

Consensus Workgroup Policy Recommendations to the 115th Congress and Trump Administration on Behavioral Health Issues in the Criminal Justice System

Background

The Consensus Workgroup met for the first time in September 2016 to promote collaboration on policy, research, and practice issues at the intersection of behavioral health and criminal justice. National policy coalitions and working groups addressing behavioral health issues (e.g., Mental Health Liaison Group) and criminal justice issues (e.g., Justice Roundtable, brown bags convened by the National Criminal Justice Association) have existed for years. Discussions across these boundaries have occurred mostly on an ad hoc basis. However, the increasing intersection of behavioral health issues and criminal justice necessitates coordinated, collaborative, and sustained efforts.

The Consensus Workgroup includes organizations representing individuals with behavioral health needs and their families, providers, correctional systems and administrators, criminal justice reformers, state and local governments, state and local program directors, and researchers. **Together, we call on the Trump Administration and lawmakers in the 115th Congress to take a comprehensive approach to addressing issues at the intersection of behavioral health and criminal justice.**

Notes on terminology. For the purposes of the Consensus Workgroup and this paper, the term “behavioral health” refers to mental health and substance use. We further parse out mental health disorders into serious emotional disturbance (SED), serious mental illness (SMI), and non-SMI categories. SED and SMI refer to diagnosable disorders, for those under age 18 and over age 18, respectively, that substantially interfere with or limit one or more major life activities, such as school or work, social relationships, and activities of daily living. In common usage, SED and SMI frequently refers to major depression, schizophrenia, and bipolar disorder, among other diagnoses. Some mental health disorders typically considered non-SMI include persistent depressive disorder, generalized anxiety disorder, post-traumatic stress disorder, and attention-deficit hyperactivity disorder. Substance use disorders (SUD) are classified as mild, moderate, or severe, depending on diagnostic criteria met in an individual case. Diagnoses are based on evidence of lack of control over use, using despite problems related to health, home, school, work, or social relationships, risky using, and other criteria. A range of health professionals help individuals struggling with behavioral health problems, providing case management, medications, and psychosocial interventions. We use the phrase “behavioral health” because of the overlapping policy and practice issues and treatment systems involved in addressing mental health and substance use.

The issues

At the 2013 White House National Conference on Mental Health, President Obama stated that “too many Americans who struggle with mental illnesses are still suffering in silence rather than seeking help.”ⁱ Mental illness is not a strong predictor of criminal or violent behavior. Yet left untreated, it can lead to behaviors that cause too many individuals to wind up in the criminal justice system. As a result, America’s jails and prisons have become de facto behavioral health care providers. A 2013 investigation found that the nation’s three largest jails—Cook County, Los Angeles County, and New York City—treated 11,000 prisoners on any given day (it is not known what proportion of this group was receiving medication only versus more comprehensive treatment).ⁱⁱ Furthermore, the rate of serious mental illness (SMI) in American jails is reported at 14.5 percent for men and 31 percent for women, compared to 4.2 percent of all adults in the United States.ⁱⁱⁱ

The most recent federal figures on mental illness—both SMI and non-SMI—and SUD among incarcerated individuals show:

- 44.8, 56.2, and 64.2 percent of federal prison inmates, state prison inmates, and local jail inmates, respectively, reported impairment over the previous year due to a mental health problem.^{iv}

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- 45.5, 53.4, and 68 percent of federal prison inmates, state prison inmates, and local jail inmates, respectively, met the criteria for drug dependence, abuse, or both.^v

A more recent federal report on restrictive housing that used a measure of psychological distress found that: 18.2 percent of prisoners and 22.2 percent of jail inmates met the criteria for an anxiety or mood disorder; and 14.6 percent of prisoners and 26.2 percent of jail inmates met the criteria for serious psychological distress.^{vi}

Juvenile justice systems also bear the burden of an overwhelmed behavioral health system and have become de facto treatment setting for many individuals under 18 who lack access to standard care. Nearly half of children and adolescents in the child welfare system have a mental health disorder, and 70 percent of youth detained in the juvenile justice system have diagnosable symptoms of a mental health disorder—three and a half times the rate among all individuals under the age of 18.^{vii} In one recent study, 61.2 percent of justice-involved youth screened positive for a substance use disorder; the study identified comorbid mental health and substance abuse disorders in 48.6% of these youth.^{viii}

What is being done

A growing awareness of this crisis has led to investments in programs and practices that better meet justice-involved individuals' behavioral health needs, make better use of public resources, and protect public safety. Pre- and post-booking diversion, such as Crisis Intervention Team models and problem-solving courts, help keep those who pose little risk to public safety out of formal criminal justice processes. Significant efforts also are under way to ensure that criminal justice and health agency partnerships, jails, and prisons effectively meet the behavioral health needs of individuals who come into contact with the justice system. All of these efforts strongly emphasize reducing the rate of reoffending and re-arrest.

