Managing the Seriously Mentally Ill in Corrections

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Key Findings

An expert workshop of correctional line staff and administrators, mental health professionals, and researchers identified the following high-priority needs for managing individuals with serious mental illness (SMI) in correctional facilities:

- Society needs to prioritize mental illness and dedicate sustainable treatment resources accordingly. The justice system should advocate for better access to treatment in the community.

- Individuals with SMI need comprehensive, coordinated supportive services (e.g., housing, employment) as well as interventions targeting criminogenic needs (e.g., substance use disorders, antisocial thinking) pre- and post-justice involvement.

- Greater emphasis is needed on prevention, early detection, and intervention, particularly for children.

- Law enforcement agencies need training for better response to incidents involving individuals with SMI and for alternatives to jail.

- The courts need guidance on effective diversion strategies.

- For those who must be incarcerated, institutions should be resourced so that they can effectively treat and manage the population (e.g., meet both mental health and criminogenic needs); effective alternatives to administrative segregation are required.

- Coordinated discharge planning is needed to ensure continuity of care between agencies and providers. Inmates should leave with "warm hand-offs," referrals, an ample supply of medication, and uninterrupted benefits.

- Barriers to collaboration and information-sharing among entities with a "need to know" must be removed.

- The divide between the criminal justice system and the mental health system (e.g., treatment focus, approaches, duplication of efforts) needs to be bridged to provide better care to individuals with SMI.

- Cost-benefit analyses are required to support the redistribution of funding to the most effective intervention points (e.g., prejustice involvement, diversion, and reentry).

On behalf of the National Institute of Justice (NIJ), the Priority Criminal Justice Needs Initiative convened an expert workshop to identify the challenges and needs associated with managing individuals with serious mental illness (SMI) under correctional control. The workshop participants included correctional line staff and administrators, mental health professionals, and researchers. The major goal of the workshop was to produce a set of prioritized needs that can help inform NIJ's research agenda. The recommendations of the participants are presented in this report.

By many accounts, the United States is in the midst of a mental health crisis. For example, more than 18 percent of adults live with some type of mental illness and many do not receive treatment (Ahrnsbrak et al., 2017). A significant percentage of this group suffers from SMI; however, it is important to note that definitions of SMI vary depending on whether the term is used for legal, clinical, or epidemiological purposes (Development Services Group, 2016). The National Institute of Mental Health (2017) defines SMI as a "mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities." These disorders can include schizophrenia and other psychotic disorders; bipolar disorder; severe forms of depression; and some anxiety disorders, such as obsessive-compulsive disorder. Using this definition, it is estimated that 4.2 percent of the adult population suffers from SMI (National Institute of Mental Health, 2017).

A disproportionate number of individuals with SMI become involved in the criminal justice system and ultimately fall under some form of correctional control. In contrast to the prevalence rate in the general population, it is estimated that 20–26 percent of the jail population, 15 percent of state inmates, 9 percent of probationers, and 7 percent of parolees are diagnosed with SMI (Feucht and Gfroerer, 2011; Treatment Advocacy Center, 2016; Bronson and Berzofsky, 2017).

Many factors have contributed to the current situation, including diminishing access to quality mental health treatment in the community. An estimated 35 percent of individuals with SMI are untreated (Ahrnsbrak et al., 2017) and common reasons cited for this lack of treatment include individuals' perception that they do not need treatment, the stigma associated with mental illness, lack of trained professionals, and limited financial resources. Even when treatment is available, the quality of such treatment might be questionable. Research indicates that only 15 percent of individuals with SMI receive care that could be considered at least "minimally adequate" (Wang, Demler, and Kessler, 2002). Furthermore, the coordination of mental health care in the community has been characterized as substandard and, as a result, service provision is fragmented, which limits access to care (Croft and Parish, 2013).

Inadequate access to quality mental health treatment has historical links to profound policy changes made in the 1970s. Often referred to as "de-institutionalization," individuals with SMI were transitioned in mass numbers from large state mental hospitals to smaller community-based facilities or treated on an outpatient basis. As a result, the number of available psychiatric beds per 100,000 people has decreased dramatically from 337 in 1955 to 11.7 in 2016 (Fuller et al., 2016). Although this shift was well intentioned, the promise of treatment in the community did not pan out as expected. Group homes, day treatment programs, and other outpatient mental health services often failed to provide adequate care to the population of individuals with SMI, particularly those with limited financial resources or social support (Shadish, Lugirio, and Lewis, 1989).

Several salient socioeconomic and demographic factors correlated with SMI also have contributed to the overrepresentation of these individuals in the correctional system. When compared with individuals with no mental illness, individuals with SMI are more likely to be unemployed, have inadequate housing, and have a co-occurring substance use disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). Not surprisingly, individuals with SMI are twice as likely to be living below the poverty line (SAMHSA, 2016). Finally, young adults aged 18–25 are more likely to experience SMI than any other age group (Ahrnsbrak et al., 2017). Individuals with SMI closely resemble the general criminal population: They are young, poor, and addicted, with unstable housing (Steadman, Cocozza, and Melick, 1978).

Aggressive drug enforcement and other policing strategies further contributed to the increase in the number of individuals with SMI under correctional control. Individuals with SMI are more likely to use and abuse substances, and therefore are more likely to be arrested for a drug-related crime. Homelessness and poverty make individuals with SMI more vulnerable to policing strategies that emphasize the enforcement of such public order crimes as panhandling, loitering, trespassing, and public urination. Individuals with SMI are more likely to exhibit troublesome—if not illegal—behavior, especially when combined with inadequate treatment options (or resistance to engage with the options that are available), which can exacerbate symptoms, bringing them to the attention of law enforcement officials, who often have little choice but to arrest and detain them. Mental illness, in a sense, has become criminalized because of a lack of viable options from both the mental health and law enforcement standpoints. It is not surprising, therefore, that individuals with SMI are two to three times as likely to have been arrested compared with the general population (Teplin, 1990).

Although there are factors that might be correlated with the overrepresentation of individuals with SMI in the criminal justice system, the relationship between illness and criminality is complex and by no means direct. Research conducted on new arrestees has demonstrated that the symptoms of illness (e.g., delusions, hallucinations, confusion) were a factor in only 8 percent of cases (Skeem, Manchak, and Peterson, 2011). In the vast majority of cases, there appears to be no direct connection between mental illness and criminality. For example, meta-analysis research has revealed that the major predictors of recidivism were the same for mentally ill offenders as for their healthy counterparts (Bonta, Law, and Hanson, 1998). An examination of particular criminal risk factors among prison inmates showed that levels of criminal thinking and attitudes are as high, or higher, among the mentally ill as compared with the non–mentally ill (Morgan et al., 2010). Moreover, the relationship between mental illness and violence is modest at best (Silver, 2006). Overall, some researchers argue that the overrepresentation of the seriously mentally ill is, in large part, because of the fact that these individuals have more criminogenic risk

In the vast majority of cases, there appears to be no direct connection between mental illness and criminality.

factors (e.g., substance use, antisocial attitudes) for recidivism than non–mentally ill offenders (Skeem, Manchak, and Peterson, 2011). In the end, many justice-involved individuals with SMI also have significant criminogenic needs—i.e., they are mentally ill *and* they are criminals (Morgan et al., 2010).

As these individuals are processed through the criminal justice system, they consume considerable court time and resources, and many end up under some form of correctional control, where agencies have no choice but to accept them. Observers have noted that "prisons and jails have become America's 'new asylums'" (Torrey et al., 2014). Indeed, jails in New York, Los Angeles, and Chicago are now the three largest institutions providing psychiatric care in the United States (Roth, 2018). Because of their disorders and unique needs, offenders with SMI often create significant management challenges for the corrections sector, whether the sanction is community-based or institutional. Those sentenced to probation or other diversion programs tend to continue to struggle if their mental health and criminogenic needs are not met in the community. As a result, many individuals with SMI end up in correctional institutions, where administrators do their best to provide adequate care. Although these institutions are generally underresourced, the sad reality is that they provide greater access to care in many jurisdictions than that available in the community. That said, correctional institutions were not designed or equipped to treat inmates with SMI.

Furthermore, the conditions of confinement (e.g., noisy, claustrophobic, harsh) might exacerbate mental illness. It is not surprising then that inmates with SMI tend to stay longer, cost more, be more difficult to manage, and be more likely to die by suicide than other inmates (Fuller et al., 2016). Upon release, most inmates struggle to reenter society. However, those with SMI face additional challenges because of the lack of coordinated, comprehensive care in the community combined with the additional barriers associated with a criminal record. As a result, individuals with SMI often churn through the justice system, experiencing multiple arrests and periods of incarceration.

Although some jurisdictions are making great strides with respect to how the criminal justice system deals with individuals with SMI, significant challenges and opportunities for improved outcomes remain. As part of a multiyear research effort sponsored by and supporting NIJ, the Priority Criminal Justice Needs Initiative has focused on identifying innovations in technology, policy, and practice that would be beneficial to the criminal justice sector. In light of the ongoing challenges the corrections sector faces in managing individuals with SMI, this project sought to better understand the contributing factors and identify the key needs associated with how these individuals become justice-involved and how to achieve better outcomes once these individuals come under correctional control.

METHODOLOGY

To explore the complex issue of managing individuals with SMI in corrections, NIJ asked the RAND Corporation and the University of Denver (DU) to assemble an expert workshop of prison, jail, probation, and parole administrators; researchers; and mental health care professionals. The major task was to frame a research agenda focused on achieving a better understanding of the issues related to the treatment and management of individuals with SMI under correctional control. A pool of candidate participants was identified through a review of published documents and recommendations from various organizations. Because different components of both the correctional and mental health systems are unique, care was taken to identify potential participants with experience and expertise in the public mental health system and multiple components of the corrections sector. Ultimately, a group of fifteen was convened. The list of members and their organizations is provided in the text box.

The initial focus of the workshop was intended to be on individuals with SMI *in corrections*; however, this structure proved too narrow for two reasons. First, it was impossible to ignore the precursors to correctional control, including the prevalence of mental illness in the larger society and the availability (or lack) of community mental health and supportive services, as well as the interactions between individuals with SMI and law enforcement and the courts. Second, among those incarcerated, 95 percent are released at some point (Hughes and Wilson, 2003). Ideally, many of these individuals will have been stabilized during their incarceration, but external factors can influence whether these individuals remain in the community or are returned to custody for a new crime or violation.

Prior to convening, participants were provided with several articles on the topic.[1] Participants also were asked to complete a pre-workshop questionnaire on major areas of significance (community-based treatment services, policing and public

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[1] The read-ahead materials were Osher et al., 2012; Judicial Council of California, Administrative Office of the Courts, 2011; and Judicial Council of California, Administrative Office of the Courts, 2015.

Workshop Participants

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safety, specialty courts and jail diversion, institutional programming, reentry coordination and relapse prevention, and data-driven accountability) as identified by the research team. Each area was framed as follows:

- **Community-based treatment services** includes community-based services available to the general public pre-justice involvement.
- **Policing and public safety** includes the law enforcement response to mentally ill persons and the perceived threat to public safety.
- **Specialty courts and jail diversion** includes mental health courts and jail diversion alternatives (e.g., probation, residential community corrections centers).
- **Institutional programming** includes mental health treatment services provided in the institutional setting.
- **Reentry coordination and relapse prevention** includes transitional hand-off from correctional institutions to community-based service (probation and parole) and subsequent supervision.
- **Data-driven accountability** includes research needs, performance metrics, data collection, data-sharing, data analysis and interpretation, and system response to reported data.

The first part of the questionnaire was structured to gather input on how the group prioritized each area. Participants were asked to consider the issues associated with each area and then rank them on a scale of 1 to 5 where 1 was "low importance" and 5 was "high importance." The results of that prioritization are presented in Figure 1.

