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Prioritizing Treatment Over Punishment

An Overview of Mental Health Diversion from Jail in Texas

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To combat the over-incarceration of persons with mental illness in Texas, state and county leaders are developing innovative strategies to divert individuals out of jail cells and into community treatment.

In the United States, over 11 million people cycle through local jails every year.[1] People with mental illness represent a disproportionate number of those involved in the justice system. Research estimates that almost two-thirds of U.S. jail inmates have a mental health problem.[2] Texas data do not stray from national findings. In 2015, over 55,000 incarcerated people in Texas received treatment in the public mental health system prior to their imprisonment.[3] Still, jails and prisons are not equipped to treat mental illness, which places community residents, people with mental health conditions, and county budgets at risk. Policymakers therefore face an urgent need to divert individuals with mental illness away from correctional settings and into therapeutic ones as quickly and safely as possible.

People with mental health conditions have not always filled prison and jail cells. In the 1970s, only about one in 20 incarcerated people had a serious mental illness, such as major depressive disorder or schizophrenia.[4] By 2015, almost one in three people in Texas jails had at least one serious mental illness.[5]

The over-incarceration of persons with mental illness resulted from seemingly unrelated policy choices. First, in 1963, Congress passed the Community Mental Health Act to transfer psychiatric treatment out of state-run facilities marred by inhumane civil liberties violations.[6] Legislators and reform advocates planned instead to serve people locally through community mental health centers (CMHCs). However, only about half of the proposed CMHCs were actually funded and built.[7] Deinstitutionalization continued to escalate between 1963 and 1975, but people with mental illness still had few places to turn for effective treatment.

Then, in the 1980s, politicians shifted their focus away from state psychiatric hospitals and toward prisons. As crime rates grew, lawmakers across the country passed tough-on-crime legislation and approved prison construction plans.[8] Unable to find adequate community services, people with mental illness became increasingly trapped in the expanding justice system. Here, their behaviors were viewed first and foremost as criminal rather than symptomatic of treatment needs.

The attempt to decentralize mental health treatment thus combined with the nation's prison boom to create a new problem – **the criminalization of mental illness**.

Though people with mental illness are disproportionately incarcerated, their diagnoses are only weakly linked to violence. Despite public fears that often connect mental illness to mass shootings, people with mental illness commit only about 4% of the nation's violent crimes.[9] Conversely, this group is disproportionately victimized by violence.[10] When they do violate the law, most people with mental illness are incarcerated for minor offenses that do not threaten public safety. Mental illness alone is not a predictor of criminality; instead, it heightens people's visibility to law enforcement[11] and hampers their ability to change their behaviors.[12]

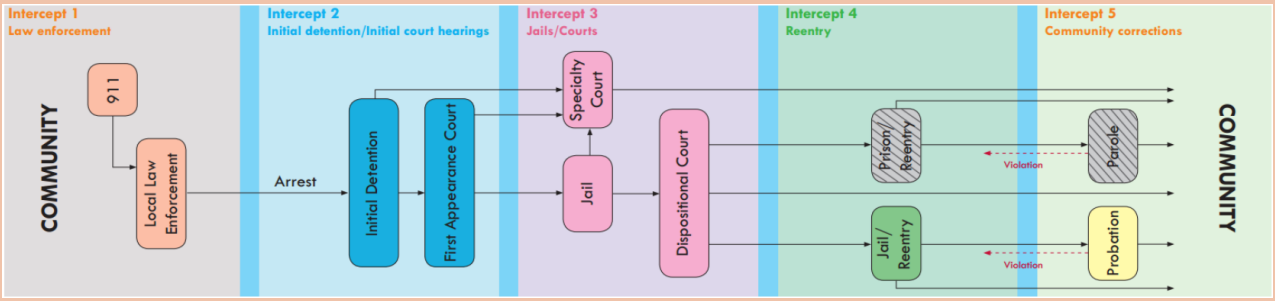
The over-incarceration of people with mental illness creates three distinct consequences. First, even short periods of incarceration can worsen a person's mental health. Incarcerated people with mental illness are more likely to experience physical abuse, sexual victimization, solitary confinement, and lengthier jail stays – all of which may exacerbate preexisting symptoms.[13] Second, imprisoning people with mental illness fails to improve public safety. Once incarcerated, these individuals face disruptions in their treatment, employment, housing, and social supports, which can increase their likelihood of recidivism.[14] Finally, incarcerating people with mental illness produces unsustainable fiscal costs. In Texas, people incarcerated in the general population cost about $50 per day;[15] in contrast, incarcerated people receiving psychiatric services cost nearly $140 per day, and they remain behind bars three times longer than their peers.[16]