Policymakers have taken note, and federal programs and legislation that address the disparate level of behavioral health needs in the criminal justice system have strong bipartisan backing. Successes from state and local efforts inform federal investments in this area, and federal agencies draw from lessons learned to guide the delivery of technical assistance and other support to local and state agencies. However, to address the extent of the fragmentation that exists across systems requires additional coordination and resources at the federal level, and individuals with behavioral health needs, correctional systems, law enforcement, and public mental health and addictions agencies urgently need additional federal support. The time has come to address behavioral health issues in criminal justice in a coordinated, comprehensive fashion.

Priority Recommendations to Federal Policymakers

The Consensus Workgroup urges federal policymakers to take immediate action in the following areas:

1. Federal support, training, and technical assistance to state and local agencies.

We strongly support existing federal efforts in this area, such as Substance Abuse and Mental Health Services Administration (SAMHSA) grant programs (e.g., Jail Diversion, Drug Court and Offender Reentry programs) and the Bureau of Justice Assistance (BJA) grant programs (e.g., Justice and Mental Health Collaboration Program, the Second Chance Act, and the Byrne Justice Assistance Grant programs). Yet, meeting the level of need seen across the nation and spurring and supporting systematic reforms requires additional support, training and funding. To that end, we recommend federal support for state and local efforts that are tailored to the needs of specific professions, locales, and decision-making points in the criminal justice system:

A. Cross-cutting

- Establish a **clearinghouse on best practices** that lead to positive outcomes for people with mental health and substance use disorders involved in the justice system. As the professional and research literature supports it, include practices specific to the roles of law enforcement, judges, prosecutors, public defenders, correctional agency administrators and officers, community supervision agency administrators and officers, mental health and substance use service agencies and providers, and community service agencies (e.g., housing authorities).

- Help state and local systems expand efforts to **universally screen and assess** at all points across the criminal justice continuum for:
 - **Mental health and substance use disorders** to inform connections to appropriate treatment and services; and
 - **Criminogenic risk** (or the likelihood that someone will commit future offenses) **and need**, to further inform recidivism reduction programming and release decisions (i.e., whether to require supervision or services to reduce the risk of reoffending).
- Connect justice-involved and at-risk individuals to **health care coverage and services**:
 - **Allow Medicaid to cover services for incarcerated individuals pre-adjudication.** Medicaid does not pay for health services provided to inmates of public institutions. Yet up to half of individuals held in jails across the nation have not yet gone to trial, let alone been convicted of, the charges for which they are being held. Medicaid should cover services for this population.
 - Support states in **suspending, rather than terminating, Medicaid coverage** during incarceration. When a person is incarcerated, even for a short time pending trial in county jail, it is common for their Medicaid benefits to be terminated. This can be a function of state policy or limitations in information systems. Reinstating Medicaid benefits can take up to several months, meaning a substantial lag in accessing treatment in the community. Research has shown that this delay in starting treatment after incarceration drastically increases recidivism.
 - **Communicate the availability of services to Medicaid recipients.** In 2017, the program will come into compliance with Mental Health and Substance Use Disorder Parity provisions, which require equal coverage for medical/surgical and behavioral health services. The application of mental health and addiction parity across health insurance providers enhances the opportunity for individuals to access needed supports in local communities, and it is imperative to provide notice of newly covered services to who are eligible for Medicaid.
 - **Connect individuals to health coverage and services** during the reentry process. Those preparing for release should apply for/reactivate Medicaid or gain coverage on the health insurance marketplace during a 60-day special enrollment window. Minimizing delays in accessing health care services is critical for those with chronic medical conditions and behavioral health needs.
- Support the specific needs of justice-involved individuals in **rural communities** through telemedicine and other means of delivering services over longer distances. Some rural communities face barriers to the provision of services because of their proximity to hospitals, qualified professionals, and community behavioral health agencies.
- Address **behavioral health disparities** and the **specific needs of special populations** involved in the justice system, including racial and ethnic minorities, women, individuals with disabilities, older adults, homeless individuals, and lesbian, gay, bisexual, and transgender people.
- Support the integrated treatment of **co-occurring disorders**. Many people suffer from both mental health and substance use disorders, referred to as a co-occurring disorder. Historically, those with co-occurring disorders have received mental health treatment services separately from substance use treatment services, funded, in part, through separate federal block grant programs. However, current research shows that individuals with co-occurring disorders are best served through integrated care. Many integrated care programs and methods exist, all of which should assess and match the patient to their appropriate level of care based on the severity of their illness. This approach often lowers costs and creates better outcomes.
- Support the expansion of **trauma-informed systems and care**. Traumatic stress, including post-traumatic stress disorder, is widespread among the justice-involved population. It can underlie emotional, cognitive, and behavioral patterns that seem to indicate other behavioral disorders and can be made worse through certain treatment modalities for other disorders. Effective

