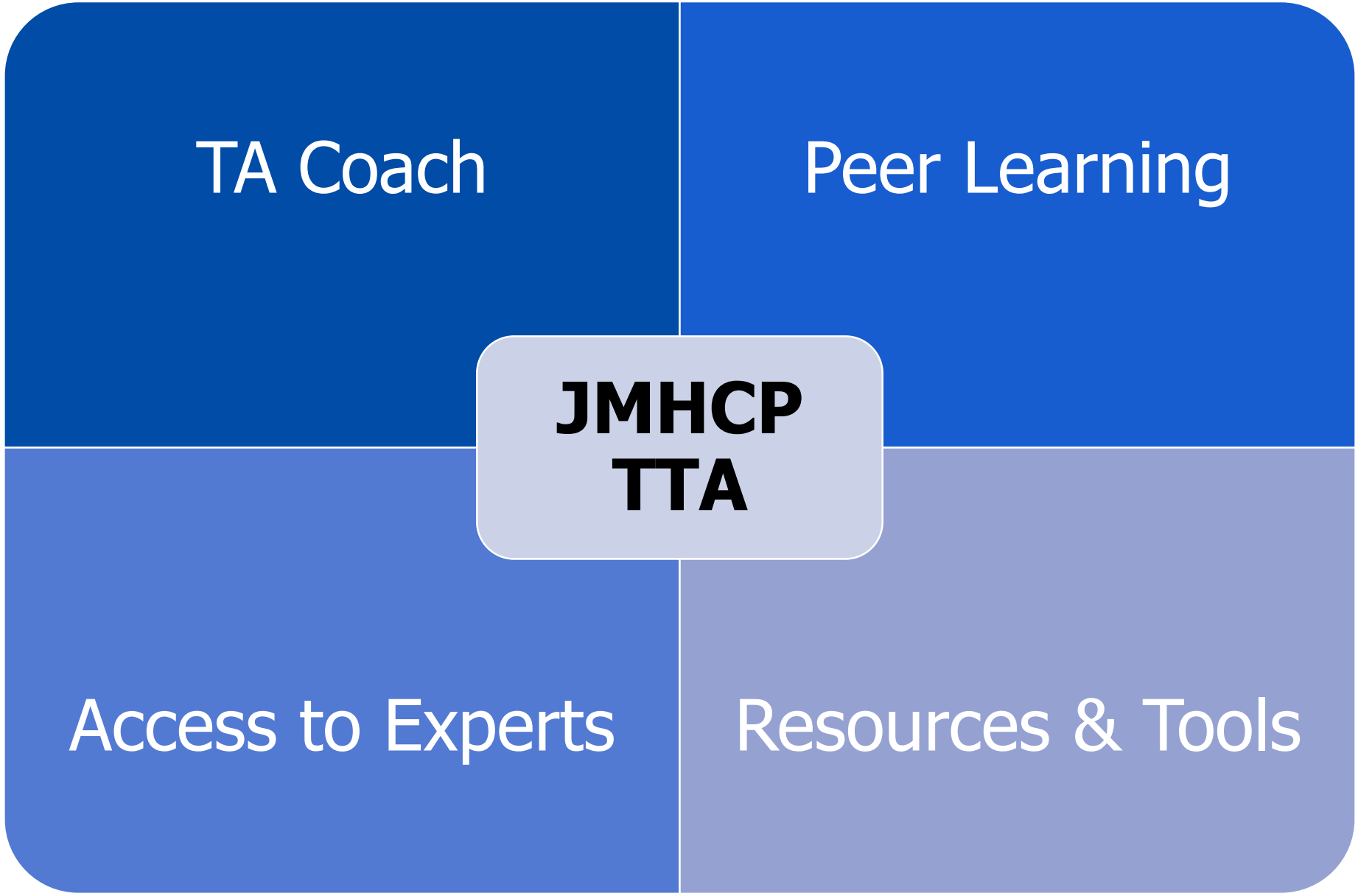
V. Questions and Answers


TA Coach
Peer Learning
JMHCP
TTA
Access to Experts
Resources & Tools


Monthly Calls
Site Visits
P&I Guides
TA Coach
Learning Commun-ities
Resources
Peer Learning

Planning & Implementation (P&I) Guide

1. Goals
2. Collaborative Partnerships
3. Target Population
4. Evidence-based Services and Supports
5. Data Collection, Performance Measurement, and Program Evaluation
6. Sustainability
7. Technical Assistance Plan