The Sequential Intercept Model

The high human, public safety, and fiscal costs of incarcerating people with mental illness caused policymakers to critically examine the connection between mental health and the criminal justice system. Since 2006, researchers, lawmakers, and practitioners have increasingly used the sequential intercept model to approach community mental health treatment in a new way. The sequential intercept model is a recovery-oriented framework that breaks down the points at which some people with mental illness can be diverted from incarceration.[17] The model outlines five chronological "intercepts" that offer unique opportunities to keep people with mental illness from penetrating deeper into the justice system. The five intercepts include:

- **Intercept 1:** Law Enforcement and Emergency Services
- **Intercept 2:** Initial Hearings and Detention
- **Intercept 3:** Jails and Courts

Figure 1. The Sequential Intercept Model



Source: Henry Steadman, "When Political Will Is Not Enough: Jails, Communities, and Persons with Mental Health Disorders," *John D. and Catherine T. MacArthur Criminal Justice Reform Initiative*, July 2014, Retrieved from http://www.safetyandjusticechallenge.org/wp-content/uploads/2015/05/when-political-will-not-enough.pdf.

- **Intercept 4:** Reentry from Jails, Prisons, and Forensic Hospitals
- **Intercept 5:** Community Corrections and Support Services

With the sequential intercept model, stakeholders can mobilize the entire community as a resource against the over-incarceration of people with mental illness. It should be noted, however, that the model does not suggest diversion for *all* people with mental illness. Instead, researchers emphasize using the model to identify individuals who do not present a safety risk to the community and who do not require imprisonment due to the nature of their offenses.

The next section of this paper will describe each intercept point in greater detail and also provide examples of successful diversion strategies that are already in place across Texas counties.

Intercept 1: Law Enforcement and Emergency Services

Relevance. Frontline public safety workers are often the first to come into contact with persons experiencing mental crises. Because situational outcomes are determined by these initial interactions (e.g., whether a person is brought to jail or given access to alternative support services), they are perhaps the most critical.[18] Without proper training and an established coordination of service, interactions with persons with mental illness can escalate to unnecessary arrests, incidents of violence, or denials of proper mental health treatment.

Diversion strategy. At Intercept 1, communities can administer comprehensive mental health and de-escalation training to service providers at each stage of the emergency services process – from 911 dispatchers, to paramedics, to fire personnel. Diversion strategy examples include Crisis Intervention Teams (CITs) and Mobile Crisis Outreach Teams (MCOTs). CITs are comprised of specialized uniformed officers trained in best practices to de-escalate encounters involving persons with mental illness. In contrast, MCOTs are staffed by medical and mental health professionals who provide on-site assistance to persons experiencing psychiatric crises. Both CITs and MCOTs steer people with mental illness toward community services, rather than into the justice system.

While increased and improved training for law enforcement professionals alone is insufficient, it remains a key component of Intercept 1. Departmental policies and practices that enable early identification and suicide risk assessment can help guide law enforcement through an initial mental health screening. For example, the practice of placing key questions on the back of booking slips can ensure safer and more effective encounters in the field. Crisis, substance abuse, and sobriety centers can also provide law enforcement with an alternative to jail facilities.

Community example. Memphis, Tennessee, became the pioneer of CITs in the wake of a police shooting in 1987. A young black man with a history of mental illness was cutting himself with a knife and threatening suicide when a team of all white officers was dispatched to the scene. After the officers confronted the man and instructed him to drop his weapon, he became enraged and charged toward them. Fearing for their safety, the officers opened fire, and the young man was killed.[19] Public outcry called for improved mental health services and demanded systemic reform within the law enforcement community.

Often referred to as the "Memphis Model," the Memphis CIT was developed to prevent similar tragedies from occurring in the future.[20] The Memphis police station command center receives all 911 calls for the city and dispatches CIT officers to incidents with mental health components.[21] Memphis CIT officers receive an intensive 40-hour training on de-escalation tactics. These officers are uniquely equipped to respond to mental health episodes. They also participate in continued professional development exercises that encourage them to adapt as new research on best practices emerges.[22]

States across the country have since followed suit in developing high-caliber CIT programs. Nine counties in Texas (including Harris and Bexar counties as described in this brief) also adopted the Memphis Model to improve public safety and to divert people with mental illness away from the criminal justice system.[23]

By the Numbers:
Bexar County Diversion Initiatives[34]

95%
Percent of police officers trained in CIT

$350
Cost to divert someone from jail vs. $2,295 to arrest, book, and confine that individual

$10M
Cost savings per year due to diversion efforts

Intercept 2: Initial Hearings and Detention

Relevance. Compared to other defendants, individuals with mental illness are systematically excluded from or given less access to pretrial release and deferred prosecution.[24] Persons who commit low-level, nonviolent crimes are often placed in jail facilities by default either due to a lack of community resources or limited space within established treatment programs.