trauma-informed systems incorporate psychoeducation for justice-involved individuals, system-wide training for professionals, and evidence-based and promising group and individual interventions.

B. Effective diversion practices (pre-arrest, pre-trial, post-adjudication)

- Encourage further dissemination and implementation of **evidence-informed and promising diversion (pre-arrest, pre-trial, post-adjudication, and short-term crisis facilities) responses**, such as law enforcement, court-based, and jail-based responses. The Consensus Workgroup recognizes that existing federal efforts exist in this area and strongly supports their expansion through training and technical assistance through state grant-making agencies to service providers.
- **Improve and expand promising law enforcement responses** to individuals with behavioral health needs. Effective assessment is essential at the earliest point of contact so that an appropriate diversion path can be determined. This requires additional training for law enforcement. Great demand also exists for training to help law enforcement respond safely to emergency situations involving individuals experiencing a mental health or addiction crisis. We recommend: creating a national center to help meet this demand; supporting training to help officers triage potential mental health crises, as well as intensive training for a smaller group of officers who will respond in a more comprehensive way to mental health and addiction crises; and supporting training of non-sworn personnel.
- Help state and local jurisdictions develop policies to **support adherence to treatment plans, supervision conditions, incentives, and reimbursement for community commitment**, including incentives and graduated sanctions that are the least restrictive necessary, reasonably calculated to prevent further criminal justice involvement, and do not inadvertently or deliberately disadvantage persons with mental health or substance use disorders. Officers also need to be able to adjust the restrictiveness and intensity of supervision conditions based on individual circumstances. Substance use disorders are defined by their chronic and relapsing nature, and federal agencies should extend support to jurisdictions that wish to implement accountability measures other than secure detention for failed drug screens.

C. Effective practices during incarceration

- Facilitate and support the universal adoption of **evidence-based screening, assessment, and treatment** in jails and prisons, including access to both psychosocial and psychopharmacological treatments, as indicated. DOJ can take model policies and practices from state and local corrections and the Bureau of Prisons and help other facilities improve the care they provide.
- **Improve correctional officer responses** to mental illness and mental health crises. Build on the work of the National Institute of Corrections to provide correctional officers with training on de-escalation and other means of safely resolving situations involving inmates in mental health crisis.
- Give jails and prisons guidance, standards, and other tools to **reduce the use of restrictive housing**. Correctional systems are placing a premium on reducing their restrictive housing populations, especially those with behavioral health needs, who may be at increased risk for worsening symptoms in these settings. DOJ should build on its restrictive housing report and Bureau of Prisons (BOP) reforms, provide support to state prisons and local jails, and disseminate lessons learned from these efforts.
- Help **local and county jails** address the unique challenges they face related to behavioral health. Jails, even more so than prisons: house a higher proportion of individuals diagnosed with severe and chronic mental illness than prisons; operate with unpredictable inmate release dates, which hampers the development of reentry plans; and have limited ability to coordinate with local behavioral health authorities, link inmates to core services in the community, and provide for continuity of care during reentry. Jails also need support specific to suicide prevention, including universal, validated suicide risk assessments and policies and services for those deemed to be at

risk. In 2013, the suicide rate among jail inmates was 46 per 100,000, while the suicide rate in the general population was 12.6 per 100,000.^{ix}

