

**A BEHAVIORAL HEALTH AND CRIMINAL JUSTICE  
Cross-System Evaluation in Allegheny County**

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## Table of Contents

<a href="#">Acknowledgements</a>	5
<a href="#">Acronyms Used in the Report</a>	6
<a href="#">Executive Summary</a>	8
<a href="#">Sequential Intercept 1</a>	14
Intercept 1: Overview	14
Intercept 1: Allegheny County Programs and Initiatives	14
CIT Training	15
911 Dispatch	21
Mental Health Crisis Services	22
<a href="#">Intercept 1 Gaps</a>	23
<a href="#">Intercept 1 Opportunities</a>	25
<a href="#">Intercept 1 Recommendations</a>	26
<a href="#">Sequential Intercept 2</a>	30
Intercept 2: Overview	30
Intercept 2: Allegheny County Procedures	31
Pretrial Services	31
Jail Intake Processes	34
Preliminary Arraignment Processes	37
Preliminary Hearings	38
Justice-Related Services	42
<a href="#">Intercept 2 Gaps</a>	45
<a href="#">Intercept 2 Opportunities</a>	47
<a href="#">Intercept 2 Recommendations</a>	48
<a href="#">Sequential Intercept 3</a>	53
Intercept 3: Overview	53
Intercept 3: Allegheny County Processes	53
Court Processing	54
Specialty Courts in Allegheny County	55
Mental Health Court	56
Veteran's Court	57
Domestic Violence Court	58
Program for the Re-Integration, Development, and Empowerment (PRIDE) Court	58
Driving Under the Influence (DUI) Court	59
Drug Court	60
Sex Offender Court	60
Phoenix Court	61
Jail	61

Assignment to Units within the Jail	62
Jail Alternative Housing	63
Jail Diversion	65
Classes and Services in the Jail	65
Data Collection and Management at the Jail	68
Competency Restoration	68
<a href="#">Intercept 3 Gaps</a>	69
<a href="#">Intercept 3 Opportunities</a>	70
<a href="#">Intercept 3 Recommendations</a>	71
<a href="#">Sequential Intercept 4</a>	74
Intercept 4: Overview	74
Intercept 4: Allegheny County Initiatives and Processes	74
Allegheny County Jail Collaborative	74
Jail Re-Entry Services	75
Re-Entry Pods	76
Re-Entry Program Description	76
Services/Classes Available with the Re-Entry Programs	77
Additional Services	75
Comparison of Allegheny County Re-Entry with Best Practices	78
Community-Based Forensic-Focused Services	80
Residential Treatment Services	83
Housing	85
<a href="#">Intercept 4 Gaps</a>	87
<a href="#">Intercept 4 Opportunities</a>	88
<a href="#">Intercept 4 Recommendations</a>	88
<a href="#">Sequential Intercept 5</a>	96
Intercept 5: Overview	96
Intercept 5: Allegheny County Processes and Initiatives	96
Adult Probation	96
Coordination with Justice Related Services (JRS)	97
Managing Violations of Probation	98
Day Reporting Centers/Community Resource Centers	98
<a href="#">Intercept 5 Gaps</a>	100
<a href="#">Intercept 5 Opportunities</a>	101
<a href="#">Intercept 5 Recommendations</a>	101
<a href="#">Summary</a>	106

References by Intercept	110
Appendix A	116
<b>TABLES</b>	
Table 1: CIT Core Elements from 4 states	16
Table 2: Most common bail conditions set at preliminary arraignment and disposition at preliminary hearing by crime type	41
Table 3: Use of bail for four most common charges by BH status	42
Table 4: GAINS Jail re-entry checklist compared to Allegheny County Jail Re-entry Program	79
<b>FIGURES</b>	
Figure 1: The Sequential Intercept Model	8
Figure 2: Total Fidelity Scores for Four Study Counties and Allegheny County	19
Figure 3: Flow chart of relevant prevalence rates needed for planning	90

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### **Acronyms Used in This Report**

ACJ – Allegheny County Jail

ACJC – Allegheny County Jail Collaborative

ACT – Assertive Community Treatment (model); also see FACT

ADT – Assisted Outpatient Treatment

AHSP – Alcohol Highway Safety Program

ARD – Accelerated Rehabilitative Disposition program

BAU – [ACJ] Behavioral Assessment Unit

BH – Behavioral Health – encompassing mental health and substance use

CAD – Computer-Assisted Dispatch system

CBT – Cognitive Behavioral Therapy

CIT – Crisis Intervention Training

CORE – Capitalizing On a Recovery Environment – a 16-bed facility for JRS clients in need of extended treatment and support