The second part of the questionnaire asked participants to identify specific challenges or obstacles faced in each area. Participants also had the opportunity to identify issues that did not necessarily fit the provided framework. Moving forward, project staff used a structured brainstorming approach to develop a set of *needs*—a term used in our work for a specific requirement—tied to either solving a problem or taking advantage of an opportunity to achieve better outcomes. The group discussed each major area one at a time. A sequential approach was taken to approximate the path of an individual with SMI beginning in the community prior to justice involvement through interaction with the justice system and reentry into the community. As expected, it quickly became apparent that many of the challenges (e.g., inadequate treatment capacity or stigma to getting treatment) are not limited to a particular stage.

Figure 1. Pre-Meeting Questionnaire Rankings of Areas of Significance
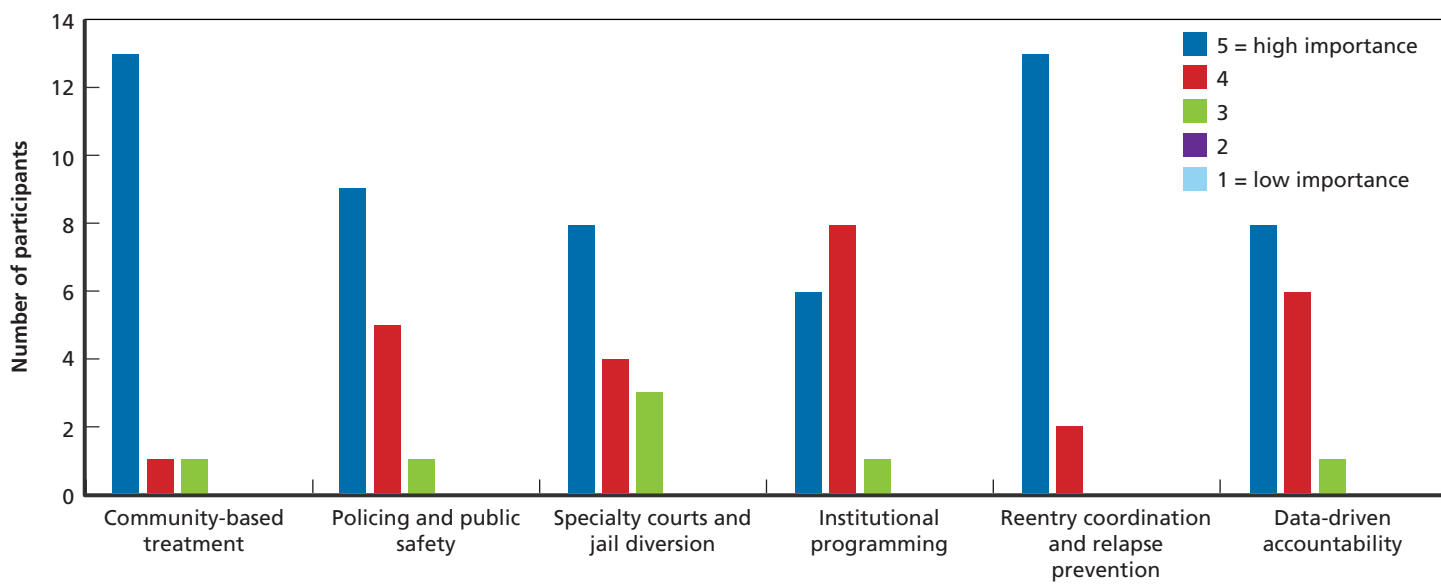
Over the course of the first day and a half, the workshop participants produced a total initial set of 65 needs. The next step was to provide structure to this large set of identified needs. We used a variant of the Delphi Method (RAND Corporation, undated) and asked the participants to first individually, and then collaboratively, rank each need based on its expected benefit (i.e., how impactful they thought it would be if the need was met) and the probability of success of actually meeting the need (i.e., technical and operational feasibility).

Project staff presented the distributions of the initial scores that each need received for impact and probability of success to the group to highlight areas of consensus and disagreement. For needs where there was significant disagreement, we asked for brief comments from participants regarding why they might have rated the need higher or lower than others in the group. The goal of the discussion was to identify areas where differences in interpretation or information might have led participants to rate a need differently (and, if those differences could be resolved, move the group toward consensus). There was no requirement that the group reach consensus; the results reflect the understanding that there could be differences in perceived value or likelihood of success across participants. At this point, the group members were given the opportunity to individually adjust their scores if the presentation of the aggregate results from the first round and any subsequent discussion about the reasons participants gave for their choices in round one persuaded them to do so.

After the workshop, the participants' ratings were multiplied to produce an expected value score, which reflects the value of meeting the need weighted by the likelihood of doing

so successfully. The participants' first-round scores were used to cluster the needs into three tiers from the highest scoring (Tier 1) to the lowest scoring (Tier 3). The clustering algorithm identified the best splits among the three groups of needs, where *best* was defined mathematically, minimizing differences between assignments of needs to the groups. The second-round results were applied to raise or lower the expected value scores for each need from the first round (weighted by the number of participants who had rated each need, because not all participants did so for each need) and, in some cases, the change in scoring changed the ranking tier to which the need was assigned. Because the needs were clustered and tiered across the entire set of needs identified, not all topics that were covered in the discussion included needs that fell into each tier. For example, needs identified related to reentry coordination and relapse prevention fell only into Tiers 1 and 2, while other topics had needs that fell into all three tiers. A more detailed discussion of the methodology is available in the appendix to this report.

This process produced a list of needs for research organized from high to low priority. We combined the closely related needs which, in the end, resulted in a total of 47 needs (see Figure 2).

We acknowledge that the needs identified and the priorities assigned to them are—as with all subjective assessments involving a limited number of participants—reflective of the views of the members of the group. Although project staff sought to include a broadly representative group of participants, it is likely that a different group would produce somewhat different results. Furthermore, while project staff consulted the literature on justice-involved individuals with SMI, the intent of this

Figure 2. Breakdown of Needs by Area
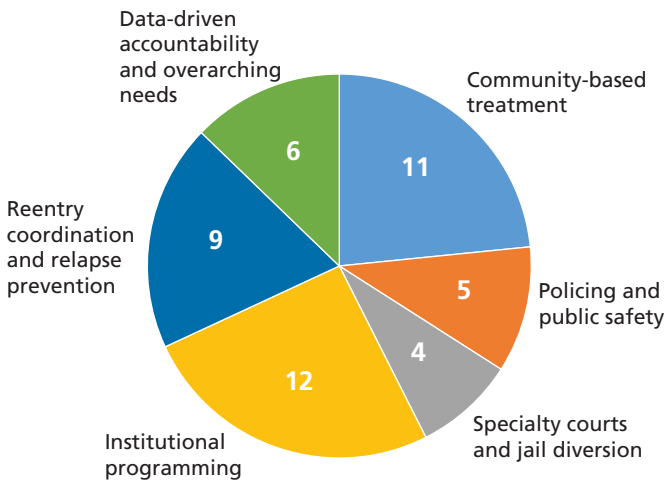
project was to explore the issues raised by the participants and to put the identified needs into better context. A comprehensive literature review and discussion of effective strategies were beyond the scope of the effort.

COMMUNITY-BASED TREATMENT SERVICES

It is difficult to discuss the issues related to managing individuals with SMI under correctional control without first examining the precursors to justice involvement. Many individuals with SMI do not receive adequate care in the community because of several factors. Mental illness is often undiagnosed and is therefore untreated. In some cases, an individual might not even recognize that he or she has a disorder, while others simply do not want to engage in treatment or are deterred by cultural or social stigmas. Awareness and motivation are only part of the dynamic, as many communities lack sufficient capacity to meet existing demand for mental health treatment.

Beyond mental health treatment deficiencies, many communities are unable to provide the requisite level of supportive services (e.g., housing, employment assistance) to help individuals with SMI navigate everyday life. Furthermore, criminogenic needs (e.g., substance use disorders, criminal thinking, antisocial peers) often are not addressed and these factors are more strongly linked to future involvement with the justice system than the underlying mental disorder.

A major gap left by deinstitutionalization policies is in services designed to treat individuals with SMI who might be violent or aggressive. Because many state psychiatric facilities

have closed, communities are unable to address the needs of these individuals, who therefore often find themselves incarcerated.

The working group considered the challenges that individuals with SMI face and discussed ways in which communities can provide early intervention and support for these individuals *before* they become justice-involved, because it was recognized that the struggles are only exacerbated beyond that point. The next section highlights the group's major recommendations with respect to community-based treatment. The full list of needs can be found in Table 1.

Quantifying the Need

It is generally accepted that there is insufficient mental health treatment (and other social service) capacity in most jurisdictions. By some accounts, the situation is getting worse, not better. For example, between 2009 and 2012, states cut $5 billion in mental health services and eliminated 4,500 (or 10 percent) of the available public psychiatric beds (Szabo, 2014). Cuts in public funding most seriously affect the poor and disenfranchised because they are least able to pay for treatment. The group consensus during the workshop was that services are definitely inadequate, but they also noted the lack of empirical data to support recommendations for the level of service that would be considered adequate in a particular jurisdiction. Lack of data can be a major impediment to efforts to ward off budget cuts or obtain new funding to expand services. The group argued that models should be developed to help jurisdictions quantify these needs. Such models should consider local usage data and the range of service needs (e.g., crisis management, supportive housing, community placement, independent living, short- and long-term residential care) necessary to deliver evidence-based treatment aligned with established standards of care.

Securing Sustainable Resources

Determining the optimal level of mental health and supportive services required for each jurisdiction is only a first step. These services must be fully resourced, sustainable, grounded in evidence-based practices, and accountable via performance-based metrics. Unfortunately, this is rarely the case, according to the workshop participants. Often, community-based service agencies must compete for limited resources. Grant funding that requires an increasing share of operating monies and matching

Table 1. Needs Identified Related to Community-Based Treatment Services

Tier	Problem or Opportunity	Associated Need
1	There are not enough mental health services (e.g., beds) in the community to serve the needs of individuals with SMI. However, it is difficult to quantify this need.	• Conduct research to determine the optimal number of mental health services beds needed in each community according to recognized community standards and supported by evidence-based practices, common performance metrics, and local usage data.
	Existing mental health services in the community are often underfunded and have performance and accountability issues.	• Ensure that the optimal level of mental health services is fully resourced and sustainable and that providers adhere to evidence-based practices and are held accountable through performance-based metrics.
	There are not enough beds to address the spectrum of current needs (e.g., inpatient, crisis management, supportive housing, community placement, independent living, short- and long-term residential).	• Conduct research to develop responsive evidence-based guidelines to address the full spectrum of needs faced by individuals with SMI.
	Individuals with SMI struggle with issues that are not directly related to their mental illnesses. Services that do not address the "whole person" are inadequate.	• Assess the benefits and efficacy of intensive case management programs that address the "whole person," not just the mental illness (e.g., substance use/abuse, physical health, housing, social support, employment).
	It is challenging to ensure that individuals with SMI in the community are treated prior to criminal justice involvement; there are insufficient mental health and related resources in most communities, and access to care is particularly difficult for those with no insurance or low income.	• Assess the impact of insufficient community resources for individuals with SMI on the corrections system, and conduct research to assess the impact of insufficient outreach by the mental health system to the corrections system.
	There is a lack of care coordination. Individuals with SMI are often passed from one provider to the next without the benefit of a single case manager for the entire treatment plan.	• Assess the costs and benefits of mental health peer navigator services.
2	Children often exhibit signs and symptoms of mental illness that can be identified and treated early. Individuals often lack motivation for treatment.	• Assess the costs and benefits of conducting early school assessments and teaching life skills at a very early age. • Assess the impact of funding additional engagement services for mental health treatment providers.
	Society has failed to prioritize the needs of the mentally ill population, particularly those with the most severe illnesses or "problematic" behaviors.	• Conduct research to identify the gaps in cooperation among professional and advocacy organizations.
3	Society stigmatizes any association with mental illness.	• Conduct additional research about the origins of stigma toward mental illness and the identification and dissemination of best practices for reducing stigma.
	Individuals often lack motivation for treatment.	• Assess the costs and benefits of Mental Health First Aid training and provide a mechanism to mandate care for high-risk individuals with SMI (before they become a threat to themselves or others).