D. Effective Reentry practices

- Support **comprehensive transition planning** that begins at the time of admission to jail or prison and continues without disruption into the community. Each individual's transition plan should be based on a risk/needs assessment and should address continuity of care, as well as other social/relational needs (i.e., criminogenic risk, housing, health care coverage, access to appropriate healthcare services and treatment, employment, family/peer relationships, etc.). Maintaining health through the reentry process is crucial to individual success in the community, as are the provision of essential supports. The availability of sober housing with supportive services for ongoing behavioral health treatment, case management, and supported employment is particularly important.
- Expand the **availability of services provided to individuals returning to the community**. Programs and services should be tailored to the unique needs of each individual based on risk and need, be developmentally appropriate, trauma-informed and responsive to the gender, age, and cultural background of the participants. Effective reentry practices consider the interactions among multiple factors (a biopsychosocial approach), particularly the connections among behavioral, physical and relational health.
- Support the expanded provision of **medication-assisted treatment**, which has been found to be successful in treating substance use disorders by combining behavioral therapy and medications.
- Federal grant programs focused on reentry (e.g., BJA's Second Chance Act program, SAMHSA's offender reentry program) should further emphasize a comprehensive approach to reentry for returning citizens with behavioral health needs in their solicitations and performance metrics.
- Prioritize **information sharing between justice systems and community physical and behavioral health providers**. When facility records are not available to community services providers, efforts to ensure seamless care can be hobbled. Federal grant programs focused on reentry (e.g., BJA's Second Chance Act program, SAMHSA's offender reentry program) should further emphasize the importance of record-sharing in their solicitations and performance metrics. Also, the federal government should provide clear guidance around the application of the Health Insurance Portability and Accountability Act (HIPAA), which is unnecessarily preventing the sharing of information.

2. Federal courts and prisons.

- **Increase resources for behavioral health programming in the federal BOP in male and female institutions.** BOP programs and policies reflect some of the best of what the field has to offer offenders with behavioral health disorders. However, to meet the goal of adequately addressing the needs of all of these inmates, BOP needs additional providers, physical space, and financial resources.
- **Engage** in more pilot programs, **expand** innovative efforts, and **disseminate** lessons learned and effective practices. BOP plays an important role in American corrections and, with increased authority and resources, can provide new models for state and local corrections to improve care for offenders with behavioral health needs.
- **Reduce the use and harmful effects of restrictive housing.** BOP has requested additional funding dedicated to removing mentally ill offenders from restrictive housing through expansion of the Secure Mental Health Step-Down Program and to placing a mental health professional in each of the agency's Secure Housing Units. We strongly support these goals. In addition, BOP can further improve their efforts by adopting successful strategies from local and state corrections.
- **Increase congressional engagement.** Congress plays a crucial role in directing agency activity, through oversight, authorization, and appropriations. To facilitate reform, it is essential for Congress to take a more active interest in BOP efforts to meet the needs of offenders with behavioral health needs—particularly in the gap between policy and what the agency can achieve with limited resources.

- Develop policies to **support adherence to treatment plans, supervision conditions, incentives, and reimbursement for community commitment**, including incentives and graduated sanctions that are the least restrictive necessary, reasonably calculated to prevent further criminal justice involvement, and do not inadvertently or deliberately disadvantage persons with mental health or substance use disorders. Officers also need to be able to adjust the restrictiveness and intensity of supervision conditions based on individual circumstances. Substance use disorders are defined by their chronic and relapsing nature, and federal agencies should extend support to jurisdictions that wish to implement accountability measures other than secure detention for failed drug screens.