CRN – Court Reporting Network

CRR – Community Residential Rehabilitation

CSC – Community Services Coordinator

CTT – Community Treatment Teams

DC – Drug Court

DHS – [Allegheny County] Department of Human Services

DRC/CRC – Day Reporting Center/Community Resource Center run by Adult Probation

DUI – Driving Under the Influence

EHR – Electronic Health Records

FACT – Forensic Assertive Community Treatment (model)

FL – Forensic Liaison

FPS – Forensic Peer Specialist

GAF – Global Assessment of Function score

H<sub>2</sub>O – Healthy Housing Outreach – provides access to BH treatment and other supports for homeless individuals and families with BH needs

IDDT – Integrated Dual Disorder Treatment

JRS – Justice-Related Services, provides services for individuals with BH problems who are involved in the criminal justice system

JSC – Jail Service Coordinator

LTSR – Long-Term Structured Residences

MAT – Medication-Assisted Treatment

MDJ – Magisterial District Judge

MH – Mental Health

MHC – Mental Health Court

OMS – Offender [Data] Management System

PBP – Pittsburgh Bureau of Police

PRIDE Court – The Program for Re-Integration, Development and Empowerment Court

RTFA – Residential Treatment Facility for Adults

SOC – Sex Offender Court

VC – Veteran's Court

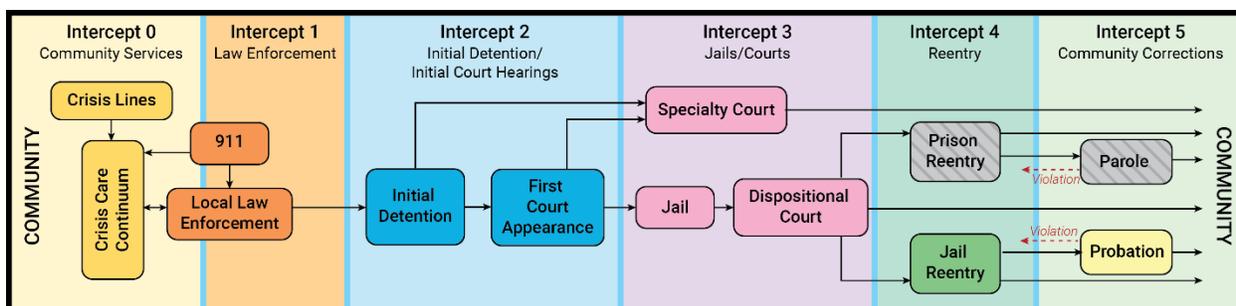
## Executive Summary

### Overview of Project

In March 2017, Allegheny County (on behalf of its Department of Human Services [DHS]) and the Allegheny County Jail Collaborative (ACJC) sought proposals to conduct an evaluation of the intersection between behavioral health (BH – encompassing mental health and substance use) and criminal justice. The ACJC, which coordinates planning and services that involve the Allegheny County Jail (ACJ), DHS and the Courts, sought an evaluation that would identify areas for improvement and make recommendations about how Allegheny County can better divert, treat and support people with BH issues who encounter the criminal justice system. The Request for Proposals (RFP) indicated that the County wanted examination of practices and suggestions for improvement at each of the Intercepts of the Sequential Intercept Model (Munetz and Griffin, 2006).

The Sequential Intercept Model (SIM, see Figure 1) is a framework for thinking about criminal justice processing that was developed to assist communities as they examine the interface between the criminal justice and mental health (MH) systems in their area. The model identifies five successive points for potential diversion to keep justice-involved individuals with a BH disorder from entering or penetrating deeper into the criminal justice system. The interception points are 1) law enforcement and emergency services; 2) initial detention and initial hearings; 3) jail, courts, forensic evaluations and forensic commitments; 4) re-entry from jails, state prisons and forensic hospitalization; and 5) community corrections and community support. Use of this model helps to organize the conversation among stakeholders as they discuss current policies and practices affecting these individuals at each intercept point; this organization is useful for understanding system gaps that can be targeted as a means to keep individuals from progressing further into the criminal justice system.