Diversion strategy. Post-arrest diversion can be used when pre-arrest strategies fail to filter

Bexar County Smart Justice Initiative

An overcrowded jail system prompted the Meadows Mental Health Policy Institute (MMHPI) to bring its Smart Justice Initiative to Bexar County in 2014.[28] Partnering with the Council of State Governments (CSG) Justice Center and Bexar County leaders, MMHPI conducted an analysis of pretrial procedures to recommend strategic systematic reforms.

Research uncovered consistent bottlenecking during the post-arrest stage of the booking process at the Bexar County Central Magistration Facility (CMAG),[29] with mental health resources and protocol falling woefully short in meeting the needs of the incoming population. Inadequate screening, assessment systems, and staffing led to significantly low numbers of eligible persons being diverted from jail to treatment. While more than 2,500 persons with mental illness passed through Bexar County Jail's hospital treatment facility, only 51 were diverted to community treatment.[30] High rates of recidivism were also a concern. More than half of those classified as having a mental illness in the county's jail population had six or more previous arrests.[31]

Since 2014, the county's Smart Justice Initiative has achieved significant milestones. Bexar County's 2015 budget included a $2.9 million allocation for renovations to the CMAG facility to expand mental health screening and assessment infrastructure.[32] Increased focus on accountability and collaboration in Bexar County have allowed the momentum to continue. Meeting for the first time in April 2015, the Criminal Justice Coordinating Council brings together civic and law enforcement leaders to address issues raised by MMHPI and CSG findings; the council also develops comprehensive solutions that can improve the county's diversion program results.[33]

Bexar County reports on two key outcome measures: 1) the expansion of law enforcement education programs and 2) the reduction of the jail population. When CIT training began in 2003, county leaders aimed to reach 20% of its patrol officers. By 2013, 95% of officers received specialized CIT training.[34] Before reform efforts began, Bexar County's jail population consistently exceeded its capacity by nearly 1,000 people, but in February 2016, the jail had 1,003 empty beds.[35] County officials estimate that each encounter with the justice system (arrest, booking, court, and confinement) costs $2,295 while each incident of diversion costs $350. Diversion efforts have thus amounted to a combined savings of $10 million per year in Bexar County.[36]

people with mental illness out of the justice system. For example, pretrial judicially-supervised treatment keeps vulnerable residents from inappropriately entering jails, prisons, and state hospitals. Counties may require individuals to appear at a magistration facility prior to being brought to jail. At the facility, clinicians and public defenders may be present to apprise defendants of their rights. This practice provides a higher level of professional support to help individuals navigate through the initial hearing phase of their local justice system.

Instant messaging programs can also speed up the flow of information about a person's history and health needs to better detect candidates for diversion. The success of this intercept relies heavily on interagency collaboration throughout the design and implementation process.

Community example. In Dallas County, justice and mental health agencies leverage technology to improve program outcomes. During the jail booking process, individuals with a documented history of mental health treatment are identified as eligible candidates for alternative detention

facilities.[25] Within one day, case information is transferred to a Mental Health Jail Diversion Coordinator using an instant messaging system. The Jail Diversion Instant Messaging System (JDIM) then directs eligible individuals to available programs.[26] JDIM also triggers mental health assessments, which can prompt discharge plans and linkages to mental health resources in the community. The system was introduced in 2005 and was designed to be HIPAA compliant.[27]

Intercept 3: Jails and Courts

Relevance. Ideally, many people with mental illness who do not pose a threat to public safety will be diverted from the criminal justice system at Intercepts 1 and 2. In reality, however, about two million adults with severe mental illness continue to be admitted to U.S. jails each year.[37] While some correctional facilities have improved mental health care delivery systems in recent years, jails are still structurally and culturally designed to prioritize security, not treatment. As a result, stakeholders have developed new diversionary tactics within Texas jails and courts.

Diversion strategy. Specialized mental health dockets and courts are common diversion tools that take a non-adversarial approach to addressing the specific needs of people with mental illness. Following the drug court model, mental health courts allow judges to develop community treatment plans instead of traditional sentences. In partnership with attorneys and practitioners, judges meet with defendants on an ongoing basis to monitor treatment compliance and accommodate for the nuances of each participant's unique mental health needs.