3. Behavioral health workforce development

- Build on current **student loan forgiveness and repayment**. Better educate medical and behavioral health professionals about Public Service Loan Forgiveness for work in criminal justice settings. Expand National Health Service Corps eligibility to local and county corrections, as well as to a wider range of addictions professionals.
- Support **partnerships between institutions of higher education, local and state correctional agencies, and community providers**, to expand opportunities for training and placement in correctional settings for students enrolled in accredited behavioral health professions training programs.
- Strengthen funding for **programs that expand the behavioral health workforce**, such as the existing Behavioral Health Workforce Education and Training Program, and that prepare behavioral health providers to work with at-risk children, adolescents, justice-involved youth, transitional-age youth, and others at high risk for developing mental health disorders. Increase training for non-clinical staff so they are able to recognize the signs and symptoms of behavioral issues and respond appropriately. Such training should be provided by qualified trainers in techniques with a strong research base.
- Provide spaces, such as conferences and remote trainings, for service providers (e.g., licensed professional counselors, psychiatrists, psychologists, social workers), judges, prosecutors, public defenders, and secure and community corrections administrators and officers to maintain ongoing dialogue about **standardization of and competencies for forensic behavioral health treatment**.
- Encourage **employment-related re-entry programs** that are designed to address the mental health, substance abuse, and developmental needs of each participant.

4. Federal research, evaluation, and coordination

- Fund **evaluations, higher-level analyses, and outcome comparisons** of pre- and post-booking diversion, medication assisted treatment, and other programs and practices. It is imperative to ongoing reform that new efforts to keep individuals from penetrating into the criminal justice system build from what works, and a dearth of literature exists on this critical topic.
- Fund studies to **bridge the gap in research on people with behavioral health disorders** involved in the justice system, such that both recovery and recidivism reduction outcomes are considered or examined. Both the reduction of mental health symptoms and recidivism reduction among this group are imperative goals, and the federal government can take a leadership role in aligning this work.
- Create an **interagency council or permanent working group** on behavioral health issues in criminal justice modeled on the Federal Interagency Reentry Council (FIRC) and the United States Interagency Council on Homelessness (USICH). Involve representatives from the U.S. Departments of Justice, Health and Human Services, Housing and Urban Development, Labor, and others. Ensure the group addresses issues related to: different funding streams; confusion around jurisdiction on Capitol Hill; and the array of federal legislation and programs that do or could address these issues.
- Support **coordinated local, state, and federal innovations**. Numerous local and state governments have placed a priority on designing interventions for justice involved individuals with behavioral health issues, and federal agencies are providing financial support for these localized initiatives through the Byrne Justice Assistance Grant program and several discretionary grant programs. With additional support for local, county, and statewide planning and national coordination, efforts across

the country can culminate into widespread effective programs. Exemplary programs involve multiple service agencies, and as such, DOJ can help to establish best practices for data collection and sharing among these agencies.

5. Juvenile Justice

- Prioritize **prevention programs** that identify and target services to at-risk juveniles and their families, to maximize the chances that juveniles do not engage with the juvenile justice system in the first place.
- **Emphasize diversion** for justice-involved youth with behavioral health needs, and include aggression management, mental health, and substance use treatment in interventions for this group. To a much larger extent than with adults, home- and community-based treatment for justice-involved youth can be provided in ways that protect public safety. Allowing more appropriate agencies, such as public behavioral health, to address the needs of these youth allows juvenile justice to focus their limited resources on the mission of rehabilitation and delinquency prevention.
- Promote policies that, when appropriate, **limit justice-involved youth from being housed in adult secure facilities**.
- Support the adoption of **evidence-based screening, assessment, and treatment** of both criminogenic and behavioral health needs for youth who must be held in secure detention or corrections. We recognize that not all justice-involved youth will receive services in the community. For this group, it is imperative that juvenile justice facilities provide the best possible services from qualified providers and staff to address risk of reoffending and behavioral health problems.

Supporting organizations

American Association of Child and Adolescent Psychiatry	National Association of County Behavioral Health and Developmental Disability Directors
American Psychiatric Association	National Association of Social Workers
American Psychological Association	National Association of State Mental Health Program Directors
Association of State Correctional Administrators	National Criminal Justice Association
Equitas Foundation	National Health Care for the Homeless Council
International Community Corrections Association	National Religious Campaign Against Torture
National Alliance on Mental Illness	Police Foundation
National Association for Rural Mental Health	
National Association of Counties (NACo)	

ⁱ Remarks by the President at the National Conference on Mental Health. (2013, June 3). Retrieved from <https://www.whitehouse.gov/the-press-office/2013/06/03/remarks-president-national-conference-mental-health>.

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^{viii} Rosenberg (2014). Trauma exposure, psychiatric disorders, and resiliency in juvenile-justice-involved youth. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6(4), pp.430-437.

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