**Figure 1: The Sequential Intercept Model**



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In late July 2017, this evaluation grant was awarded to Edward P. Mulvey, PhD at the University of Pittsburgh, with assistance from Carol A. Schubert, MPH and a consultant, Patricia Griffin, Ph.D. Two law students also contributed as research assistants. The team proposed four broad

areas of evaluation activities which incorporated a mix of evaluation methods (both quantitative and qualitative) to address questions posed in the solicitation. The approach used strategies to capitalize on the extant data integration capacities of the County data systems and the demonstrated ability of system stakeholders for effective collaboration.

Over the course of the subsequent ten months, the evaluation team talked with over 65 individuals and four stakeholder groups involved in each intercept. These included individuals from the Allegheny County Criminal Justice Advisory Board, City of Pittsburgh police, Municipal and County police, the 9-1-1 dispatch center, reSolve and Mercy Crisis Services, the ACJ, Magisterial District Judges (MDJs), Public Defenders, District Attorneys, Court Judges, Court Administration, Justice-Related Services (JRS), forensic liaison services, multiple provider agencies, consumer advocacy groups and DHS. We also examined court data, researched the evidence for existing programs, and held two workshops with interdisciplinary representation from County stakeholders. This report summarizes and integrates the information learned from these activities. It addresses the following issues at each sequential intercept: overview of current practice, gaps in practice, opportunities and recommendations.

### **Summary Overview and Recommendations by Intercept**

#### **➤ *Intercept 0/1 – Community Services and Law Enforcement***

Intercept 0/1 considers options that might be applied to keep individuals with BH disorders from being arrested and charged when the offending behavior is related to the BH condition more so than criminal intent. Taking advantage of these situations to make appropriate diversions and referrals requires adequate resources for, and coordination among, three entities: 1) dispatch services, 2) police responders and 3) MH crisis services. Allegheny County agencies have taken steps to develop services to support diversion and referral at this initial point of contact, and they seem poised to move toward a more effective system for this potential intercept point. However, there is room for growth in education and a need for expanded crisis services.

#### ***Intercept 0/1 Recommendations***

- Develop an up-to-date and accessible data base of Crisis Intervention Training (CIT)-trained officers currently working in the Pittsburgh Bureau of Police and municipal police departments and integrate this list with the 9-1-1 dispatch system so that the information is available in real time.
- Provide specialized CIT training for 9-1-1 call takers and dispatchers, and conduct cross-training exercises with behavioral crisis personnel.
- Expand and decentralize the administration of CIT training.

- Establish locally-based forums that meet regularly to examine the operations among MH crisis centers, police departments and social service providers.
- Allegheny County should identify and examine individuals who have frequent contact with the criminal justice and MH systems. Identifying and examining the characteristics of these individuals may provide clues for supporting them in a way that is both humane and cost-effective.
- Expand the capacity of officers in the field to obtain MH consultation by increasing access to MH professionals.
- Develop case processing and assessment centers where officers can take individuals in lieu of jail booking.

➤ ***Intercept 2 – Initial Detention and Initial Court Hearings***

The second sequential intercept offers opportunities for diversion at the point of initial detention and hearings. The introduction of electronic health records in the jail, the use of pretrial risk assessment and the provision of counsel at early stages of criminal justice processing are promising developments. However, there is room to promote awareness among magisterial district judges regarding BH issues and to better coordinate information in the jail.

**Intercept 2 Recommendations**

- Integrate the ACJ data systems and link them to DHS computer systems.
- Expand the assessment of inmate homelessness at jail intake and re-entry.
- Simplify the MH assessment process, devise a system for scoring aspects of the screening and assessment, and keep a database of the codified information.
- Establish a computerized service to automatically notify Justice-Related Services (JRS) and relevant BH providers when an active or recent client has entered the jail.
- Increase the likelihood of conditional bond being used at arraignment and preliminary hearings by identifying BH cases for which alternative plans may be appropriate and feasible.
- Expand the role of the probation Day Reporting Centers/Community Resource Centers (DRCs/CRCs) to provide services to individuals on conditional bond.
- Use telepsychiatry to provide assessment and consultation at arraignments and preliminary hearings.