> The group argued that investments in community-based treatment services can be made with savings realized by diverting individuals with SMI from entering the justice system.

funds can be problematic. Just as a viable program becomes stabilized and functional, decreasing federal or state grant money can put the program's sustainability at risk. The group discussed strategies to secure sustainable funding, focusing primarily on the Justice Reinvestment Initiative (JRI) model. In alignment with JRI, jurisdictions should explore ways to intelligently reallocate the criminal justice budget to achieve better outcomes without sacrificing public safety. The group argued that investments in community-based treatment services can be made with savings realized by diverting individuals with SMI from entering the justice system. For example, research indicates that a 10-percent increase in community-based inpatient treatment will shrink the jail population by 1.5 percent. Others estimate that it can cost two to three times more for an individual with SMI to become involved in the justice system compared with receiving treatment in the community (Cloud and Davis, 2013). The workshop participants called for more research examining the impact of insufficient treatment in the community on downstream expenditures (including law enforcement, courts, and prisons) to help justify reinvestment initiatives.

The group argued that more-effective advocacy and education can raise public awareness and help secure sustainable funding. One strategy discussed called for traditional mental health advocacy organizations to collaborate with other groups with common goals. For example, many individuals seek out faith-based organizations when dealing with life's challenges; therefore, partnerships with these groups can be effective in reaching individuals at risk. Furthermore, SMI—or, more precisely, society's response to SMI—has significant impact on criminal justice system operations. Therefore, the compo-

nents of the criminal justice system (law enforcement, courts, and prisons) have a major stake in this issue. The participants argued that the professional associations that represent the criminal justice system should take stronger public stances in favor of investments in community-based treatment. Ultimately, coordinated messaging from diverse groups could have greater impact in galvanizing support. These collaborations also might begin to break down barriers in some jurisdictions between agencies and providers who serve justice-involved individuals and those that do not. The group members argued that these entities should not be in competition; rather, they should focus on the common goal of treating individuals with SMI in the community as opposed to in institutions whenever possible.

Addressing Barriers to Treatment

Even those few jurisdictions fortunate enough to have adequate treatment capacity can still struggle to identify and engage individuals with SMI. The group reported believing that intervention at the earliest indications of illness—which, in many cases, is in childhood—is critical. America's youth are suffering from mental illness at astounding rates. Almost half of all adolescents aged 13 to 18 have ever had a mental disorder and more than 22 percent of these have had severe impairment (Merikangas et al., 2010). Furthermore, half of all chronic mental disorders begin by age 14 (Kessler et al., 2005). The workshop participants argued that early identification of the symptoms of mental illness and adverse childhood experiences (e.g., traumas, abuse, dysfunctional home environments) that are linked with future mental illness (Hughes et al., 2016), followed by referral and care, could allow many young people to avoid future involvement in the justice system. However, research is needed to help determine the most-effective intervention points and settings (e.g., primary schools, faith-based organizations, pediatric physicians) in which to conduct screenings to identify previously undiagnosed mental illness without stigmatizing the child. Furthermore, the costs and benefits of these and other strategies should be investigated. In a related need, group members observed that many individuals with mental illness struggle because they do not have the basic life, problem-solving, and social skills to connect with existing services or manage the daily challenges related to housing, employment, and other basic needs. The root issue, the group asserted, is that many individuals (not just those with SMI) simply never develop these skills in childhood. The group argued for greater access to evidence-based life-skills training

for children at an early age in community or school settings. Armed with these skills, children might be better prepared to manage their disorders (that either preexist or might develop) and the associated challenges that tend to bring them to the attention of the justice system. Similar programs for parents are required so that they can better support their children.

Of course, the onset of symptoms of mental illness can occur at any age, so more-effective outreach and engagement services on a broader scale are required. The participants argued that the current level of effort in this area is insufficient, noting bureaucratic impediments as a possible cause. For example, because of variability in requirements across private and public insurers, these "pre-treatment" services might not be billable and, as a result, providers might not receive compensation for these efforts. The workshop group reported believing that this is an important disconnect worthy of examination and recommended cost-benefit assessments to evaluate the impact of fully funded outreach and engagement services on downstream outcomes.

Early intervention is not necessarily limited to institutions and organizations. Individuals also can play key roles. Such initiatives as Mental Health First Aid teach individuals in the community and workplace settings the skills to identify someone experiencing a mental health crisis, provide preliminary assistance, and connect the individual with the appropriate resources. The group noted that these initiatives appear promising and called for cost-benefit analyses and funding to replicate successful programs.

Despite the prevalence of mental illness, strong stigma remains. Many view the mentally ill (or the symptoms exhibited) with discomfort, and many view them as dangerous. Furthermore, there are cultural, religious, ethnic, racial, and socioeconomic stigmas associated with mental illness that can deter individuals with SMI from seeking treatment, which can exacerbate symptoms. The workshop group called for research examining the origins of stigma toward mental illness as well as the development of best practices and culturally sensitive strategies to overcome stigma and increase the percentage of

individuals engaging in treatment. For example, public service announcements and community awareness campaigns can help destigmatize mental illness, particularly as celebrities and other popular culture figures express their own struggles.

Despite all efforts, some individuals with SMI can remain resistant to treatment. In some cases, this is because of anosognosia, a disorder characterized by the inability to recognize that one is mentally ill (Lamb and Weinberger, 2011). Approximately 50 percent of individuals with schizophrenia and 40 percent of individuals with bipolar disorder are affected by this insight deficiency, which can cause these individuals to not seek treatment and/or not take medications as directed (Torrey, 2017). This becomes a critical concern when individuals with SMI decompensate to the point at which they clearly require acute care, but their conditions fall short of legal standards for involuntary evaluation or commitment. The group was divided on this issue. On one hand, mental health advocates strongly oppose mandated medication and treatment for non–justice-involved individuals with SMI. On the other hand, some group members argued that waiting until individuals with SMI are a danger to themselves or others is imprudent and that appropriate, mandatory intervention get the individuals the help they need and keep them out of jail. A balance is required between an individual's legal right to refuse care and society's desire to preserve the safety of both the individual and those around him or her. Research is needed to explore practical, effective, and ethical responses to this dilemma.

Improving Care

Workshop participants strongly advocated for coordinated, comprehensive case management for individuals with SMI in the community that focuses on the whole person. As discussed, these individuals often have a multitude of needs beyond mental illness that must be addressed. In most cases, the behaviors associated with criminogenic needs—rather than the mental disorder itself—lead to involvement with the justice system. These issues can interfere with access to care in a variety of

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ways. For example, individuals with SMI might not have transportation to the treatment provider's location or they might be ineligible for some programs because of addiction. It is therefore critical to address multiple needs simultaneously. The workshop participants recommended research to assess the benefits and efficacy of comprehensive case management programs as well as funding to replicate those with proven outcomes. Furthermore, they argued that the use of peer navigators should be leveraged to a greater extent. Peer navigators are individuals who work for community-based service providers to assist clients with whom they share life experiences. The peer navigator, as part of a larger team, provides emphatic support and practical assistance in such matters as obtaining identification, benefits, and transportation and encouraging social engagement. The group reported that this model is promising, as better coordination and continuity of care would likely improve treatment engagement and overall outcomes; however, research is required to assess the costs and benefits of the strategy to determine whether it is an evidence-based model that should be adopted nationwide.

Many individuals with SMI, particularly those who are untreated, will encounter law enforcement at some point in their lives. The workshop participants next considered the challenges and opportunities present at this critical juncture.

POLICING AND PUBLIC SAFETY

Because of a variety of factors, individuals with SMI are involved in 10 percent of all calls for police service and are two to three times more likely to be arrested compared with the general population (Chappell, 2013; Teplin, 1990). Many of these interactions are the result of relatively minor, nonviolent

> Currently, many jurisdictions do not provide police officers with specialized training on effective interaction with individuals with SMI.

offenses not directly associated with mental illness (e.g., loitering, vagrancy, public intoxication, aggressive panhandling), or are responses to individuals in crisis. On average, the New York City Police Department handles more than 400 "emotionally disturbed persons" calls per day (Whitford, 2017) and, nationally, individuals with SMI who are in crisis are more likely to encounter police than get medical help (National Alliance on Mental Illness, 2018). Currently, many jurisdictions do not provide police officers with specialized training on effective interaction with individuals with SMI. Consequently, officers often fall back on traditional tactics in an attempt to quickly gain control of the situation (i.e., containing and restraining the subject), which can inadvertently cause the encounter to escalate rapidly. These encounters often result in negative outcomes according to a variety of measures. For example, calls involving the mentally ill can consume 87 percent more police resources compared with those with the non–mentally ill (Charette, Crocker, and Billette, 2014) and result in a disproportionate number of individuals with SMI being booked into jails because of a lack of treatment-oriented alternatives. Law enforcement efficiencies and jail bed usage issues aside, these encounters are often unpredictable and dangerous for police officers and can be deadly for the subject: An estimated 25 percent of fatal police encounters involve an individual with SMI (Fuller et al., 2015).

Once they become justice-involved, it becomes quite difficult for individuals with SMI to extract themselves from a life cycle of "churning through the system"—i.e., from the community to jail and to prison, then back to the community to begin the cycle again through repeat offense and arrest. Furthermore, a criminal record can limit access to treatment and public housing. This interaction point, therefore, is a critical juncture with significant public safety implications, not to mention long-term individual and societal costs.

The next section highlights the group's major recommendations with respect to policing and public safety. The full list of needs is provided in Table 2.

Specialized Training

Because of the lack of mental health services, police officers often are the first responders to individuals with SMI who are in crisis; the public simply does not know who else to call. To improve the outcomes of these encounters, the workshop participants argued that communities should expand the use of the Crisis Intervention Team (CIT) model, which empha-

sizes collaboration and coordination between law enforcement agencies and mental health providers. In some jurisdictions, police officers and mental health crisis staff are coordinated and respond to calls for service involving individuals with SMI as a team. Key to the CIT program model is specialized training for police officers, which provides knowledge about the nature of mental illness and strategies to better handle interactions with this population. CIT programs have been shown to reduce arrests, reduce officer injuries, and improve officer effectiveness while increasing the likelihood that the individual will receive treatment (Compton et al., 2008). Group members recommended that more law enforcement agencies provide culturally sensitive CIT training to more officers, ideally during initial academy training, and reinforce that training periodically in service. They also called for further research including cost-benefit analyses and effectiveness assessments to provide additional data to support expansion of CIT programs.

Because most interactions begin with a call to the 911 dispatcher, these staff can play a significant role in the eventual outcome. For example, members of the group noted that dispatchers often do not gather and relay critical information about a subject's mental illness to the responding officer, which might hinder that officer's ability to appropriately approach the subject and/or coordinate with crisis resources. The workshop participants suggested that including dispatchers in CIT training might improve outcomes and called for a cost-benefit analysis of this strategy.

The workshop participants recognized that there might be obstacles to adopting the CIT model because many law enforcement agencies remain "arrest-oriented" and might not view crisis intervention as part of their role. To incentivize broader adoption, the group suggested that grant-funding organizations should consider requiring agencies to demonstrate a significant level of commitment to the CIT approach as a prerequisite to funding eligibility.

Alternatives to Jail

The CIT model, while promising, is only part of the solution. Police officers can be trained to more effectively manage these encounters, but without viable alternatives, individuals with SMI will likely end up in jail. Although some offenders with SMI should be detained in a secure facility based on their criminal risk, workshop participants argued that alternatives (e.g., hospitals, acute care drop-off, crisis restoration centers) are much better options in many cases. Several jurisdictions have implemented this strategy successfully. In Bexar County, Texas, for example, a partnership between the justice and mental health systems helped create a "Crisis Restoration Center." The center functions like a jail but is different in two major ways.