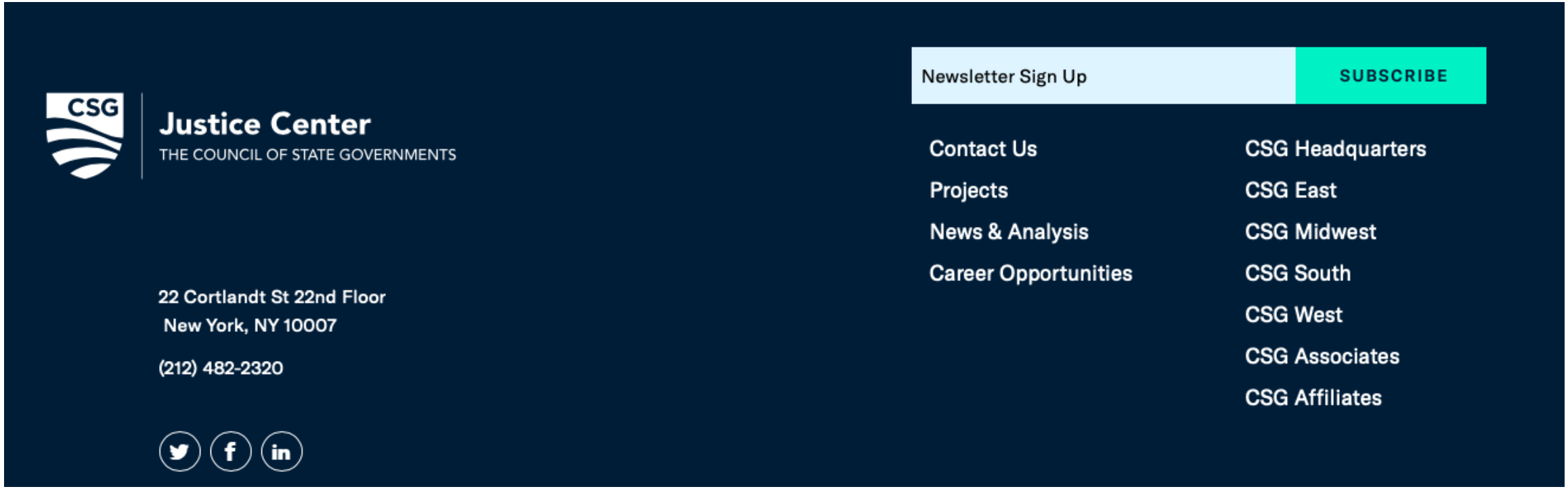
Development of TA Plans

- Each TA coach will work with the grantees to develop a training and technical assistance plan
- This will lay out goals for TA that will be continuously reviewed and updated
- The site will identify TA needs with the TA coach and they will work toward meeting the TA goals
- This is all focused on moving the grantee forward to meet their grant milestones

FY2020 Learning Communities

1. Purpose Area 1- Embedding Clinicians in Law Enforcement Agencies
2. Purpose Area 2- Community Mental Health Centers
3. Purpose Area 3- Mitigating Threats of Targeted Violence
4. “High Utilizers”
5. Data Collection, Information Sharing, and Evaluation

Monthly Behavioral Health Newsletter



Agenda

I. Welcome and Introductions

II. Overview of Behavioral Health Diversion and Reentry Strategies

III. Overview of JMHCP

IV. Technical Assistance

V. Questions and Answers

Questions and Answers

JMHCP Orientation Webinars

- ***JMHCP Orientation Webinar Part 2***

  December 1st 3:00 p.m. – 4:30 p.m. ET

- **JMHCP Grantee Purpose Area-Specific Orientation Webinars**
  - Each of the three purpose areas will have an orientation webinar in December
  - Your TA Coach will provide the information on the purpose area orientation webinar for your grant team to attend
  - This will provide some additional purpose area specific information and an opportunity to learn more about the other grantees

Resources

- Collaborative Comprehensive Case Plans: https://csgjusticecenter.org/nrrc/collaborative-comprehensive-case-plans/
- Police Mental Health Collaboration Toolkit: https://pmhctoolkit.bja.gov/
- Law Enforcement Mental Health Learning Sites: https://csgjusticecenter.org/law-enforcement/projects/mental-health-learning-sites/
- Stepping Up Initiative: https://csgjusticecenter.org/mental-health/county-improvement-project/stepping-up/

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