### ➤ **Intercept 3 – Jails/Courts**

Intercept 3 covers the criminal justice system processes after the determination that a case will be held for trial. Cases that have proceeded this far may involve charges of sufficient severity to tip the balance toward a concern with public safety; however, this is also the point in criminal justice case processing where case disposition by the court can be directly tied to involvement with treatment services (using such strategies as specialty courts). Allegheny County has established some cross-system collaborative working relationships and a network of specialty courts to manage justice-involved individuals with BH issues. However, there is little transparency regarding the filtering of offenders to these programs and these courts do not function as true diversion courts (i.e.; they are post-plea). In addition, the ACJ has existing alternative housing and diversion options for which eligibility is limited.

#### **Intercept 3 Recommendations**

- Consider allowing individuals in pre-plea status to enter specialty courts. There may be ways to integrate a deferred prosecution model into the specialty court practice with certain subgroups.
- Expand the criteria for involvement in the jail diversion program beyond just those with substance use disorders; include MH clients as well.
- Expand the alternative housing program.
- Re-examine the guidelines and operations of the Drug Court.

### ➤ **Intercept 4 – Re-entry**

Intercept 4 focuses on transition planning by the jail or in-reach by providers. The ACJ has a strong re-entry program but it is not matched with an ample supply of community-based services and housing options, particularly for those with BH needs.

#### **Intercept 4 Recommendations**

- Analyze existing data to estimate the system's capacity to meet the service needs of justice-involved individuals with BH needs and to identify barriers to continuity of service for jail releasees.
- Establish forensic communities of practice (similar to the communities of practice model in child welfare) and a learning collaborative model for forensic community service providers.

- Expand the amount and type of community supportive housing dedicated to serving justice-involved individuals with BH problems, including the establishment of a “step down” facility for individuals moving from the ACJ to a more permanent housing arrangement.
- Revisit and revitalize prior collaborative efforts with the Housing Authority and Probation to establish a policy allowing probationers into public housing.
- Integrate forensic peer specialists (FPSs) into the service network used to support community re-entry.
- Examine the possible utility of Assisted Outpatient Treatment (AOT) and convene a workgroup with court and law enforcement personnel to see if there are acceptable local procedures and resources to pursue this option.

### ➤ **Intercept 5 – Community Corrections**

Intercept 5 considers access to recovery supports, benefits and housing as well as probation supervision practices regarding monitoring and managing violations and new offenses. Probation has made concerted efforts to reduce technical parole violations and reduce length of supervision if the individual demonstrates successful integration to the community; it has not, however, adopted the use of specially trained officers for managing probationers with BH needs, despite positive evidence about this practice. Continuing efforts to free up probation officer time by introducing innovative supervision strategies for low-level offenders would permit more focused time and energy for those with complex BH and social needs.

#### **Intercept 5 Recommendations**

- Continue and expand current efforts to use alternative supervision methods with low-risk cases to free-up resources for more specialized services for probationers with BH needs.
- Establish a system for sharing information with probation staff regarding the BH status of each client coming onto supervision.
- Continue efforts to reduce the length of probation terms for all probationers.
- Expand the services provided at DRCs/CRCs to provide BH evaluation and treatment services to probationers when possible by regulations.
- Create specialized BH caseloads assigned to probation officers with extensive training. These probation officers will be expected to work closely with BH case managers in a

collaborative team to provide services for high risk, high need clients using a Forensic Assertive Community Treatment (FACT) team model.

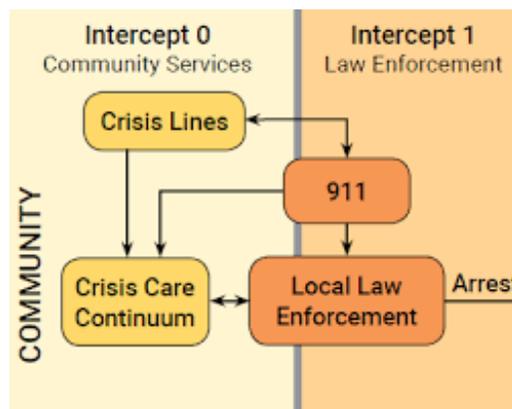
In the following pages, we provide more detail about the context for each of these recommendations and additional information regarding the rationale and nuances for our suggestions. We also make five overarching recommendations based on our analysis of the significant strengths and accomplishments of the Allegheny County stakeholders.

