# Commission on Alternatives to Incarceration
**Chairman Joseph Kroeber**

**Testimony by the**
**Jail Intervention Coordinating Committee, Cass County**
**March 21, 2006**

My name is Sheree Spear; I'm a family member of a person with severe mental illness, and represent NAMI ND – the National Alliance on Mental Illness as volunteer project coordinator for Cass County's Jail Intervention Coordinating Committee (JICC). I'm privileged to speak today on behalf of this extraordinary group of people. The Jail Intervention Coordinating Committee has dedicated a great deal of time, and brought much expertise to bear, on identifying how to affect changes to improve the outcome for people with severe mental illness with or without a co-occurring substance abuse issue, who are at risk of, or come into contact with the criminal justice system. You have a list of Committee members. Additionally, several people have given of their time to answer questions and give input as we've moved through the planning process. ND Supreme Court Chief Justice VandeWalle, Judge Bruce Bohlman of Grand Forks, staff for States Attorney Birch Burdick, defense attorney Mark Friese, Judge Georgia Dawson, and former police chief Chris Magnus are some of the individuals who have been kind enough to let us bend their ear and help point us in the right direction. Our objective today is to share information and update you on our project, and seek your recommendations and support.

The Jail Intervention Coordinating Committee has followed the recommendations put forward by the Council of State Government's project called : "The Criminal

Justice/Mental Health Consensus Project". North Dakota is a member of the Council of State Governments (CSG). You have a project overview hand-out. The Project report contains 46 policy statements, program examples and detailed descriptions for implementation. This document reflects countless hours of counsel from over 100 of the most respected criminal justice and mental health practitioners and policymakers in the United States, and is unprecedented. It states: "Legislators, policymakers, practitioners, and other agents of change can champion and implement the detailed recommendations in this report knowing that each has been developed and approved by experts from an extraordinarily diverse range of perspectives who work in and administer the departments, agencies, and organizations trying every day to address the needs of people with mental illness in the criminal justice system." Consistent with, and supporting these recommendations are documents from the national TAPA Center for Jail Diversion, SAMSHA, the national GAINS Center for Co-Occurring Disorders, as well as numerous journal articles.

**Post-booking and Pre-booking Diversion Programs**

In following these recommendations we have divided our project into two phases, identified by the point in the criminal justice system where early intervention and/or diversion may occur for an effective "front-end" response. We're at the end of the planning process for Phase I: Post-booking diversion, where we've focused on deferred imposition of sentence as an alternative to incarceration, using a jail-based model. Discussion of the concept and resources for a post-booking diversion pilot are the focus of our presentation today. However, we would like you to be aware that we are in the early planning stage for a pre-booking diversion program, which will include - but not be

limited to - implementation of a police-based model. I'll take just a moment to tell you a little about that.

Essential to a successful pre-booking diversion program is fidelity to the CIT (Crisis Intervention Team) model, now considered a "Best Practice" nationally. It was developed by Major Cochran, Memphis PD, and has proliferated across the Country. There are two key components of this model: 40 hours of specialized law enforcement training and the establishment of an Assessment/Triage Center that is open 24/7 and has a "no refusal policy". The Fargo Police Department recently sent an individual for training on this model. And we are seeing good, informal collaboration between the police department and the Human Service Center already taking shape which is re-directing some individuals.

Unique to our project is the fact that our "Crisis Response" subcommittee will also seek to identify *all* the people in the community who may interact with a person with severe mental illness, and who may be able to influence the outcome for that person. In some cases, involvement with law enforcement may be avoided. Training and resource needs, and process changes will be determined and support for implementation for pre-booking diversion strategies will be sought in the future.

**Historical Perspective**

Before moving through the flow chart for the process we're proposing, it may be appropriate to take a moment and – from a broad, historical perspective – recognize the

significance of your Commission and the role you may play in shaping the future for thousands and thousands of people to come. One hundred years ago there was no perceived need to even consider Alternatives to Incarceration for people with a severe mental illness. And one hundred years from now, I hope there will be no need to study this topic, because of what was done at this moment in history – by agents of change, such as yourselves.

When Clozapine came on the scene some twenty years ago, it was the first medication that appeared to rid people of the incessant, often terrifying, inner voices that are characteristic of schizophrenia. I don't think any of us can really image what it must be like to have loud voices in our heads 24-7 telling us horrible things about ourselves and what is going to happen to us. A person suffering in this way is tormented to their very soul. There was a quote from my son published in The Forum a few years ago where he described what it is like to have schizophrenia. It said, "I know now that there is a heaven and a hell. And they are here on earth. And I can see them as clearly as I can see you sitting there. Because what is constant pain and suffering? That's hell. That's where I'm at. And I see heaven, and I watch other people who are living in it. But I can't get there."