Since 2003, more than 300 mental health courts have been set up around the U.S.,[38] and their measurable impacts are strong. Studies show that mental health courts can create net savings by decreasing both jail stays and recidivism.[39] For example, mental health court participants are half as likely as similarly situated individuals to be rearrested.[40] Mental health courts also increase the number of case dismissals and alleviate the collateral consequences of a criminal record.[41]

Although researchers find positive impacts, mental health courts still face two challenges. First, this strategy is resource-intensive. Collectively, the courts can enroll only a small fraction of eligible individuals who could benefit from the program. Second, recent data report racial and gender disparities in access to mental health courts; this problem further hinders the success of male minorities in the justice system.[42]

Community example. In Travis County, officials use a Mental Health Public Defender (MHPD) Office and a mental health docket to tackle Intercept 3. In 2007, Travis County (which does not operate a public defender office) received a four-year grant to create the nation's first stand-alone MHPD Office. Attorneys, social workers, and case managers utilize their legal and clinical expertise to advocate for treatment-oriented dispositions and connect clients to local services. By 2011, the Travis County MHPD Office achieved each of its initial goals: the office decreased jail bed days by up to 20% for case management clients, increased the number of case dismissals to 42%, improved legal representation for people with mental illness, and decreased recidivism.[43]

In 2009, Travis County also started a specialty docket dedicated to people with mental illness accused of low-level crimes. The docket's judges partner with the MHPD Office and the District Attorney's Mental Health Unit to develop dispositions that acknowledge defendants' medical, housing, and counseling needs. The new docket decreased average jail stays in the county from 109 days in 2009 to only 50 days in 2011.[44] As a result, Travis County reserved jail beds for people charged with violent crimes, cleared up other court dockets, and saved county funds.

Intercept 4: Reentry from Jails, Prisons, and Forensic Hospitals

Relevance. Each year, nine million people are released from local jails back into their communities.[45] Once released, these individuals face difficulties meeting their basic needs.[46] People with mental illness experience even greater challenges than individuals detained with the general jail population. For example, 70% of people with serious mental illness returning to the community also have a substance use disorder, and they are two times more likely than their peers to be homeless before entering jail.[47]

Though these risk factors make individuals more likely to reoffend, Texas jail administrators are not required to provide reentry assistance to people with mental illness. This gap in services reinforces the revolving door between the community and incarceration.

Diversion strategy. Jail staff and community leaders can improve outcomes for people with mental illness by engaging with individuals during the most critical period of the reentry process – the months prior to release. A jail "in-reach" service provider can meet with people while they are still incarcerated to develop release plans that help participants avoid challenges that often lead to re-arrest, such as drug use, homelessness, and medication disruptions. Jail in-reach programs that reduce recidivism by only 2% have even been shown to pay for themselves.[48]

Reentry strategies that incorporate peer support services can make jail in-reach programs even more effective. Peer support is a cost-effective, evidence-based strategy that recruits people with lived mental health experience to serve as mentors for jailed individuals with mental illness who are returning to the community. The use of recovery-oriented peers can increase feelings of personal empowerment,[49] reduce clinical symptoms,[50] and decrease recidivism among formerly incarcerated participants.[51]

By the Numbers:
Travis County MHPD Office[43]

42%
Percent of legal cases closed as dismissals between 2001 and 2011

20%
Percent decrease in jail bed days consumed by case management clients between 2001 and 2011

8 individuals
Decrease in the number of individuals per day in the average county jail population

Community example. In 2015, advocates began crafting a reentry peer support program in Texas using Pennsylvania's Peerstar program as a model. Created in 2010, Peerstar is a private peer support provider that connects certified peer support specialists with incarcerated people 30 to 90 days before their release.[52] Peers provide mentorship, release planning, and advocacy throughout the community supervision process. Thus far, the program has improved public safety. Peerstar participants report a 24% three-year recidivism rate[53] compared to a 46% rate among Pennsylvania's general incarcerated population.[54]

After observing Peerstar's program, Texas passed a 2015 budget rider requiring the creation of reentry peer support programs across the state. In April 2016, the Department of State Health Services began funding three pilot programs led by providers from Harris County, Tarrant County, and Tropical Texas Behavioral Health (which serves Cameron, Hidalgo, and Willacy counties). The sites will expand their existing peer support services to specifically target people in jail with mental health conditions. Via Hope, a nonprofit agency that certifies peers in Texas, also partnered with formerly incarcerated individuals to develop a specialized training curriculum for the reentry peer specialists. Reports on the pilots' effectiveness will be released in December 2016 and September 2017.

Intercept 5: Community Corrections and Support Services

Relevance. In the United States, two-thirds of people under correctional control are on probation or parole in their communities.[60] In Texas, one in 40 adults are under community supervision compared to only one in 52 adults nationwide.[61]

Harris County Jail Diversion Pilot Program

Harris County is home to the third largest jail in the United States. Every day, about 25% of the county jail's population requires psychotropic medications.[55] People with mental illness in the jail cost 1.5 to 5 times more than their peers in the general jail population.[56] Still, in the face of growing demand and costs, the Harris County Jail has become a national model in mental health service delivery and jail diversion.

In 2013, Texas legislators expanded Harris County's existing mental health service strategies to create a comprehensive jail diversion pilot program. The four-year, $20-million pilot aims to reduce recidivism, increase access to housing and integrated care services, and improve participants' quality of life.[57]

To achieve these goals, stakeholders designed a system of services specifically tailored to divert people with mental illness away from jail at Intercepts 3 and 4. At Intercept 3, the Harris Center for Mental Health uses a jail-based team of providers to initiate treatment before participants are released to the community. Then, at Intercept 4, the Harris Center uses community-based treatments, such as case management and critical time intervention services, to break the cycle of re-incarceration and link participants to existing shelter resources.