## Analysis by Intercept

### Sequential Intercept 0/1 – Community Services/Law Enforcement

#### Intercept 0/1: Overview

Initial, on-scene responses to potentially criminal situations involving individuals with behavioral health (BH) problems are the first opportunity to avoid unnecessary involvement of these individuals with the criminal justice system. Taking advantage of these situations to make appropriate diversions and referrals requires adequate resources for, and coordination among, three entities: 1) dispatch services, 2) police responders and 3) mental health (MH) crisis services. Allegheny County agencies have taken steps to develop services to support diversion and referral at this initial point of contact, and they seem poised to move toward a more effective system for this potential intercept point.



It is useful to first understand some of the constraints on decision making and the possible alternatives considered during these situations. Three of these are:

- *Police officers have a limited amount of time to spend on any given call.* In general, patrol officers have to be ready to respond to incoming calls, and a quick resolution to any call is preferred.
- *Dispatchers often have limited information about the individuals involved in any incident.* Calls coming in to dispatch services are identified primarily by address, and it is possible for dispatch services to access an information file regarding cautions based on prior calls (e.g., presence of weapons) or requested information about individuals at that address (e.g., an adolescent with autism).
- *MH crisis services do not have authority to hold an individual against their will unless they are willing and able to file a 302 commitment order, which requires a demonstration of imminent harm to self or others.* MH crisis workers are trained to assess type and level of clinical disturbance, but they must rely on engagement, rather than coercion, of an individual.

Proposed systems for diversion at the point of crisis calls must accommodate to these current realities of the ways that dispatching, police response and MH crisis services operate.

#### Intercept 0/1: Allegheny County Programs and Initiatives

Over the last ten years, Allegheny County has initiated several programs to support the diversion of individuals with BH problems at the point of initial encounter with police. These include a robust Crisis Intervention Training (CIT) program for City, municipal and other agency law enforcement officers, an enhanced crisis call system that uses both an MH crisis worker and

a law enforcement dispatcher on the line at the same time, and a mobile crisis team of MH professionals that responds to police requests for on-site assistance. Each of these services contributes to the potential to develop an integrated system of diversion at this point of involvement with the criminal justice system.

### ***CIT training***

A crisis intervention training curriculum was established by the Pittsburgh Bureau of Police (PBP) in 2007. There is a clear commitment from the PBP to this training. The PBP oversees the CIT training program, with the training director from the PBP and the co-director from the Port Authority Police Department. In addition, the PBP requires completion of the CIT course as part of basic training for all new officers, and all sergeants in the PBP are required to complete the training.

The PBP conducts monthly CIT training sessions, primarily with police officers from the PBP but with other groups as well if space permits. These other agencies include municipal police departments, Allegheny County Police Department, Port Authority Police and other agency personnel (e.g., school resource officers). CIT trainers come from police departments throughout the county, local BH care providers, advocacy and support groups, and outside consultants. Officers from all departments in the County can be trained in this centralized program. Although there is a separate police training academy run by the Allegheny County Police, the County training academy does not offer CIT training.

In 2017, 250 officers were trained, coming from 14 different police agencies (e.g., City, municipality, university) as well as other first responders (e.g., fire, EMS, civilians). The goal of the PBP is to have all officers trained in CIT principles and practices, with this training being offered in the curriculum for the PBP academy training beginning approximately eight years ago (2010) and continuing today.

*Current training curriculum and practices:* The majority of CIT training programs include elements promoted in the Memphis Model (the flagship CIT program appearing over 30 years ago) with varying degrees of modification to fit local needs. Table 1 presents the approach and topics used in several other model locales that have systematically documented and published their materials and curriculum. Using this information, we can make a comparison of the approach taken in Allegheny County with other locales who have invested in the CIT model rather heavily and have seemingly learned something from their ongoing efforts.

The information in Table 1 was compiled as part of a prior field research study done to assess the effectiveness of CIT training in four different counties in Pennsylvania (Mulvey & Schubert, 2016: PCCD grant # 24225). In this prior work, documents detailing the core elements of CIT training adopted by four states - Tennessee (Memphis), Florida, Ohio and Virginia – were

reviewed and coded.<sup>1</sup> These states were chosen based on an internet search and/or phone calls to program representatives from each locale. These states also had detailed information available that could be used to determine the core elements adopted by each locale.