Table 2. Needs Identified Related to Policing and Public Safety

Tier	Problem or Opportunity	Associated Need
1	Many law enforcement officers do not receive comprehensive training (e.g., culturally sensitive CIT training) or periodic refreshers to effectively deal with the growing number of mentally ill individuals in the community.	• Assess the benefits and costs of conducting CIT training, cultural sensitivity training, and de-escalation training (including introductory versions) earlier in a law enforcement officer's career (e.g., at the basic training academy). • Assess the costs of conducting CIT training on an ongoing basis for a larger pool of officers (e.g., through web-based training).
	Even engaged agencies with well-trained officers are stymied by the lack of community-based resources that can serve as alternatives to jail (e.g., hospitals, acute care drop-off, crisis restoration centers).	• Assess the benefits and best practices for existing "alternatives to jail" programs and leverage synergies between the justice and mental health systems.
	Many public safety dispatchers do not receive CIT training to effectively deal with the growing number of calls regarding the mentally ill.	• Assess the costs and benefits of extending CIT training to dispatchers at the public safety answering point (911 call center), so that they can assess potential SMI issues and advise first responders accordingly.
	Many law enforcement agencies do not have the resources or expertise to assess the needs and benefits of CIT training.	• Develop tools for departments to be able to conduct self-assessments for the need and potential impact of CIT training.
2	Many law enforcement agencies are predominately arrest-oriented rather than focusing on crisis intervention.	• Encourage funding organizations to require CIT training in order to be eligible for grants.

First, offenders are not charged or booked, so their time in the center does not result in a criminal record. Second, the center provides the individual with necessary treatment and support (Graziani, 2016). The group recommended the development of best practices to leverage similar synergies between the justice and mental health systems as well as research into the costs and benefits of treatment-oriented alternatives to jail. Furthermore, there is a need to evaluate the longer-term outcomes of these programs and to replicate approaches that produce results in a manner that ensures adequate coverage in a particular geographic area.

Absent viable alternatives at the policing level, the offender with SMI will go before a court and perhaps receive mental health treatment or another diversionary program in lieu of incarceration. The workshop participants grappled with this component next.

SPECIALTY COURTS AND JAIL DIVERSION

Individuals not diverted (or inappropriate for diversion) at the policing level typically advance to the next stage of the justice system: appearance before a court. In a growing number of jurisdictions, such cases might be transferred from the general criminal docket to a mental health court, with the consent of the prosecuting attorney. The goal of these specialty courts is to work with the individual to address the underlying problem—in this case, mental illness—in a supported, community-based setting, because it is acknowledged that punishment through incarceration might be a more expensive and less effective response. Although the structure of a mental health court can vary by jurisdiction, in general, key social service agencies, community treatment providers, and the local probation department are involved in formulating a treatment plan, which is subject to the approval of the presiding judge. If the individual accepts the conditions, the criminal charges might be dropped, provided that he or she remains in treatment and avoids rearrest. Research on mental health courts has documented generally favorable outcomes. When compared with offenders processed through regular court, mental health court participants are more likely to be connected with treatment services, are rearrested less frequently during and after the program, and spend less time in jail. Furthermore, program completers have more-favorable outcomes than dropouts (Almquist and Dodd, 2009).

Although specialty courts are a step in the right direction, the workshop participants noted that mental health courts often still reflect a disconnect between forensic mental health and community-based mental health approaches. Some courts continue to operate with a view that the mental illness is the root cause of criminality; however, some studies have indicated that the treatment intervention provided during the program had no relationship with recidivism or jail days, which might further support the position that mental illness is not a direct cause of crime (Fisler, 2015). Ultimately, blended approaches that address the whole person (e.g., such criminogenic needs as substance use disorders, criminal thinking, and antisocial attitudes; housing and employment; and mental health treatment) appear most likely to be effective at reducing recidivism. The next section highlights the group's major recommendations with respect to specialty courts and jail diversion. The full list of needs is provided in Table 3.

Leveraging Mental Health Courts

As mental health courts have demonstrated some success, they have grown in popularity, yet they still number fewer than 400 across the country (Szalavitz, 2015). Indeed, only about 5 percent of all cases involving mentally ill offenders are processed

Ultimately, blended approaches that address the whole person (e.g., such criminogenic needs as substance use disorders, criminal thinking, and antisocial attitudes; housing and employment; and mental health treatment) appear most likely to be effective at reducing recidivism.

Table 3. Needs Identified Related to Specialty Courts and Jail Diversion

Tier	Problem or Opportunity	Associated Need
1	Criminal justice professionals would benefit from additional knowledge regarding mental illness and effective approaches to management.	• Develop educational resources and risk-assessment tools for judges, prosecutors, public defenders, and case managers.
1	Probation and parole officers often fail to recognize the reasons that some clients with SMI are noncompliant and might unnecessarily seek revocation before other interventions can be tried.	• Develop model policy and training for probation and parole handling of compliance issues.
2	Specialty courts are not broadly utilized and lack the capacity to meet the demand.	• Assess the amount of community resources required to allow mental health courts to function well (often, these courts hold individuals if resources are not available in the community).
3	It can be challenging to secure sustainable funds to establish and operate specialty courts and to hire treatment and supervision staff with proper qualifications.	• Provide tools to conduct sustainability assessments for specialty courts.

through a mental health court (Andrews, 2015). The workshop participants identified several challenges that might impede expansion of the mental health court model.

It can be difficult to understand exactly why these courts produce successful outcomes, in large part because they all operate differently. Furthermore, access to mental health courts and treatment is uneven and dependent on where the individual with SMI was arrested. Therefore, it is not uncommon for an individual in one judicial district to have access to a mental health court while a similarly situated counterpart in a neighboring district does not. The major challenge appears to center on access to community mental health and supportive services that are willing to work with the justice-involved. The creation of a mental health court can be an impetus for coordinated, comprehensive care, but does not inherently expand treatment capacity. This scarcity raises some concerns. As mental health courts demonstrate success in linking offenders with SMI with treatment services, the increased caseload of justice-involved individuals can effectively reduce the availability of treatment for non–justice-involved individuals, thereby creating a pernicious outcome—i.e., the only way to get care is to become justice-involved (Schwartz, 2008; Mental Health America, undated).

The group suggested that many jurisdictions fail to consider the level of resources necessary to establish and sustain these courts. Decisionmakers would benefit from the development of tools and models to help their jurisdictions assess both the level of treatment services and the ongoing operational support required to achieve objectives, given the uncertainty of grant funding.

Other Diversion Strategies

Mental health courts might not be viable for every jurisdiction; furthermore, it is not yet clear whether this approach is even cost-effective. Although it seems intuitive that higher expenses for treatment services might be offset by reductions in jail stays and recidivism, in some cases it is difficult to demonstrate definitively (Ridgely et al., 2007). Indeed, some argue that equal or better results might be achievable through other diversion strategies that are perhaps more sustainable (Fisler, 2015). As a result, other approaches should be explored. However, to successfully do so, jurisdictions need greater access to the knowledge, skills, and tools necessary to achieve better outcomes with this population. The group reported believing that it is therefore imperative that key stakeholders (e.g., judges, prosecutors, public defenders, case managers, probation officers) increase their knowledge base. Specifically, stakeholders need a greater understanding of mental illness in general, how these disorders (and associated factors, including co-occurring disorders, poverty, and criminogenic needs) affect individuals and their ability to live law-abiding lives, the unique risks posed by offenders with SMI, and effective approaches to managing these individuals in the community. Training is particularly important for those responsible for monitoring these individuals (e.g., probation officers). The workshop participants expressed concern that officers often fail to recognize the underlying reasons that some individuals with SMI appear to be willfully noncompliant. Without adequate training (which might include CIT and information about anosognosia) and intervention options, officers could unnecessarily seek revocation for technical violations, which might result in incarceration. Indeed, compared with their relatively healthy counterparts,

> [D]iverting appropriate individuals from justice involvement and incarceration can result in cost savings that can be used to improve care, both in the community and in correctional facilities.

probationers and parolees with mental disorders are more likely to have their supervision revoked for technical reasons (Eno Louden and Skeem, 2011). The group called for better guidance for probation officers through the development of model policy and training. Furthermore, because research indicates that the relationship between mental illness and criminality is largely indirect (Peterson et al., 2014), stakeholders require guidance with respect to how to leverage the value of traditional risk-assessment tools that can predict recidivism, regardless of mental illness and programs that target criminogenic factors, while being responsive to the unique clinical needs of the offender with SMI.

Offenders with SMI who are not diverted by the courts into alternatives might be incarcerated in jail or prison. The workshop participants explored this component next.

INSTITUTIONAL PROGRAMMING

Although the group acknowledged that the needs of many justice-involved individuals with SMI are *generally* better served in the community, participants also recognized two important realities. First, many offenders who could be diverted will still end up in jail or prison, in part because of a lack of community-based resources that address both mental health and criminogenic needs and insufficient stakeholder commitment to explore alternatives. Second, some offenders do pose significant risk to public safety and therefore *should* be incarcerated. Once incarcerated, this population can present major challenges.

For example, compared with the general inmate population, the mentally ill tend to require more resources, create more behavioral management problems, experience longer periods of confinement, be more likely to self-harm and die by suicide, and be more likely to be victimized (O'Connor, Lovell, and Brown, 2002; Kim, Becker-Cohen, and Serakos, 2015; Pope and Delany-Brumsey, 2016).

Despite these challenges, agencies have a legal obligation to treat inmates with SMI. Landmark cases include *Estelle v Gamble* (1976), *Bell v Wolfish* (1979), and *Ruiz v Estelle* (1980) (Metzner, 2002). Furthermore, class action lawsuits in several states continue to challenge the adequacy of the care currently being provided to this population. The standard of care that has been collectively established in these cases has been well articulated by the American Psychiatric Association (APA): "The fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice process that should be available in the community" (2000).

Potentially, the most important word in the APA standard of care statement is *should*. Discussions about standards of care revealed that many correctional agencies simply are not resourced or best suited to provide this level of care. More importantly, adequate mental health services are often *not* available, even in the community, which is part of the reason that some individuals with SMI become justice-involved in the first place. This paradox caused some group members to express concern that focusing on improving care for individuals with SMI who are already incarcerated, while important, might divert precious resources from treatment efforts in the community before an individual becomes justice-involved. Ultimately, this should not be an either-or proposition: Investments in adequate treatment resources are required in either scenario. Furthermore, diverting appropriate individuals from justice involvement and incarceration can result in cost savings that can be used to improve care, both in the community and in correctional facilities. The next sections highlight the group's major recommendations with respect to institutional programming. The full list of needs is provided in Table 4. Although the recommendations focus primarily on the delivery of mental health services, it was understood that all inmates, including those with SMI, require programming to address their criminogenic needs.

Table 4. Needs Identified Related to Institutional Programming

Tier	Problem or Opportunity	Associated Need
1	It is difficult to attract and retain quality treatment staff to work in a correctional setting (contract or direct hire), particularly those who can prescribe and monitor psychotropic medications.	• Develop best practice guides to help agencies leverage such programs as loan forgiveness, tuition reimbursement, partnerships with academic institutions, and partnerships with the National Health Service Corps and state health service agencies (for designation as medically underserved area). • Explore the costs and benefits of using mid-level providers (e.g., physician assistants and nurse practitioners) and telehealth services to expand the pool of available staff.
	Not all correctional staff have the temperament to work effectively with the SMI population.	• Develop screening tools to identify staff who are especially suited to working with inmates with SMI.
	Correctional institutions are inherently dangerous and stressful. This affects staff's ability to serve this unique population.	• Develop trauma-based care for staff.
	Administrative segregation is still the only option for extremely dangerous inmates with SMI in many correctional facilities, but it is perceived as cruel and unusual punishment.	• Conduct research to identify alternatives to administrative segregation for the most dangerous individuals with SMI.
2	It can be challenging to keep offenders engaged in programs for extended periods. SMI housing units often are either understaffed or staffed by correctional officers who lack the experience and training to effectively motivate inmates to engage in treatment.	• Identify and highlight existing best practices with regard to staffing and behavioral incentive programs that motivate inmates with SMI to engage in treatment.
	Most corrections agencies do not have the budget, resources, or capacity for the level of behavioral health treatment staffing and services needed to adequately serve the SMI population.	• Conduct a validated, evidence-based assessment of the risks and benefits of funding shortages that is designed to be consumable by state and local legislative bodies.
	The effectiveness of such institution-based interventions as Thinking for a Change and CIT-type training for correctional officers is not known for measures or outcomes (e.g., recidivism).	• Conduct research to determine the effectiveness of institution-based interventions on recidivism.
	The cost of psychotropic medications is a challenge.	• Develop best practices for managing correctional agency formularies.
	Correctional facilities were not designed to be mental health hospitals.	• Document best practices for physical plant changes (including technologies) to protect and support officers while enhancing structured life skill opportunities for inmates with SMI in a safe and secure manner.
	Mental illness and co-occurring disorders are underdiagnosed; some corrections agencies lack defined mental health classification systems.	• Develop a classification system for types of SMI conditions along with the best management practices that are appropriate or inappropriate for each type of SMI.
3	Motivation for treatment can vary from patient to patient, and inmates with SMI often do not recognize that they are decompensating.	• Identify incentives that increase the number of individuals signing psychiatric advance directives that allow the agency to make decisions on behalf of inmates with SMI.