Between August 2014 and March 2016, the Harris County diversion program served 764 people with mental illness.[58] An initial analysis of results showed a 47% reduction in the number of jail bookings among pilot participants and an estimated savings of $3 million over less than two years.[59] In December 2016, Harris County will submit a formal evaluation of the program to the Texas Legislature.

Unfortunately, the structure of community supervision often leads to re-incarceration for people with mental illness because they tend to have greater difficulty complying with supervision's detailed requirements. As a result, people with mental illness are more likely than other groups to have their supervision revoked for technical violations.[62] Violations may include failure to attend mental health treatment, though these treatments have not been proven to decrease recidivism.[63] Probation and parole officers wield great discretion in how they choose to respond to such rule-breaking, but their more intensive surveillance of those with mental illness tends to increase re-incarceration rates without simultaneously improving public safety.[64]

Diversion strategy. Communities can address this problem by engaging probation and parole officers in evidence-based diversion opportunities, such as forensic assertive community treatment (FACT) teams. FACT teams are justice-health partnerships that use around-the-clock resources to address individual and systematic recidivism risk factors. Over half (56%) of existing FACT teams engage directly with probation or parole officers in order to combine clinical treatments with legal leverage and, as a result, improve justice-related outcomes.[65]

Partnerships between service providers and criminal justice agents can be challenging if the groups apply clashing philosophies to their encounters with participants. However, when structured as a client-centered diversion tool, FACT teams can decrease jail bookings and improve community reintegration.[66]

Community example. In 2011, the Heart of Texas Region MHMR started a FACT team to serve formerly incarcerated people across six counties near Waco. In February 2016, the team maintained a 5:1 client-to-staff ratio and provided participants with 24/7 wrap-around services, including transportation, basic needs assistance, individual and group clinical supports, and advocacy with local probation departments.[67]

Though the FACT team does not include probation officers directly on its team, employees use strong relationships with local criminal justice systems to discourage supervision revocations. Between 2013 and 2016, the FACT team worked to reduce recidivism by 20% and decrease hospitalizations among clients.[68]

Policy Recommendations

Intercept 1: Train First Responders in De-Escalation and Mental Health Identification

Ideally, individuals with mental illness who do not threaten public safety will be diverted from the criminal justice system during their initial encounter with first responders. To achieve this optimal result, 911 dispatchers, firefighters, and other emergency service professionals should engage in intensive mental health training programs.

If incidents escalate to involve law enforcement, then frontline public safety workers can dispatch specialized CIT officers equipped with the proper knowledge and resources to de-escalate situations. Persons in mental health crisis can then be directed to treatment facilities and community services rather than taken to jails.

Intercept 2: Provide Early, Consistent Legal Advocacy for Persons with Mental Illness

Innovative approaches to pretrial diversion can be seen throughout Texas, and each requires consistent interagency collaboration. Individuals with mental illness should be provided legal assistance from advocates with mental health-related knowledge as early and consistently as possible. This may be achieved by designing a magistration framework that specifically targets individuals with mental illness and involves mental health professionals in the pretrial process. Then, local justice systems may engage in fairer review of defendants and guide eligible persons toward community resources more efficiently.

Intercept 3: Expand Mental Health Training Curricula and Scale Up Specialty Courts

Despite efforts made at Intercepts 1 and 2, counties will likely continue incarcerating individuals who, if not for their mental illness, would not be involved in the justice system. Stakeholders should take two steps to manage this reality. First, county judges, attorneys, and jailers should increase their mental health-related knowledge. In 2015, legislators passed SB 1507, which requires judges and attorneys to receive training on alternatives to state hospitalization.[69] Local stakeholders should expand the new curricula to include county-specific alternatives to incarceration. Jailers should also receive mental

Policy Recommendations

Intercept 1:
Train First Responders in Crisis Intervention

Intercept 2:
Provide Early Legal Advocacy

Intercept 3:
Expand Mental Health Training & Courts

Intercept 4:
Make Reentry Peer Support More Accessible

Intercept 5:
Appoint Specialty Officers & FACT Teams

Holistic Reform:
Move Beyond Crisis Intervention

health training to enhance their ability to identify detained persons who are appropriate for treatment and diversion.

Second, researchers should analyze ways to scale up data-driven Intercept 3 strategies. Mental health courts produce positive outcomes, but, because of their high per-person costs, they only serve a fraction of potential participants. Policy analysts should uncover how court services can be optimized and expanded to reach more people.