Two individuals independently reviewed the materials from each state and identified the elements seen as essential for CIT training and the essential program features. Each reviewer further specified if the specific element was perceived to be a “core element” or simply “desirable.” The two lists were compared and discussed by both reviewers, with the study Principal Investigator as the “tie breaker.” This process produced a consensus document representing a matrix of 85 essential elements for CIT training and program characteristics seen in Table 1.

**Table 1: CIT Core Elements from 4 states**

X = CORE ELEMENT, / = DESIRABLE

	Memphis	Virginia	Florida	Ohio
<b>Partnerships</b>				
Law Enforcement involved in planning, training and on-going support of CIT	X	X	X	
Consumers involved in planning, training and on-going support of CIT	X	/	X	
Family members involved in planning, training and on-going support of CIT	X	/	X	
Advocacy groups involved in planning, training and on-going support of CIT	X	/	X	
Mental health community involved in planning, training and on-going support of CIT	X	X	X	
<b>Community Buy-In</b>				
Individuals from community involved in planning, training and on-going support of CIT	X	X		
Community oversight committee guides initial planning and implementation and on-going oversight		X		
Local professionals volunteer to assist in training	X			
<b>Policies and Procedures</b>				
Policy for transporting consumers to MH care	X	X		
Inter-agency agreements	X	X	X	
Process in place to provide feedback to CIT officers and MH administrators on a regular basis and when problems arise			X	X
Regularly scheduled meetings for stakeholders			X	X
Adequate number of patrol officers trained so that CIT officer is available at all times	X	X	X	X
All dispatchers trained in abbreviated session (minimum hours vary from 4 to 8)	X	X	X	X
Nearest CIT officer is dispatched	X	X		
-in at least 50% of identified CIT calls				X
Policies maximize officer's discretion	X	X		
Policy directs CIT officer to guide resolution of crisis event (unless extraordinary circumstances)	X	X		
Policies allow for wide range of inpatient and outpatient referral sources	X	X		
In least restrictive setting		X		
Barriers preventing immediate access to MH treatment eliminated	X			

<sup>1</sup> The specific documents reviewed for each state were: Tennessee: *Crisis Intervention Team Core Elements* (R. Dupont, S. Cochran & S Pillsbury; September, 2007); Florida: *The Florida Crisis Intervention Team (CIT) Program* (Adopted March, 2005 by the Florida CIT Coalition), *Florida's CIT Program Assessment: Measuring Fidelity to the Memphis Model* (M. Saunders, no date); Ohio: *CIT Program Assessment and CIT Desk Audit Checklist* (The Ohio Criminal Justice Coordinating Center of Excellence and NAMI Ohio); Virginia: *Essential Elements for Virginia's CIT Programs* ([http://vacitcoalition.org/essential\\_elements\\_of\\_virginia\\_cit](http://vacitcoalition.org/essential_elements_of_virginia_cit))

Barriers preventing immediate access to MH treatment are addressed		X		
Turnaround time for CIT officer is less than or equivalent to turnaround time for jail	X			
Turnaround time for CIT officer is minimized		X	X	X
<b>Operational Elements</b>				
Officers volunteer	X	X	X	
Supervisors select/approve officers	X	X	X	X
Final selection of CIT officers is made after the training			X	
Officer maintains patrol role	X		X	
Officer is experienced		X		
CIT officers issued agency-authorized CIT pin to wear on uniform			X	
<b>Coordinators</b>				
CIT coordinator	X	X	X	X
Has experience as a law enforcement officer	X			
Works in law enforcement department			X	
Pre-existing relationships with LE and mental health communities		X		
Is CIT officer				X
Mental health coordinator (may be informal or involve several individuals)	X		X	X
Advocacy coordinator (may be informal or involve several individuals)	X		X	
Program coordinator who facilitates inter-departmental communication, data collection, record keeping and schedules training	X			
<b>Training</b>				
CIT training classes offered at least annually			X	X
<i>Training faculty</i>				
complete comprehensive 40-hour course	X			
participate in ride-along with police	X		/	/
Willing to become "police familiar"			X	X
<i>Patrol officers</i>				
40 hours	X	X		
40 consecutive hours over 5 days		X		
Training includes didactics/lectures	X	X	X	X
Training includes visitation to several mental health facilities	X	X	X	
Training includes intensive interaction with individuals with mental illness	X	X	X	X
Training includes scenario-based de-escalation skill training	X	X	X	X
Training includes community service options for mental health/substance abuse			X	X
Maximum class size = 30		X	X	
Officers strongly encouraged to wear civilian clothes throughout training, civilian clothes mandatory for site visits		X		
In-service/advanced CIT trainings offered for those officers who have completed the 40-hour comprehensive course	X		X	X
<i>Dispatchers</i>				
Dispatchers recognize behavioral crisis calls	X			
Ask appropriate questions to ascertain info the CIT officers needs	X			
Dispatch a CIT officer	X			
Dispatchers receive in-service training	X			
<b>Mental health receiving facility</b>				
Designated single source of entry to mental health system (or well-coordinated multiple sources)	X	/		X
Access 24/7	X	/		X
No clinical barriers to care (accepts referrals regardless of diagnosis or financials)	X	/		X
Facility has access to emergency health care	X	/		
Facility has access to emergency drug and alcohol services	X	/		
Provides feedback and engages in problems solving with CIT partners	X			
A diversion mechanism or protocol that is an agreement-based process incorporating the community's strengths, resources and needs, in order to divert individuals into community care and treatment while also reducing officer involved		X		