It is imperative, according to the group, that officers working with this population possess the appropriate temperament and personal characteristics.

Improving Institutional Mental Health Treatment Capacity

Litigation has forced many agencies to devote greater resources to address the special needs of inmates with SMI. That said, just as in the community, resources for mental health services are not commensurate with the demand. Lack of—or inadequate—treatment can exacerbate illness. The results can be longer jail or prison stays because of related disciplinary issues and ultimately higher social costs for these individuals and the communities to which they return after release. To help correctional agencies justify requests for funding to provide the requisite care, the group argued for analyses quantifying the impact of institutional-based treatment on downstream intersystem and societal costs. These analyses should be easily consumable by state and local legislative bodies.

Another challenge that influences capacity is the difficulty that agencies experience recruiting and retaining treatment staff, particularly those qualified to prescribe and monitor psychotropic medications. This, in part, is a reflection of the overall national shortage of mental health providers but the problem is compounded by the perception that work in correctional institutions is less desirable than other options. To address this challenge, the group called for the development of best practices that highlight innovative strategies and incentives to attract treatment staff. Examples discussed include loan forgiveness programs, tuition reimbursement, partnerships with academic institutions, and partnerships with national and state entities to obtain designations as medically underserved areas or Health Professional Shortage Areas. Other creative approaches to expand capacity that were discussed include using mid-level practitioners (e.g., physician assistants and nurse practitioners) and leveraging such technology as tele-psychiatry to deliver services in a cost-effective manner.

The Role of the Corrections Officer

Although mental health staff are critical to the management and treatment of inmates with SMI, correctional officers have much more interaction with these individuals and therefore can play a key role in their adjustment to confinement. It is imperative, according to the group, that officers working with this population possess the appropriate temperament and personal characteristics (e.g., patience, understanding, strong interpersonal skills, ability to deescalate confrontational situations). The group called for the development and validation of screening tools to identify those officers best suited to work with inmates with SMI. Furthermore, these officers should receive specialized training (e.g., CIT) and periodic refreshers. It should be noted that this recommendation might be more difficult to implement in the many states currently experiencing severe correctional officer shortages (Fifield, 2016).

In a related theme, the group acknowledged that working with inmates with SMI often adds additional stress to an already demanding job. For example, officers could be exposed to such traumatic incidents as inmate suicides, suicide attempts, or self-mutilation (Spinaris, Denhof, and Morton, 2013). Stress that is not managed well can lead to negative officer health outcomes, negative officer behaviors, and, as a result, more-negative outcomes for inmates (e.g., disciplinary reports, disciplinary segregation, lost time credits, and delayed parole). The group acknowledged the importance of caring for correctional staff who work with this difficult population and supported the development of trauma-based care strategies. Furthermore, just as Mental Health First Aid training can be useful in the community before criminal justice involvement, the group argued that correctional officers, as well as the general inmate population, should receive similar training to be able to better address their own needs. Better awareness about mental health issues and symptoms could prevent negative outcomes, including deaths by suicide.

Inmate Management Policy

When inmates act out, administrative segregation is still the only option in many institutions. Compared with the general inmate population, those with SMI tend to exhibit more disruptive behavior, particularly when untreated, and therefore more

often end up in segregation. Physical plant design constraints and staffing issues often preclude meaningful out-of-cell time and interpersonal communication opportunities for these inmates. These conditions can be extremely harsh for any inmate, but appear to have particularly negative effects on individuals with SMI. Many experts believe that long-term segregation significantly exacerbates preexisting symptoms (Lee, 2017). On a national level, the constitutionality of administrative segregation is under intense scrutiny and several lawsuits have been filed on behalf of mentally ill inmates by organizations like the Disability Rights Network. The American Correctional Association (ACA) has adopted performance-based standards for restrictive housing that discourage the use of segregation for inmates with SMI and require increased monitoring and decreased duration of segregation for even the most problematic offenders (ACA, 2016). These guidelines, agreements, and court orders are forcing agencies to modify their operational practices, and the group acknowledged that such agencies are struggling to achieve compliance without sacrificing institutional safety and security. To help address this concern, the group recommended research to identify viable alternatives to administrative segregation for the most dangerous individuals with SMI.

Treatment Concerns

The group discussed several challenges related to delivering treatment in a correctional setting. One major issue is the lack of standardization with respect to mental illness assessment and classification (as opposed to a clinical diagnosis) in a correctional context, which can result in underdiagnoses in some agencies. The group argued for the development of a uniform classification system with corresponding best practices for managing and treating offenders of different risks and needs.

Many institutions have had to make physical plant adaptations for the SMI population, including the creation of mental health housing units with observation cells and dedicated therapeutic and recreational spaces. The group argued that agencies would benefit from the development of a best practices guide to successful physical plant modification strategies (to include technology deployment) that prevent inmate suicide, protect and support staff, and enhance structured programming opportunities for inmates with SMI in a safe and secure manner.

Mental health housing units can help provide a supportive, structured environment for inmates with SMI; however, just as in the community, it can be difficult to get individuals to engage in treatment. To address this issue, the group called for research and evaluation of best practices with regard to motivational incentives for inmates to engage in and sustain treatment over the long term. Furthermore, the group identified the key role of staff in creating an environment conducive to treatment and argued that best practices are needed with respect to staffing requirements (quantity and quality of both custody and treatment staff) to ensure optimal outcomes.

Some of the treatment interventions used require further study, according to the group. For example, CIT for officers and other staff and inmate programs that target antisocial cognition, such as Thinking for a Change, appear to be promising in terms of improving inmate management outcomes. However, little is known about the impact of these programs on such longer-term outcomes as recidivism. The workshop participants called for research partnerships between institutions and academics to identify appropriate performance metrics, validate effectiveness, and guide changes (e.g., curriculum, duration) as directed by the evidence.

Finally, the group discussed issues related to the medications that many inmates with SMI require for stabilization and the associated implications on operations. One perspective is fiscal, as most correctional institutions are resource-challenged and psychotropic medications can be costly. Mental health care service providers have generally done well in instituting strict formularies; however, some critics would suggest that the formularies are more cost-driven than patient-driven. The group argued that there is a need to develop best practices for managing correctional agency formularies. The other perspec-

> Compared with the general inmate population, those with SMI tend to exhibit more disruptive behavior, particularly when untreated, and therefore more often end up in segregation.

> # Recovery is a process, and relapse is part of that process, but recovery is certainly possible.

tive discussed was related to consent to medicate. The group argued that obtaining psychiatric advance directives could be valuable because of the cyclical manifestation of symptoms in some individuals with SMI. These individuals might experience extended periods when they feel fine. As a result, they tend to stop taking medications and, eventually, decompensation results. At this point, inmates might not have the ability to provide consent if medication is required to stabilize them. Although case law permits the involuntary administration of psychiatric medications, provided that certain criteria are met, a signed psychiatric advance directive indicating prior consent would be more expedient and would help remove obstacles to treatment in case of crisis (Etheridge and Chamberlain, 2006). The group argued that this practice should be leveraged further and called for exploration of the use of incentives to get more inmates with SMI to sign these directives.

Whether after a short jail stay or a lengthy prison term, the vast majority of inmates with SMI will return to the community. The group next considered the issues and challenges related to preparing these individuals for reentry.

REENTRY COORDINATION AND RELAPSE PREVENTION

Returning to the community from jail or prison can be a difficult transition. Many offenders enter correctional institutions with limited job skills; low levels of education; unstable housing; and unaddressed criminogenic needs, such as substance use disorders and criminal thinking patterns. When they leave, these problems can persist and be significant impediments to successful reentry. Consider offenders with SMI, many of whom carry the burdens previously mentioned and also suffer from a chronic disease that can interfere with social and emotional adjustment. As discussed, many of these offenders receive limited, if any, treatment during incarceration and, once

released, often find insufficient support in the community. It is not surprising then that offenders with SMI are more likely to recidivate and return to prison faster than non-SMI offenders (Cloyes et al., 2010).

To achieve better reentry outcomes for offenders with SMI, the group argued for person-centered discharge planning that targets the individual's full range of needs, better case management and coordination of care, and a collaborative team approach between justice agencies and social service agencies. Furthermore, a change in perspective is required: Stakeholders need to recognize that these offenders will have ongoing and recurring needs. Recovery is a process, and relapse is part of that process, but recovery is certainly possible. One study revealed that one-third of individuals who have ever been diagnosed with SMI were in remission for at least the previous 12 months (Salzar, Brusilovskiy, and Townley, 2018). Given the proper mental health treatment and supportive services to address criminogenic needs, these individuals can succeed in the community.

The transition from the institution to the community is another critical intersection for individuals with SMI. The following section highlights the group's major recommendations with respect to reentry coordination and relapse prevention; the full list of needs is provided in Table 5.

Transition from the Institution to the Community

The group argued that the chance that an inmate (particularly, an inmate with SMI) is successful upon release is highly dependent on the reentry planning work that occurs while the inmate is incarcerated and that agencies must therefore make such planning a priority. Reentry planning should begin immediately upon admission, particularly in jails, where the individual's release date might not be certain. This process often is not comprehensive or person-centered, so failures occur for many of the same reasons that caused the individual to become justice-involved in the first place—e.g., lack of community support and resources that address not only the mental health issues, but also housing, employment, and such criminogenic needs as substance use disorders and antisocial relationships. Resource constraints aside, the group noted that corrections agencies and community-based providers need better coordination and cooperation in order to achieve desired outcomes. This should begin before release in the form of "in-reach" initiatives, in which social service agencies are invited into the institution

Table 5. Needs Identified Related to Reentry Coordination and Relapse Prevention

Tier	Problem or Opportunity	Associated Need
1	Inmates often are released from institutions with inadequate supplies of medications.	• Identify best practices with regard to reentry and discharge planning and coordination (including release medication, medication compliance monitoring, supported medical appointments, and health care data-sharing among mental health providers and correctional agencies) and implement these critical services in all communities to ensure a "warm hand-off" between agencies serving individuals with SMI.
	The requisite community-based resources to support a warm hand-off to community-based providers and reentry coordination and relapse prevention are not broadly available—supply generally cannot meet the demand.	• Identify best practices with respect to dedicated funding for community reentry programs.
	Smaller communities often are unaware of existing resources that can be used to fund transitional services.	• Develop a best practices guide that would help communities identify, access, or apply for resources.
2	Reentry planning and services often do not address the entire person and all of his or her needs (i.e., housing, employment, support system, substance use issues).	• Develop best practices that address a mandatory in-reach and warm hand-off policy for health services personnel.
	Correctional agencies often lack performance metrics (e.g., adherence to evidence-based approaches) for contracted community providers, which makes it difficult to measure success.	• Identify best practices for contracting with community providers.
	Some providers do not want to work with the justice-involved population, while other organizations in the community that are willing to serve the SMI population often are unaware of what is required to provide services for particularly violent individuals.	• Develop a best practices guide or standards that would help providers identify the requirements. • Develop a model curriculum for mental health providers that includes a background in justice-related issues (e.g., certificate program or continuing education).
	Improving care for individuals with SMI in the correctional system disincentivizes the community from providing additional reentry resources outside the correctional system.	• Assess the costs and benefits of funding and providing equivalent services outside of correctional institutions.
	Discontinuities of care result from starting and stopping coverage types as offenders transition in and out of agency responsibility.	• Assess the societal impact of maintaining and extending Medicaid coverage during confinement.
	Individuals with SMI often lack motivation for treatment.	• Conduct research to identify approaches that improve outcomes following release.

to meet with inmates about their needs and create a plan for addressing those needs upon release. Strategies should be leveraged to ensure a "warm hand-off" between the institution and the community-based providers, including setting up appointments and following up. The group argued that jurisdictions would benefit from the development of best practice guides that address effective discharge planning and transitional service-coordination strategies that include involving the inmate's family and incentivizing participation of community-based providers.