Intercept 4: Make Reentry Peer Support More Accessible

Texas leaders should take two steps to make reentry peer support more accessible. First, legislators should revise Texas Medicaid policies to make a peer's work more widely reimbursable. Current reimbusement policies require peers to serve persons who qualify for rehabilitative services. As a result, a peer's assistance is only available to individuals with high clinical levels, not to those with lower-level needs who could still benefit from a peer's lived experience. Reimbursement policies stifle the impact of peer support services and imply that such services are supplemental to recovery. In reality, peer support is complementary to other mental health services, such as talk therapy and medication management.[70] Thus, peer support should be reimbursed accordingly and expanded to serve persons with diverse needs.

Second, county sheriffs and CMHCs should collaborate to ensure that peers can work within each jail's mental health care system. Sheriffs currently wield the power to ban people with previous justice involvement from obtaining employment in local jails, while LMHAs are often bound by state hiring policies that prohibit service provision by people with certain criminal convictions. More flexible hiring practices at the state and county levels could enhance the impact of peers with past justice experience.

Intercept 5: Appoint Specialty Supervision Officers and FACT Team Partnerships

People with mental illness are more likely than others to have their community supervision revoked for technical violations that do not threaten public safety. To curtail this problem, counties should allow probation and parole officers to opt for mental health-specific caseloads. CMHCs may then to provide specialty officers with training on community resources and appropriate supervision conditions for people with mental illness. After the officers receive their training, community service providers and specialty officers should join forces to create local FACT teams. Together, team members can prioritize public health, reduce recidivism, and link people to cost-effective community resources.

Moving Toward Holistic Justice Reform

After the incarcerated population with mental illness ballooned, Texans developed diverse strategies to transfer individuals out of jail cells and into the community. Across the state, counties focused on differing intercept points with the same end goal – divert eligible people with mental illness away from the criminal justice system as quickly and safely as possible.

The efforts of the past decade, however, present a new question: **to what services are we actually diverting this group?**[71] In Texas,

stakeholders have built a strong system of crisis intervention, but they have not adequately invested in initiatives that can prevent justice involvement in the first place.

Moving forward, lawmakers should continue their diversionary efforts, but they must also ensure that robust treatment programs exist in the community. To pay for these programs, county leaders should pool the savings achieved at various stages of the sequential intercept model and reinvest those resources in the community's mental health infrastructure. Then, people with mental illness can be diverted to a strong system of proactive mental health services, not merely to reactive programs that can only be accessed following an arrest, booking, or conviction.

Conclusion

Decades after deinstitutionalization, many people with mental illness can be found in Texas jails rather than in their communities receiving treatment. By employing the sequential intercept model, state and county leaders can finally break the cycle of incarceration that often traps Texans with mental illness. Diverting people with mental health issues away from county jails will require police officers, judges, jailers, and mental health providers to integrate their services at each step of the criminal justice process.

Incarcerated people with mental illness, and the unique challenges that they present, do not only affect county jails. Rather, these Texans create an opportunity for entire communities to prioritize mental health and, as a result, positively impact health outcomes, public safety, and county budgets.

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References

[1] Peter Wagner and Bernadette Rabuy, "Mass Incarceration: The Whole Pie 2015," *Prison Policy Initiative*, December 8, 2015, http://www.prisonpolicy.org/reports/pie2015.html#releasefigure

[2] KiDeuk Kim, Miriam Becker-Cohen, and Maria Serakos, "The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis," *Urban Institute*, March 2015, 8, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf.

[3] Sonja Gaines (HHSC Associate Commissioner for Mental Health) in electronic discussion with the author, April 6, 2016.

[4] D. Runinow, "Out of Sight, Out of Mind: Mental Illness Behind Bars," *American Journal of Psychiatry* 171, no. 10, (2014): 1041, http://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.2014.14060712.

[5] L. Lacefield Lewis, *Presentation to the Senate Criminal Justice Committee*, September 22, 2015, 3, http://www.dshs.state.tx.us/legislative/default.shtm.

[6] M. Testa and S.G. West, "Civil Commitment in the United States," *Psychiatry* 7, no. 10 (2010): 30-40, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3392176/.

[7] D. Mechanic, D.D. McApline, and D.A. Rochefort, *Mental Health and Social Policy: Beyond Managed Care* (Boston, MA: Pearson Education, Inc., 2014), 52.

[8] J. Travis and B. Western, *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington, D.C.: The National Academies Press, 2014), 70, 80.

[9] M. Metzl and K. MacLeish, "Mental Illness, Mass Shootings, and the Politics of American Firearms," *American Journal of Public Health* 105, no. 2 (2015): 241, http://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2014.302242.

[10] David B. Kopel and Clayton E. Cramer, "Reforming Mental Health Law to Project Public Safety and Help the Severely Mentally Ill," *Howard Law Journal* 58, no. 3 (2015): 726.