Well, he *has* gotten there, and there are people in this room who helped make that happen. But the point is, that it is inhuman and simply negligent to not intervene and aid people who have profound thought disorders that impair their ability to seek treatment on their own. Particularly at a time when huge medical advances have brought us an array

of new medications in the last 10 years. Treatments are working. They aren't perfect and many have side-affects. But they're working. And for the first time in history ***the promise of a fulfilling life in the community is very real and happening***, for many.

Advances in science often open new doors, and change how we do business. We need to affect changes so our systems are up-to-date and complement the medical advances, so that new doors are open for all people who are struck with a severe mental illness. One way we can do that is by implementing diversion programs.

Effective diversion programs, as proposed by our Committee, improve the quality of life for people with mental illness by directing them to treatment and support. They increase public safety, and they reduce the amount of money wasted every year on dealing with and processing these people through systems that were never designed or intended to address their needs.

And studies that have evaluated the outcomes of these programs are highly encouraging. The Outcome Evaluation for King County in Seattle, WA, for example, one of the most respected programs in the Country, confirms their program is not only cost effective but also significantly reduces recidivism. You have a copy of their report. This is the kind of report we plan to produce as well, and Dr. McDonald can speak to the research component of our pilot. You'll note theirs is a formal mental health court, and while ours is not, the process we're proposing is very similar. Data from King County includes the following:

I. A significant reduction in recidivism. A 75.9% decrease in the number of offenses committed.

II. A significant reduction in the occurrence of violent criminal activity among its participants. Data indicate an 87.9% decrease in the percentage of violent offenses committed by its graduates.

III. A high level of customer and consumer satisfaction. Over 90% of graduates felt that their life was better after their involvement with the program. When asked their overall impression of the program, 61.5% found it to be Very Good and 38.5% rated it as Good. None of the participants was dissatisfied.

A graduate of the program had this to say, *"When I first entered the mental health court, I did not want to be there, I didn't like it. When I started to realize that they weren't there just to put me in jail, but to try to help me, I started to turn my life around. Now I have two jobs, I keep myself busy, and I'm independent again, that's important to me."*

**Concept and Resources**

Dr. Thomas McDonald of NDSU, our lead advisor and the individual heading up the data collection, information sharing, and research aspect of our proposed pilot, said this at one of our subcommittee meetings: "When someone tells me something works, I don't know what they mean. *What* works? The concept that the project is built on, the resources applied to it?" He indicated that the success of a project will depend upon all of the "Big Three":

1) clarity and consensus around the Concept,

2) the Resources applied to it, and

3) How *both* the resources and concept are Managed.

As we go through the process flow chart from booking on, we hope to convey the message that **new** dollars are needed to provide the treatment services that are part of an effective alternative to incarceration program. We simply cannot expect our local Human Service Center to provide the treatment services needed out of existing resources because we are already severely under-capacity in this region. Due to the population growth we've experienced and the increased needs that go along with that, we must build the capacity to meet the needs in our community.

**Process for Deferred Imposition of Sentence & Funding Requirements**

At this time, I'd like to draw your attention to the colored Flow Chart which provides an overview of the process for Deferred Imposition of Sentence as an alternative to incarceration. We've selected a jail-based rather than a court-based diversion model, so individuals would be initially screened at the jail, not from the court's arraignment list. This process can be thought of as being divided into three general categories:

I Screening, Selection, & Treatment Plan Development
II Treatment Plan Implementation & Monitoring
III Evaluation of Outcomes and Program Management

Referring to the flow chart, a person is booked into jail and is screened by trained jail staff. Individuals identified as having, or who may have a severe mental illness are referred for an expanded assessment, which would be conducted by the Clinical Mental Health Coordinator. This would be a new position, a full-time employee (possibly a

County employee) with the experience and credentials required to complete expanded assessments, develop draft Treatment Plans for review, effectively interact with the detainee and that individual's defense attorney, prosecuting attorney, and the Judge. Referrals can come from jail staff, defense or prosecuting attorneys, or the Court.

If results of an expanded assessment indicate the individual may be a candidate for an alternative sentence, and if the individual volunteers to participate in the program if offered, the Clinical Mental Health Coordinator makes this recommendation and drafts a proposed Treatment Plan with involvement from the individual who has the mental illness. A review team consisting of experts in psychiatric treatment, chemical dependency, and case management services must review and give approval to the proposed Plan before it is moved forward. While plans will be customized, adhering to prescribed medications and staying engaged with a mental health professionals are the foundation for such plans.

If agreement is reached that the candidate meets eligibility criteria, and the Treatment Plan offered in lieu of incarceration is accepted, the Court would order adherence to the Treatment Plan as condition of a deferred imposition of sentence. The Court would be kept appraised of the case, and the participant would receive treatment and services. The case manager and probation officer would be involved in a recommendation to the Court regarding whether or not to revoke, should the individual not adhere to conditions of the sentence. Upon successful completion of the program, charges will be dismissed and plans made to keep the client engaged with a service provider.