Maintaining Medicaid eligibility can be critical to continuity of care and successful reentry. Inmates generally lose

Medicaid coverage upon incarceration, but states have three options with respect to the individual's eligibility status: they can terminate coverage, suspend coverage, or leave the status unaltered. This policy decision can have significant implications on outcomes. For example, several states terminate eligibility, which forces the inmate to reapply upon release (Pew Charitable Trusts, 2016). Delays securing reinstatement to Medicaid can be very costly, because the period immediately following release is critical, not only in terms of recidivism, but also with regard to health implications. Psychiatric medications can run out and cannot be refilled. Failure to maintain a regimen can result in decompensation and increased substance use,

which can expose the individual to new criminal or violation of supervision charges. Overall access to mental health and other services can be hindered. The group contended that the costs and benefits of maintaining Medicaid coverage (through suspension or unaltered status) during confinement should be examined. With respect to medications, the group expressed concern that, in spite of standards established by national organizations, inmates with SMI often are released with inadequate supplies—and sometimes, with no supplies at all. This gap can set these individuals up for failure and must be addressed.

Community-Based Providers

Correctional agencies rely on a variety of community-based organizations to provide mental health and other supportive services to offenders with SMI, and the group discussed a variety of challenges that can hinder service delivery and eventual outcomes. Resources are generally scarce, and some communities, particularly those that are smaller or in rural areas, often struggle to develop mental health services. The group argued that there is a lack of awareness of the various types of resources available (e.g., public and private grants, donations, and fundraising and public awareness initiatives) and believed that it would be beneficial to document best practices to help communities identify, access, or apply for these opportunities.

The group also noted challenges associated with misconceptions or misgivings that community-based providers might have regarding the justice-involved SMI population. Many providers refuse to accept patients with a prior criminal conviction or a history of violence, which limits access to care upon release. Other providers might erroneously perceive all indi-

> Resources are generally scarce, and some communities, particularly those that are smaller or in rural areas, often struggle to develop mental health services.

viduals with SMI to be potentially violent. On the other hand, some providers might be willing to serve this population, but are not adequately prepared or capable of dealing with those individuals who are truly violent. Furthermore, many providers lack an understanding of the nuances of the justice system and the implications of community supervision. To help address these concerns, the group recommended the development of a model curriculum (e.g., certificate program or continuing education) for mental health service providers that includes a background in justice-related issues and evidence-based correctional treatment practices. Better understanding of the justice-involved SMI population should lead to improved access to quality care. Similarly, probation and parole officers and administrators should receive better training (e.g., CIT) so that justice and mental health efforts are more in alignment.

Correctional agencies often struggle to quantify the effectiveness of the providers they contract with to provide services for offenders with SMI. The major challenges, according to the group, are identifying appropriate performance metrics based on evidence-informed practices and crafting contract language to hold providers accountable. Best practices and model contracts would help agencies navigate this process.

DATA-DRIVEN ACCOUNTABILITY AND OVERARCHING NEEDS

Individuals with SMI often interact with numerous public and private organizations over the course of their lives. Some of these organizations are part of the justice system (e.g., police, courts, probation, jails, prisons, parole), while others are part of the mental health or social services systems (e.g., welfare, housing, family services). This complex web of interfaces can introduce significant bureaucratic challenges that hinder both access to care and continuity of care in a variety of ways. For example, information exchange across these entities can be challenging, in part because patient privacy regulations (e.g., HIPAA) often are misinterpreted, according to the group. Entities tend to take a conservative stance and are resistant to sharing health care records with others with a genuine need-to-know. What results is a disservice to both the individual and the entity. At a minimum, service provision can be hampered. In extreme cases, lack of information-sharing can have immediate and irreversible implications. Consider the case of the law enforcement officer responding to a call without the benefit of critical information about the mental health status of the subject. Too

The group argued for greater collaboration between mental health practitioners, academics, and policymakers in organized working groups with the goal of highlighting the evidence-based research and creating a framework for putting the research into practice.

often, these cases result in arrest and detention, and, in the worst-case scenario, it might escalate into a deadly encounter. Similarly, jails that are not provided with timely mental health histories are disadvantaged when making self-harm and suicide-risk evaluations.

Although the group acknowledged the importance of patient privacy regulations, group members argued that these tragic outcomes could be mitigated if justice agencies had timely access to critical information. In many states, this is not possible; however, Texas was identified as an outlier. Texas law *requires* agencies to exchange information on offenders with SMI regardless of whether other state law makes that information confidential (Texas Health and Safety Code, 2017). The law further requires agencies to exchange information about the offender's identity; needs; treatment; social, criminal, and vocational history; supervision status and compliance with conditions of supervision; and medical and mental health history. The group recommends that the federal government assess the risks and benefits of modifying existing health privacy legislation to allow for improved information-sharing in support of public safety missions; or, in the alternative, states might consider adopting legislation similar to the law in Texas. To support this, the development of best practices and model legislation designed to mandate information-sharing among service providers is needed.

Eliminating barriers to information-sharing and other bureaucratic impediments (e.g., necessity for each agency to have a signed release of information before any aspect of the case can be discussed) that hinder collaboration would improve outcomes in other areas, particularly to assist in a "warm hand-off" between treatment providers. As individuals churn through the system, they often fall through the cracks, which can result in medication lapses, relapses, decompensation, and interruption of services.

According to the group, there can be significant gaps between evidence-based practices for managing co-occurring serious mental illness and criminality and the policy decisions made by legislators, and, ultimately, this disconnect can be an impediment to effective treatment. One of the issues cited was the challenge in operationalizing the existing research, with the acknowledgment that best practices can evolve. The group argued for greater collaboration between mental health practitioners, academics, and policymakers in organized working groups with the goal of highlighting the evidence-based research and creating a framework for putting the research into practice.

One specific impediment to research is the lack of standard definitions of terms (e.g., SMI, recidivism, high utilizers) across justice and non-justice agencies. This condition hampers data-collection, analysis, and performance-measurement efforts. Although it is admittedly difficult to achieve, the group recommended exploring the feasibility of developing standardized terminology for use at the state level, if not at the national level.

Finally, the offender's existence in the parallel universes of the justice system and the public mental health system can create a variety of challenges that complicate the provision of care. Each universe has somewhat different terminology, values, and goals. For example, community-based providers are adept at assessing individuals for their mental health needs and developing a treatment plan accordingly. These entities tend to work with a team approach to care and are fully cognizant that mental illness can be a chronic disease and that relapse is part of recovery. Justice agencies, on the other hand, often are more hierarchical and focus on public safety and risk of recidivism. Mental illness might only be a peripheral factor in many cases, and is secondary to criminogenic needs. It is not surprising that there is some dissonance in the approaches used (e.g., assessment tools, treatment modalities) by both systems. Although some aspects of this divide might be irreconcilable, the group

believed that increased collaboration and connectivity among justice agencies and providers who serve justice-involved populations would be helpful in reducing inefficiencies and improving outcomes. The group called for best practices that highlight effective strategies to accomplish this (see Table 6). For example, there is a disconnect between the treatment approaches used with criminal justice populations (e.g., reasoning and rehabilitation, moral reconation therapy, thinking for change) and those used in community-based programs. As community-based programs continue to serve justice-involved individuals, it is important that these programs maintain a focus on strategies that target criminogenic needs. Likewise, correctional systems should leverage mental health treatment approaches rather than focus solely on criminal risk. The group argued that there is a need to develop a continuum of care to bridge the forensic mental health model and the standard community mental health model. Coordinating services under one umbrella could be one of these strategies. In New York City, for example, correctional health services are under the purview of the Department of Health and Mental Hygiene (Davis and Cloud, 2015). Wisconsin relies on a collaboration between the Department of Corrections and the Department of Health Services to provide

comprehensive reentry programming for offenders with SMI (Osher et al., 2012). These are two examples of initiatives that can be replicated if they are shown to be effective.

CONCLUSION

The criminal justice system, and the correctional system in particular, is overwhelmed by the growing number of individuals with SMI coming through its doors. Deinstitutionalization polices, combined with a lack of adequate community-based treatment alternatives and policing strategies that target the issues with which many individuals with SMI struggle (e.g., homelessness, substance use disorders, poverty), helped to create a condition that some view as the "criminalization of mental illness." Others argue that, in the majority of cases, these individuals have the co-occurring disorders of mental illness and criminality. The consensus is that corrections agencies generally lack the resources and the expertise to effectively treat and manage this population. This is not a new phenomenon. Some 46 years ago, a psychiatrist in a county jail in California recognized that, as state mental hospitals were closing, the number

Table 6. Needs Identified Related to Data-Driven Accountability

Tier	Problem or Opportunity	Associated Need
1	Bureaucratic challenges between agencies and organizations hinder collaboration and can unnecessarily delay access to care (e.g., necessity for each agency to have a signed release of information before any aspect of the case can be discussed).	• Identify best practices and develop model legislation that is designed to mandate information-sharing among service providers.
	Many jurisdictions lack coordination among agencies and providers required to identify (and more effectively manage) high utilizers of mental health services.	• Assess the risks and benefits of modifying existing health privacy legislation to allow for improved information-sharing in support of law enforcement missions.
2	Existing research often is not used in policymaking. Many agencies lack the analytic capacity and resources to leverage data collection into informed strategies to improve outcomes.	• Organize groups of practitioners, academics, and policymakers with the goal of operationalizing and highlighting the evidence-based research.
	The lack of standard definitions of terms across justice and non-justice agencies hampers data-collection, analysis, and performance-measurement efforts.	• Identify best practices and potential benefits of standardizing SMI terms at the national level (or adopting state definitions), especially for correctional and mental health purposes.
	Often, a lack of uniformity in the assessment tools used on the same individual makes continuity of care more challenging.	• Develop a catalog and identify best practices (and appropriate training) for integrating the wide variety of very useful assessment tools into community provider and correctional operations.
	There is a disconnect between the treatment approaches used with criminal justice populations (reasoning and rehabilitation, moral reconation therapy, thinking for change) and those used in community-based programs.	• Develop a continuum of care that bridges the forensic mental health model and standard mental health models.

of mentally ill inmates in his jail was rapidly rising (Abramson, 1972). More recently, several jurisdictions have made remarkably innovative strides toward addressing the needs of individuals with SMI, both in the community and in the justice system. Unfortunately, these examples remain exceptions rather than the rule. The next section outlines the key points from the group describing what is needed to change this narrative.

Prioritize the Needs of the Seriously Mentally Ill

Looking across the needs that were identified, the working group reached an implicit consensus that society has failed to prioritize the needs of the SMI population. Despite the fact that almost one in five Americans lives with a mental illness, these diseases are generally misunderstood by the public. Mental illness is underdiagnosed and undertreated. Many view the mentally ill (or the symptoms exhibited) with discomfort and as dangerous and wrongly associate the disease with a propensity for violence (Lamb and Weinberger, 2011). Furthermore, stigma can deter the mentally ill from seeking treatment, which can exacerbate symptoms. That said, with proper treatment and support, even the seriously mentally ill can recover. Unfortunately, those who suffer from mental illness are not afforded the same level of compassion, understanding, and support as those who suffer from other diseases. A variety of advocacy groups are outspoken about the consequences of inadequate intervention, but these efforts have not translated into sustained funding. More-focused efforts, perhaps in collaboration with diverse groups including the justice system, might help increase awareness and spark a shift in public attitudes about mental illness and those who suffer from it.