[11] A.S. Avdija, "Policing Mental Illness," in *Strategic Responses to Crime*, ed. M. de Guzman, A.M. Das, and D.K. Das (New York: CRC Press, 2012), 142.

[12] Carol Fisler, "When Research Challenges Policy and Practice: Toward a New Understanding of Mental Health Courts," *Judges' Journal* 54, no. 2 (2015): 11, http://www.courtinnovation.org/sites/default/files/documents/JJ_SP15_54_2_Fisler.pdf.

[13] E. L. Johnston, "Vulnerability and Just Desert: A Theory of Sentencing and Mental Illness.: *The Journal of Criminal Law & Criminology* 103, no. 1 (2013): 158-174.

[14] Council of State Governments Justice Center, *Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements*, 2015, 9, Retrieved from https://csgjusticecenter.org/wp-content/uploads/2015/09/Improving_Responses_to_People_with_Mental_Illnesses_at_the_Pretrial_Stage_Essential_Elements.pdf.

[15] Legislative Budget Board, *Fiscal Note, 84th Legislative Regular Session in Re: HB 1205*, April 1, 2015, 2, http://www.capitol.state.tx.us/tlodocs/84R/fiscalnotes/pdf/HB01205I.pdf#navpanes=0.

[16] Texas Public Policy Foundation, *Enhancing Public Safety and Saving Taxpayer Dollars: The Role of Mental Health Courts in Texas*, April 2015, 2, 5, http://www.texaspolicy.com/library/doclib/PP-The-Role-of-Mental-Health-Courts-in-Texas.pdf.

[17] M. Munetz and P. Griffin, "Use of the Sequential Intercept Model as an approach to the Decriminalization of People with Serious Mental Illness," *Psychiatric Services* 54, no. 4 (2006): 544-549, http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2006.57.4.544

[18] National Mental Health Association. *Jail Diversion for People with Mental Illness: Developing Supportive Community Coalitions*, accessed February 20, http://www.namhpac.org/PDFs/01/jaildiversion.pdf.

[19] Betsy Vickers, "Memphis, Tennessee, Police Department's Crisis Intervention Team," *Bureau of Justice Statistics Practitioner Perspectives,* July 2000, Retrieved from https://www.ncjrs.gov/pdffiles1/bja/182501.pdf.

[20] Ibid.

[21] Ibid.

[22] Randolph Dupont, Major Sam Cochran, and Sarah Pillsbury, "Crisis Intervention Team Core Elements," September 2007, Retrieved from http://cit.memphis.edu/pdf/CoreElements.pdf.

[23] University of Memphis CIT Center, accessed April 2, 2016, http://cit.memphis.edu/citmap/texas.php.

[24] John Clark, "Non-Specialty First Appearance Court Models for Diverting Persons with Mental Illness: Alternatives to Mental Health Courts," February 2004, Retrieved from http://www.pacenterofexcellence.pitt.edu/documents/Non-Specialty%20First%20Appearance%20Court%20Models.pdf.

[25] Texas Taskforce on Indigent Offense and Office of Court Administration, "Representing the Mentally Ill Offender: An Evaluation of Advocacy Alternatives," April 2010, Retrieved from https://ppri.tamu.edu/files/Representing_the_Mentally_Ill_Offender.pdf

[26] Ibid.

[27] Laura Edmonds (Dallas County Mental Health Diversion Program Manager) in discussion with the author, March 30, 2016.

[28] Council of State Governments Justice Center. *Bexar County Smart Justice Initiative,* Retrieved from https://csgjusticecenter.org/wp-content/uploads/2015/07/Bexar-County-Smart-Justice-Handout.pdf.

[29] Ibid.

[30] Ibid.

[31] Ibid.

[32] Ibid.

[33] Ibid.

[34] Gilbert Gonzales (Bexar County Mental Health Department Director) in discussion with the author, March 4, 2016.

[35] Ibid.

[36] Ibid.

[37] Council of State Governments Justice Center, *Improving Responses to People with Mental Illnesses at the Pretrial Stage: Essential Elements*, 2015, 7, Retrieved from https://csgjusticecenter.org/wp-content/uploads/2015/09/Improving_Responses_to_People_with_Mental_Illnesses_at_the_Pretrial_Stage_Essential_Elements.pdf.

[38] The Council of State Governments Justice Center, "Mental Health Courts," accessed February 13, 2016, https://csgjusticecenter.org/mental-health-court-project/.

[39] L.N. Honegger, "Does the Evidence Support the Case for Mental Health Courts? A Review of the Literature," *Law and Human Behavior* 39, no. 5 (2015): 483.

[40] Marlee E. Moore and Virginia A. Hiday, "Mental Health Court Outcomes: A Comparison of Re-Arrest and Re-Arrest Severity between Mental Health Court and Traditional Court Participants," *Law and Human Behavior* 30, no. 6 (2006): 667.