time [acknowledging that a functioning 24/7 receiving facility may not be realistic in all localities]				
Mental health/substance abuse system will receive individuals identified by CIT officers who are in need of crisis services, voluntary and involuntary			X	X
User friendly "drop-off" policy with quick turnaround time for officer			X	X
<b>Evaluation and research</b>				
Data collected to allow outcome research	X		X	X
CIT programs required to collect data on <ul style="list-style-type: none"> <li>• How CIT officers are linked to mental health calls</li> <li>• How long CIT officer remains involved in call</li> <li>• Injuries involved (if any)</li> <li>• Final disposition of call</li> </ul>		X		
Pre/post training self-assessment for trainees on mental health crisis knowledge and skills		X		
Evaluation of instructors and overall class			X	
<b>Recognition and Honors</b>				
Awards, certificates of recognition, banquets (or similar) are provided as an incentive to continue CIT work and to honor exceptional officers	X		/	X

One of the maxims of the Memphis model is that police departments will alter the topics and procedures of the training somewhat to meet the demands of the local community adopting this approach. This is borne out in Table 1. There is state-level variability in the assessment of core elements for CIT; some elements are viewed as core by all states, some for which there is discrepancy regarding its level of importance, and some that are not mentioned in any model other than Memphis. Completing a review of the current CIT practices and curriculum used in Allegheny County and examining them next to the elements above provides a useful benchmark about how the approach taken here compares to that taken in other model locales.

In the prior study, each of the four participating Pennsylvania counties was assigned a “fidelity score” to see how completely their approach included the elements identified above. Based on a complete set of materials provided by the County about the curriculum and practices of their CIT training, raters assigned scores to each element listed above. A value of 2 was given if the element was clearly present, a value of 1 was given if some aspect of the element was present, and a value of 0 indicated that the element was not present.

A summed score was computed, simply adding up the presence/absence ratings score (2 - present, 1 – partially present and 0 – not present) across the 85 elements for each of the four counties in the prior study and Allegheny County. These scores are as follows:

- County A: 100
- County B: 97
- County C: 128
- County D: 105
- **Allegheny County 120**

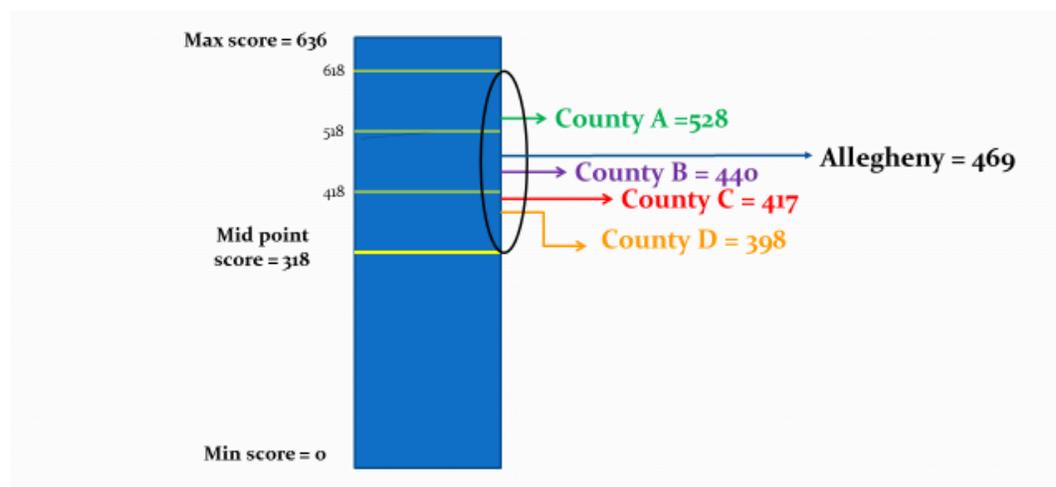
These scores indicate that each county has integrated the vast majority of the 83 elements into its training and program implementation, and that there is limited overall variability among the counties. Allegheny County and County C, however, stand out slightly as integrating more fully the elements listed in the template.