Invest in Early Detection and Interventions

Many individuals with chronic mental illness first experience symptoms in adolescence, but a significant proportion go untreated. It is therefore critical to develop strategies to identify symptoms (or those at risk) at an early age and make the appropriate referrals. Research is needed to determine the most effective intervention points and settings (e.g., primary schools, places of worship, pediatric physicians) to screen for mental illness in a way that does not stigmatize the child. Furthermore, greater emphasis on life-skills development in early childhood might prepare individuals to handle the day-to-day challenges that can be overwhelming to the mentally ill.

Improve Community-Based Mental Health Care and Supportive Services

Many communities, particularly those in rural areas, lack sufficient capacity to meet the demand for mental health treatment. These communities also struggle to provide the requisite level of supportive services (e.g., housing, employment assistance, and services that target such criminogenic needs as substance use disorders). These deficiencies can impede the ability of an individual with SMI to sustain treatment and are more strongly linked to involvement with the justice system than the underlying mental disorder. Models are needed to help communities determine the levels of mental health care (inpatient and outpatient) and supportive services needed to meet demand. These services should be comprehensive, person-centered, coordinated, and sustainable. With respect to those with SMI who might be aggressive or violent, better options are needed, including exploration of the feasibility of some level of mandated care *before* these individuals become a risk to themselves or others.

Focus on Treatment Rather Than Punishment

Investments and improvements in the previously mentioned areas should result in fewer individuals with SMI engaging with the justice system. That said, many will inevitably be contacted by law enforcement and enter the system. Law enforcement officers, and all the subsequent criminal justice system decisionmakers, need better knowledge and training regarding mental illness and appropriate responses. Collaborative strategies (e.g., CIT) between law enforcement and mental health professionals should be replicated in more jurisdictions. Whenever possible, individuals with SMI should be transported to fully funded community-based crisis centers or similar facilities rather than to jail. Courts and prosecutors should have a better understanding of the risks and needs posed by this population and seek diversionary, community-based programs rather than incarceration, provided that public safety is not compromised. It is understood that some individuals with SMI might be a genuine threat to public safety and must be incarcerated. Correctional institutions must be resourced so that they can provide safe environments in which to deliver treatment that targets both mental health and criminogenic needs. The goal should be the improvement of the individual, not merely stabilization. Finally, collaborative efforts are required between correctional systems and community-based providers

> Correctional institutions must be resourced so that they can provide safe environments in which to deliver treatment that targets both mental health and criminogenic needs.

to ensure that offenders have comprehensive reentry plans in place and leave the institution with Medicaid benefits and with an ample supply of medications, as needed. Such efforts also should arrange "warm hand-offs." Postincarceration supervision should continue to emphasize treatment and continuity of care rather than punishment, keeping in mind that relapse can be part of the recovery process.

Reinvest Public Funding

Although an influx of funding might be required to meet the demand for community-based and institution-based mental health and supportive services, a systemic view of how current dollars are spent could identify opportunities for greater returns. For example, inadequacies in community-based programs have real downstream impacts on justice expenditures. Justice agencies are generally ill-equipped to address the needs of the SMI population, which can consume considerable resources. Reallocation of the criminal justice budget should be explored. For example, reduced reliance on jails as the first stop for individuals with SMI can create savings that can be

better used in prevention efforts. Diverting lower-risk individuals from jails and prisons into community-based services that can meet their individual needs can achieve better outcomes at lower costs and without compromising public safety.

Bridge the Divide Between the Justice and Mental Health Systems

Barriers to collaboration between justice system and mental health system entities continue to disrupt continuity of care for the mentally ill, who are among the most vulnerable in society. Overconservative interpretations of patient privacy regulations can impede information exchange. At a minimum, this can lead to duplication of efforts and gaps in care; in worst-case scenarios, the lack of timely information can have irreversible implications.

These systems have different philosophies, values, and goals, but in many cases they serve the same individual with co-occurring disorders (mental illness and criminality). Efforts to better understand the different perspectives and facilitate greater collaboration and connectivity are needed. Improving mental health and reducing justice system involvement are not competing interests; they are interrelated. Thus, a more unified, team-oriented approach could be more effective.

The majority of needs identified in this report are not new. Indeed, several issues closely mirror previous recommendations made by national advocacy groups and correctional health care organizations. This would seem to imply that the practitioners who work with this population essentially understand what is required to improve outcomes. Like many other issues, the gap appears to be a matter of prioritization and insufficient resources. That said, the needs identified here represent a strong and diverse agenda that can serve as a foundation for transformational change, given the social and political will to pursue this direction.

APPENDIX: MANAGING THE SERIOUSLY MENTALLY ILL IN CORRECTIONS DETAILED METHODOLOGY

This appendix presents additional detail on the workshop process, needs identification, and prioritization carried out to develop the research agenda presented in the main report.

Pre-Workshop Activities

To prepare for the workshop, participants were provided with materials in advance. The read-ahead documents are discussed in the main report. In addition, the participants were asked to fill out a questionnaire assessing the challenges associated with managing the seriously mentally ill in corrections. The results of the ranking portion of the questionnaire are summarized in Figure 1 in the main report.

The complete pre-workshop questionnaire can be found at the end of this appendix. The workshop agenda is presented in Table A.1

Prioritization of Needs

To develop and prioritize a list of technology and policy areas that are likely to benefit from research and development investments, we followed a process that has been used in previous research (see, for example, Jackson et al. [2016] and references therein). The participants discussed and refined issues and problems in each category and identified potential needs (e.g., solutions) that could address each issue or problem. Once each

group had compiled and refined its list of issues and needs, those issues and needs were converted into a web-based survey (using the Qualtrics service). Subsequently, each participant was asked to individually assess each issue and its associated need with respect to three dimensions. Each of the following dimensions was assessed on a 1–9 scale, with 1 representing "low" and 9 representing "high":

- **Importance or payoff:** How much of an impact would solving this problem have on managing individuals with SMI in corrections? In an attempt to provide each participant with a similar mental "anchor" for what should be considered a large payoff, we instructed them to consider a high score (e.g., 9) as having a 20–30 percent (or more) improvement on outcomes. The low anchor for the scale was set where a rating of 1 corresponded to zero improvement to give participants the opportunity to indicate that they did not see a value to meeting the need.
- **Likelihood of success:** Are there technical barriers? If so, how hard would it be to get beyond them? Are there operational or deployment barriers (including cost) that would lead agencies to not adopt a solution if it was available? If so, how hard would it be to get beyond them?

For likelihood of success, a score of 9 represented a judgement by the panelist that there was a high likelihood (90 percent or higher) that any barriers to addressing the need and subsequent adoption could be overcome, while a score of 1 represented a judgment that the probability of overcoming barriers was low, so successful development and adoption was unlikely

Table A.1. Workshop Agenda

Day 1		Day 2	
8:30	Welcome, Overview, and Introductions	8:30	Challenges and Solutions Discussion (continued)
9:15	Identify High-Priority Challenges and Solutions Related to the Seriously Mentally Ill in Corrections	10:00	Break
10:30	Break	10:15	Priority Ranking Exercise—Round 1
10:45	Challenges and Solutions Discussion (continued)	11:15	Group Discussion on Results of Initial Rankings
11:30	Lunch	12:00	Lunch
12:45	Challenges and Solutions Discussion (continued)	1:15	Priority Ranking Exercise—Round 2
2:45	Break	2:15	Meeting Wrap-Up/Administrative Issues
3:00	Challenges and Solutions Discussion (continued)	3:00	Adjourn
5:00	Adjourn		

(10 percent or lower). Participants also had the opportunity to provide comments to justify or support their choices.

When the first round of assessment was completed, the group's responses and comments were anonymously collected and summarized into a single report. The report contained a "kernel density" distribution figure and a summary of the group's comments for each issue and need. Figure A.1 is an example of one of the issue-need summaries from the group. This report was used to facilitate discussion among the participants about areas of relative disagreement. During the discussion of the results from round 1, participants were given a second, clean web-based survey and asked to provide a second round of responses while keeping the group's collective response and any discussion in mind.

Once the round 2 responses were collected, they were ranked by calculating an expected value using the method outlined in Jackson et al. (2016). Specifically, for each question, the payoff and the likelihood of success were multiplied together and the median of that product was the expected value. Then, the resulting expected value scores were clustered using a hier-

archical clustering algorithm. The algorithm that we selected was the "ward.D" spherical algorithm from the "stats" library in the R statistical package, version 3.4.1. We prefer it for this purpose to minimize within-cluster variance when determining the breaks between tiers. The choice of three tiers is arbitrary, but was done in part to remain consistent across the set of technology workshops conducted for NIJ. Also, the choice of three tiers represents a manageable system for policymakers. Specifically, the top tier is made up of the priorities that should be the primary policymaking focus in the immediate term, the middle tier should be examined closely, and the third tier probably can be deferred and reexamined in the future, as perceptions about impact and likelihood of success change over time. Figure A.2 shows the distribution of the needs by the expected value score. The height of the bar indicates the number of needs that had that score and the color of the bar indicates the tier to which the need was ultimately assigned by the clustering algorithm.