[41] Krystal Muller, "Hoping to Close the Revolving Door," *The Prosecutor* 42, no. 5 (2012), http://www.tdcaa.com/journal/hoping-close-revolving-door.

[42] Bradley Ray and Mary Brooks Dollar, "Examining Mental Health Court Completion: A Focal Concerns Perspective," *The Sociological Quarterly* 54, no. 4 (2013): 662.

[43] Eric Anderson and Tonya Mills, *Mental Health Public Defender Office Cost Benefit Analysis, Part 1: Analysis of Performance of the Texas Task Force on Indigent Defense Grant*, May 2011, 2-3, https://www.traviscountytx.gov/images/criminal_justice/Doc/cost_ben_MHPD_110922.pdf.

[44] Krystal Muller, "Hoping to Close the Revolving Door," *The Prosecutor* 42, no. 5 (2012), http://www.tdcaa.com/journal/hoping-close-revolving-door.

[45] The Council of State Governments Justice Center, "Reentry Facts & Trends," accessed February 13, 2016, https://csgjusticecenter.org/reentry/facts-trends/.

[46] Urban Institute, *Understanding the Challenges of Prisoner Reentry*, 2006, http://www.urban.org/research/publication/understanding-challenges-prisoner-reentry/view/full_report.

[47] The Council of State Governments Justice Center, "Reentry Facts & Trends," accessed February 13, 2016, https://csgjusticecenter.org/reentry/facts-trends/.

[48] Urban Institute, *The Elected Official's Toolkit for Jail Reentry: Talking Points*, 2011, http://www.urban.org/research/publication/elected-officials-toolkit-jail-reentry/view/full_report.

[49] Jean Campbell, "Federal Multisite Study Finds Consumer-Operated Service Programs are Evidence-Based Practices," *Missouri Institute of Mental Health*, 2009, 7, http://cosp.mimhtraining.com/2010/12/federal-multi-site-study-finds-consumer-operated-service-programs-are-evidence-based-practices/.

[50] Ibid, 8.

[51] Peerstar LLC, *Forensic Peer Support Services*, accessed February 19, 2016, 26, http://media.wix.com/ugd/c3634e_f2c07cb23a184d85b9256d31f7f86b67.pdf.

[52] Ibid, 24.

[53] Ibid, 26.

[54] Center for Public Policy Priorities, *From Recidivism to Recovery: The Case for Peer Support in Correctional Facilities*, August 2014, 13, http://forabettertexas.org/images/HC_2014_07_RE_PeerSupport.pdf.

[55] Regenia Hicks, "Harris County Mental Health Diversion Program," *Police, Jails, and Vulnerable People Symposium*, January 22, 2016. To view the presentation, visit https://www.youtube.com/watch?v=LRgNJh2aZuY&index=2&list=PLu2WuYWXjUtcxvWsUGuF3KXhTuUJZ2c1t.

[56] Ibid.

[57] Ibid.

[58] Regenia Hicks, *Presentation to the Texas Senate Committee on Health and Human Services*, June 16, 2016.

[59] Ibid.

[60] Prison Policy Initiative, "Mass Incarceration: The Whole Pie 2015, December 8, 2015, http://www.prisonpolicy.org/reports/pie2015.html#releasefigure.

[61] Bureau of Justice Statistics, *Probation and Parole in the United States, 2014*, 2015, 1, 16, http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5415

[62] Jennifer E. Louden and Jennifer L. Skeem, "How Do Probation Officers Assess and Manage Recidivism and Violence Risk for Probationers with Mental Disorder? An Experimental Investigation," *Law and Human Behavior* 37, no. 1 (2013): 23.

[63] Ibid, 23.

[64] Ibid, 32.

[65] J. Steven Lamberti, Alison Deem, Robert Weisman, and Casey LaDuke, "The Role of Probation in Forensic Assertive Community Treatment," *Psychiatric Services* 62, no. 4 (2011): 419.

[66] Vera Institute of Justice, *Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost Savings Implications*, February 2013, 2, http://www.vera.org/sites/default/files/resources/downloads/treatment-alternatives-to-incarceration.pdf.

[67] David Baker (FACT Team Program Director) in discussion with the author, February 19, 2016.

[68] Ibid.

[69] S.B. 1507, 84th Texas Legislature. (2015). §3. https://legiscan.com/TX/text/SB1507/id/1231702/Texas-2015-SB1507-Enrolled.html.

[70] Center for Public Policy Priorities, *From Recidivism to Recovery: The Case for Peer Support in Correctional Facilities*, August 2014, 2, http://forabettertexas.org/images/HC_2014_07_RE_PeerSupport.pdf.

[71] Gilbert Gonzales (Bexar County Mental Health Department Director) in discussion with the author, March 4, 2016.