**Identifying and Selecting Participants for Diversion**

Agencies have been doing working to meet the needs in our community. Southeast Human Service Center, under the direction of Nancy McKenzie and now Candace Fuglesten, has been progressive in their approach and has established an effective collaboration with the Cass County Jail to provide expanded assessments and medical treatment to incarcerated individuals with severe mental illness. In addition to providing clinical staff who make on-site visits to the jail to conduct expanded assessments and provide psychiatric treatement, they review New Admission lists provided by the jail daily and make contact with incarcerated individuals who are current clients.

The Cass County Jail, under the direction of Major Glenn Ellingsberg, has already selected an additional screening instrument to facilitate the identification of people with a mental illness who are in need of an in-depth assessment and/or treatment. The jail forwards a New Admission list regularly to the Human Service Center to ensure that case managers are aware that a detainee already connected with the service provider, is in the facility. This immediate and direct communication enables the case manager to initiate contact with the detainee.

The Jail has also, with the support of the County Commission, provided staff to serve on subcommittees and chair the Jail Intervention Coordinating Committee, as well as hosting meetings for the group.

Limitations: There is only one person from the Human Service Center that conducts assessments that goes into the jail to conduct assessments, and that person has to cover five jails. They simply are not able to do all the assessments for people flagged by the jail as needing one. People cannot receive services from a Human Service Center unless they have a diagnosis. And they cannot get a diagnosis, unless an assessment is done. So an accurate assessment is the first step in linking someone to the most appropriate services.

New Resources needed: *(see attached Funding Requirements worksheet)* A full-time Clinical Mental Health professional at the jail to conduct expanded/in-depth assessments, recommend individuals for the program, interact with the Court, and monitor the individual's progress. "The Funding Requirements" worksheet details expenditures, including creation of this new position. Please note the additional items on this page.

**Implementing an Effective Treatment Plan**

The best Treatment Plan in the world will not result in the desired outcome for individuals if the services needed to implement and monitor the plan are not available. Page two of the Funding Requirements worksheet outlines these types of costs.
"If medication monitoring doesn't happen, people just end up right back with us again," stated a prominent North Dakota States Attorney. Page two of the Funding Requirements worksheet A common challenge and barrier realized by many programs in the Country is the lack of appropriate housing. In Cass County, there is already a drastic lack of sufficient crisis beds, transitional housing, supportive housing, and residential treatment

programs for people with co-occurring mental illness and substance abuse/chemical dependency.

Stable housing, staying engaged with a service provider, adhering to prescribed medications, treatment for any chemical dependency, and employment and skills building training, are some of the key predictors of whether or not a person with severe mental illness will cycle in and out of the criminal justice system.

Limitations:

Currently, **case managers** in this region are handling case loads that are twice as high as what Best Practices indicates they should be. And, that is after having narrowed even further the eligibility criteria for who can receive case management services. The highest percentage of people in the State who have longer-term, chronic conditions are in this region. So, when we talk about narrowing criteria further, we are not talking having to deny these services to people who will be fine without them. We are talking about people who are the most vulnerable, most deserving, and most in need. A full-time case manager must be added.

In terms of **transitional housing** that gives people the skills they need to live independently in the community, or **supportive housing**, we are severely lacking in our region. All we have is Dakota Pioneer which always has a waiting list. **Respite beds** and **crisis beds** are drastically under-funded, with only 2 respite beds and 8 crisis beds to serve the entire 5 county region. These are some of the limitations and the proposed

budget is higher than we had hoped, simply because it has to include building capacity that is just not there for us to draw upon.

New Resources needed:
Please review the items listed under "Treatment Plan Implementation & Monitoring" on the Funding Requirements worksheet.

**"Mentally Ill Offender Treatment and Crime Reduction Act"**

As we seek ways to implement diversion programs, one source of funding we may be able to pursue is through legislation President Bush signed in October of 2004 called, "The Mentally Ill Offender Treatment and Crime Reduction Act". Funds to implement the Act were appropriated in November 2005. The grant process will be highly competitive, however, with only about 26 grants awarded nationally. This legislation passed with broad bipartisan support, the culmination of a ground-swell across the nation calling for a different response to people with severe mental illness who connect with our criminal justice system. A front-end response that diverts people away from the criminal justice system and directs them toward treatment and community-based services. While the initial $100,000,000. request was reduced to $5,000,000. actually being appropriated, funds will be awarded this year for planning and/or implementation of jail-based, court-based and police-based diversion programs. The Request for Application for these funds will be issued any day and will likely need to be submitted 30 days later. We're looking

to Cass County to be the grant applicant for our project. We hope your Commission will support our efforts.

**Summary**

The project we've discussed today, along with any other program to diversion people with severe mental illness from our criminal justice system, will likely need new dollars in order to be effective. Our committee has found current dollars aren't sufficient to support current programs due to the population growth in the area and the increased needs that go along with that. However, we simply cannot do business as we always have when there are models we can introduce here which will increase public safety, make better use of funds, and put people on the road to recovery.

Thank you very much for giving us an opportunity to present to you today. I'll be happy to take any questions you may have now.

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