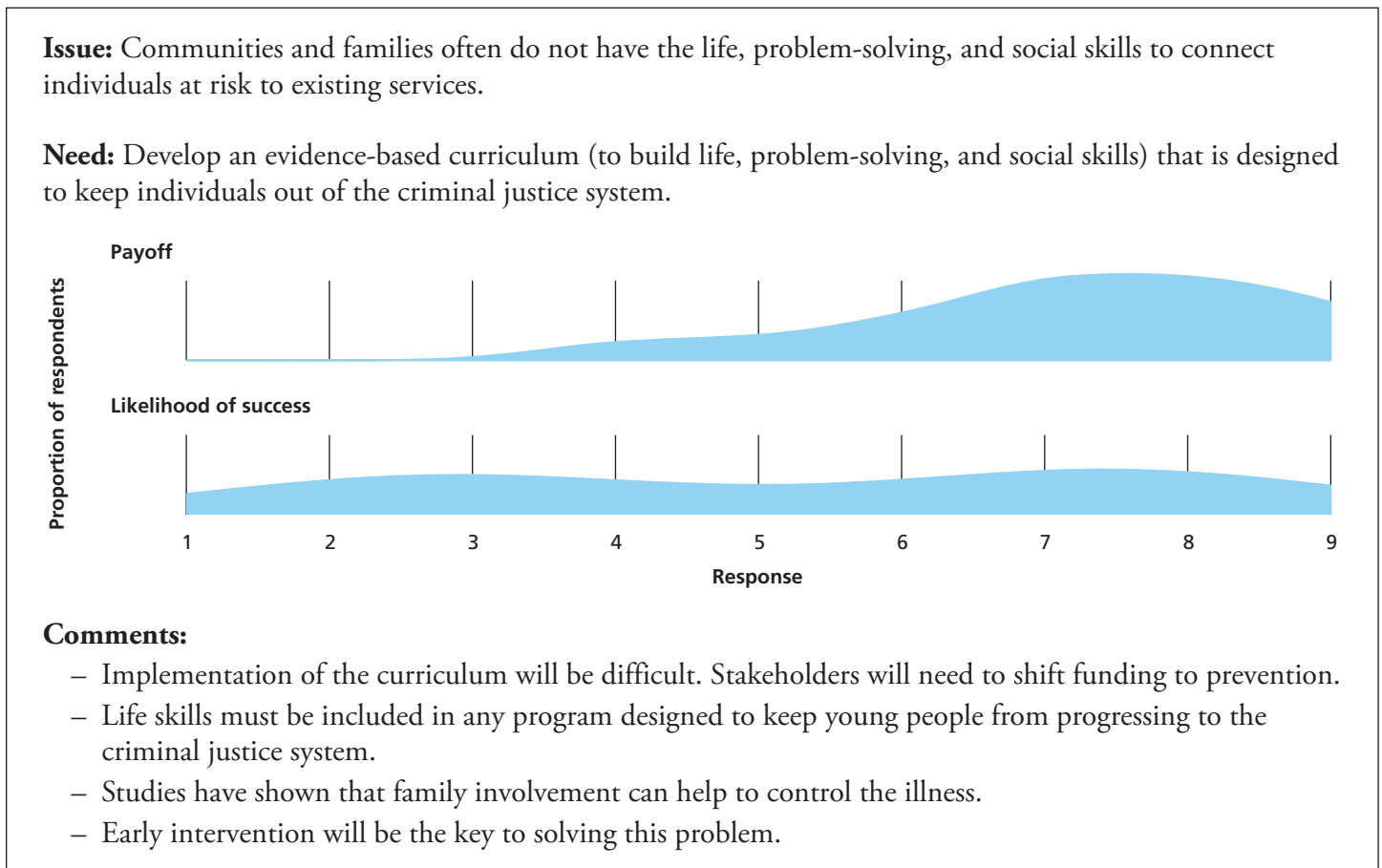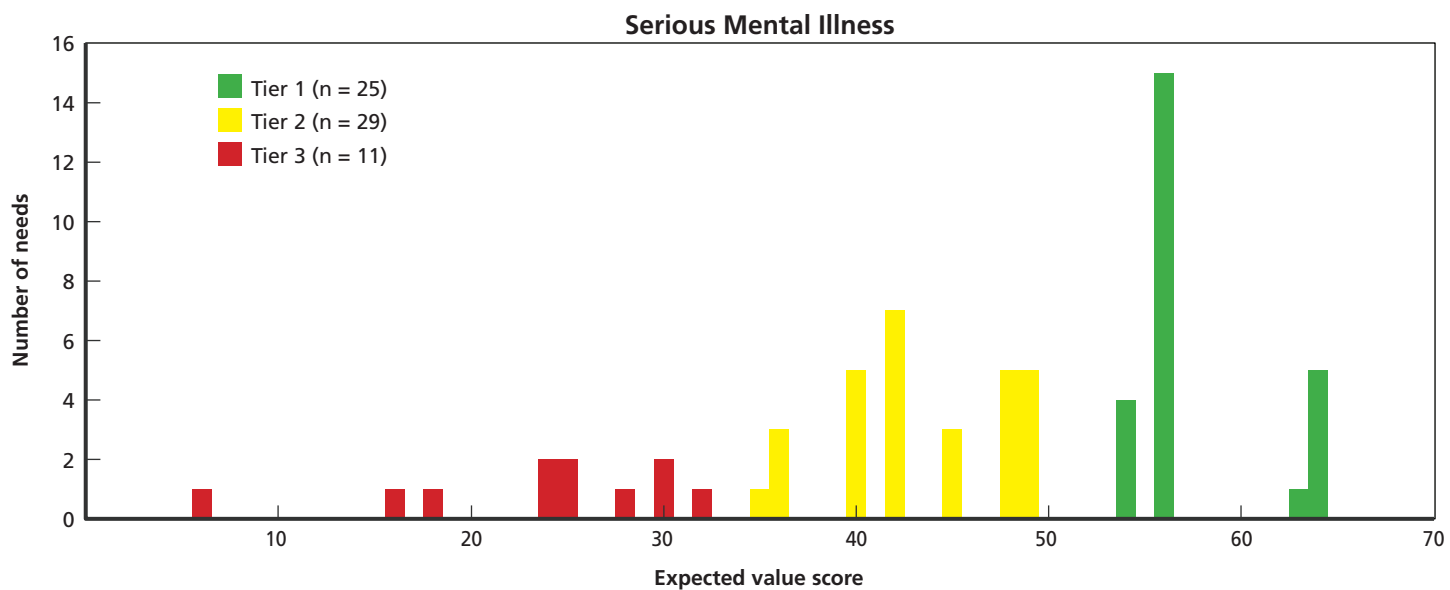## Figure A.1. Example Round 1 Delphi Summary Question

Issue: Communities and families often do not have the life, problem-solving, and social skills to connect individuals at risk to existing services.

Need: Develop an evidence-based curriculum (to build life, problem-solving, and social skills) that is designed to keep individuals out of the criminal justice system.

Comments:
- Implementation of the curriculum will be difficult. Stakeholders will need to shift funding to prevention.
- Life skills must be included in any program designed to keep young people from progressing to the criminal justice system.
- Studies have shown that family involvement can help to control the illness.
- Early intervention will be the key to solving this problem.

Figure A.2. Distribution of the Clustered Needs Following Round 2 Delphi Rating

Serious Mental Illness

Legend:
- Tier 1 (n = 25)
- Tier 2 (n = 29)
- Tier 3 (n = 11)

Y-axis: Number of needs

X-axis: Expected value score

Managing the Seriously Mentally Ill (SMI) in Corrections Advisory Panel Background Information and Questionnaire

Background

Thank you for agreeing to participate in the Managing the Seriously Mentally Ill (SMI) in Corrections Advisory Panel, part of the Priority Criminal Justice Needs Initiative sponsored by the National Institute of Justice (NIJ). The panel brings together corrections administrators, researchers, and other experts to prioritize the needs of the sector and to help NIJ develop its future corrections-related research goals.

Serious mental illness (SMI) is generally defined to include schizophrenia and other psychotic disorders; bipolar disorder; other severe forms of depression; and some anxiety disorders, such as obsessive-compulsive disorder, that cause serious impairment (Judicial Council of California, Administrative Office of the Courts, 2011, p. 13). The criminal justice system oversees a disproportionate number of individuals with serious mental illness and co-occurring substance abuse disorders (see Table A.2).

Table A.2. Estimated Percentage of Adults with Mental Health, Substance Use, and Co-Occurring Disorders in the U.S. Populations and Under Correctional Control and Supervision

	General Public	State Prisons	Jails	Probation and Parole
Serious mental illness	5.4	16.0	17.0	7–9
Substance use disorders (alcohol and drugs)—abuse and/or dependence	16.0	53.0	68.0	35–40
Drug abuse only	1.4	17.0	18.0	N/A
Drug dependence only	0.6	36.0	36.0	N/A
A co-occurring substance use disorder when serious mental illness is diagnosed	2.0	59.0	72.0	49.0

SOURCE: Data are from Osher et al., 2012, p. 6.
NOTE: N/A = not applicable.

Often, individuals with SMI churn through the criminal justice system, experiencing multiple arrests and periods of incarceration. As community psychiatric facilities were closed in an effort to deinstitutionalize people suffering from mental illness, many of them were "transinstitutionalized" to jails and prisons (Lamb and Weinberger, 2011). Correctional facilities have replaced hospitals as primary facilities for individuals with SMI who cannot get the help they need in community settings. Jail and prison conditions might exacerbate illness. Once incarcerated, SMI offenders tend to stay longer, cost more, become more difficult to manage, and are more likely to die by suicide (Fuller et al., 2016).

The SMI are at risk in the community because of a lack of services, inability to access available resources, inadequate support and supervision, or some combination of the three. According to many experts, "little consensus exists among behavioral healthcare and community corrections administrators and providers on who should be prioritized for treatment, what services they should receive, and how those interventions should be coordinated with supervision" (Osher et al., 2012, p. viii). Fortunately, with the more recent focus on mental health courts, jail diversion, and community reentry, this seems to be evolving.

In preparation for the meeting next month, we would like you to consider the questions and challenges posed in the Pre-Meeting Questionnaire on the next page.

Managing the Seriously Mentally Ill (SMI) in Corrections Advisory Panel Pre-Meeting Questionnaire

Your responses to the questions below will provide us with initial input that will maximize our time together during the panel. You are free to skip any questions that you do not wish to answer, but we hope input from the panel is as complete as possible to help us frame the workshop discussion.

During the workshop, we will discuss the needs of seriously mentally ill offenders and those with co-occurring substance abuse disorders as well as potential solutions to these challenges. We have identified several distinct subsets of the issue, including community services/supervision, policing/public safety, mental health courts/jail diversion, institutional programming, reentry coordination, relapse prevention, data-driven accountability, and the costs associated with each intervention. We understand that these components are interrelated; but to the extent possible, we would like your input on the relative importance of each component. This will inform the panel discussion by allowing us to weight different potential innovations that might be useful in achieving the objectives of each component.

For each component, please assign a level of importance on a scale of 1–5 where 1 is low importance and 5 is high importance.

Though we expect each person's responses will be informed by their individual experience, we encourage you to think broadly about the state of corrections in general as opposed to your individual perspective.

Part I

Please assign levels of importance (from 1 to 5), where 1 is low importance, and 5 is high importance

	1 (low)	2	3	4	5 (high)
Community-Based Treatment Services (General) includes community-based services (prior to criminal justice involvement).	o	o	o	o	o
Policing and Public Safety includes police response to mentally ill offenders and the perceived threat to public safety (considering training and resource needs).	o	o	o	o	o
Specialty Courts and Jail Diversion includes mental health/ substance abuse/veterans courts, such jail diversion alternatives as residential community corrections centers, and probation services (considering operational and resource needs and potential justice reinvestment initiatives).	o	o	o	o	o
Institutional Programming includes mental health and substance abuse treatment services provided in the institutional setting (considering operational and resource needs, and potential justice reinvestment initiatives).	o	o	o	o	o
Reentry Coordination and Relapse Prevention includes the transitional hand-off from correctional institutions to community-based services (including parole) and the response of supervising agents when relapse occurs (considering operational and resource needs, and potential justice reinvestment initiatives).	o	o	o	o	o
Data-Driven Accountability includes research needs, performance metrics, data collection, data-sharing, data analysis/interpretation, and system response to reported data (considering operational and resource needs).	o	o	o	o	o

Other (please specify):

Part II: Specific Challenges

We will be discussing each of these major areas during the workshop. To prepare for the discussion, please identify the top issues or challenges that prevent corrections from achieving desired outcomes with the SMI population. Please give us as many issues as you would like. If this questionnaire does not provide enough space, please feel free to email us with any additional information.

Community-Based Treatment Services (General) includes community-based services (prior to criminal justice involvement).
What are the major issues or problems related to community-based treatment services (prior to criminal justice involvement)?

Policing and Public Safety includes police response to mentally ill offenders and the perceived threat to public safety (considering training and resource needs).
What are the major issues or problems related to policing and public safety?

Specialty Courts and Jail Diversion includes mental health/substance abuse/veterans courts, such jail diversion alternatives as residential community corrections centers, and probation services (considering operational and resource needs, and potential justice reinvestment initiatives).
What are the major issues or problems related to specialty courts/jail diversion?

Institutional Programming includes mental health and substance abuse treatment services provided in the institutional setting (considering operational and resource needs and potential justice reinvestment initiatives).
What are the major issues or problems related to institutional programming?

Reentry Coordination and Relapse Prevention includes the transitional hand-off from correctional institutions to community-based services (including parole) and the response of supervising agents when relapse occurs (considering operational and resource needs and potential justice reinvestment initiatives).
What are the major issues or problems related to reentry coordination and relapse prevention?

Data-Driven Accountability includes research needs, performance metrics, data collection, data-sharing, data analysis/interpretation, and system response to reported data (considering operational and resource needs).
What are the major issues or problems related to data-driven accountability?

Other (please specify):
Are there any other points about issues/problems that you think are important for us to include in setting up the workshop discussion?

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About This Report

On behalf of the U.S. Department of Justice, National Institute of Justice (NIJ), the RAND Corporation, in partnership with the Police Executive Research Forum (PERF), RTI International, and the University of Denver, is carrying out a research effort to assess and prioritize technology and related needs across the criminal justice community. This initiative is a component of the National Law Enforcement and Corrections Technology Center (NLECTC) System and is intended to support innovation within the criminal justice enterprise. For more information about the NLECTC Priority Criminal Justice Needs Initiative, see www.rand.org/jie/justice-policy/projects/priority-criminal-justice-needs.

This report is one product of that effort. It presents the results of an expert workshop focused on identifying and prioritizing ways to manage the population of individuals with serious mental illness in correctional facilities. This report and the results it presents should be of interest to planners from corrections agencies; research and operational criminal justice agencies at the federal level; private-sector technology providers; and policymakers active in the criminal justice field.

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