As noted above, though, locales can also vary in which elements they choose to keep or ignore. While some localized “tweaking” of the Memphis model is desirable, we wanted to capture the diversity in implementation in a way that reflected retention of more agreed-upon important component of CIT. The scores above do not account for the inclusion/exclusion of elements that the comparison documents all stated were essential (e.g., inclusion of family members) versus the inclusion/exclusion of elements for which the comparison documents were less consistent (e.g., the inclusion of police ride-alongs). In short, we wanted a method that gave a higher score for including elements that were uniformly viewed as “essential” across state models.

We did this by assigning a weight to each element and getting a summary “fidelity” score. Weighting values ranged from 2 – 7. Items that were identified as essential in all four state models were weighted the highest (weight value =7) and items that were identified as essential by only one state were given the lowest weight (weight value = 2). The presence/absence value (0, 1 or 2) for each of the 83 elements was multiplied by the weight value (range 2-7) for that element to generate an element-level score. The element-level scores were then summed to generate the total fidelity score for each participating county. If all 83 core elements were rated as fully present (value = 2), the maximum total fidelity score that a county could obtain was 636 (2 X 318).

he fidelity scores for each county in the earlier study and the one derived for Allegheny County are presented in Figure 2.

**Figure 2. Total Fidelity Scores for Four Study Counties and Allegheny County**



Once again, there is not a large amount of variability in the scores. Each county appears to be including a large number of elements deemed essential in the four state documents used to elicit the essential elements. Allegheny County also follows this pattern, again having a higher score here, indicating that it includes topics and procedures with a high level of consensus regarding their importance.

We want to emphasize that the intent of assigning this score was not to “grade” each county program for how it compares to other programs; CIT was explicitly designed to be modified to meet the needs of each locale. Rather, our intent was simply to identify a common template or set of elements against which all participating counties could be compared. A lower score, in this case, signifies a county which has modified their CIT training program more so than other participating counties. It does not equate to a training program that is performing poorly. It is instead a template for the county to see which elements it has designated as less important for that locale and to explore whether the elements that have been eliminated still make sense for the current situation in that locale. As part of this evaluation, the more detailed rating sheet for Allegheny County has been provided to the CIT coordinator for this purpose.

*Measures of effectiveness of CIT in Allegheny County:* In most locales nationwide, the effectiveness of CIT training in changing officer behavior is more assumed than demonstrated (Cross et al., 2014). Allegheny County is no different. There are limited assessments of this training on officer attitudes or behaviors. In addition, there is little systematic assessment of the Allegheny County CIT program in terms of the number of people with BH problems who have been diverted from arrest or the proportion of individuals under court supervision who have been in contact with these services.

In discussions with officers, supervisors and chiefs from several departments throughout the County, there was strong support for this training. CIT training is seen consistently as a method for expanding officers’ general skills at defusing crisis situations and providing a more informed choice of alternatives in resolving crisis situations involving individuals with BH problems. In addition, a prior structured evaluation of CIT in Allegheny County (Nolan, Blandford, & Kirin, 2012) showed some impact of the County training program in imparting information about MH issues and altering officer attitudes regarding individuals with BH. These types of shifts in officers’ skills and attitudes have been found in numerous locales nationwide (Cross et al, 2014) with limited, but positive and encouraging, results indicating downstream effects on officer behavior in the field in terms of reduced arrest and increased referral to treatment (Compton, et al., 2014a, 2014b; Mulvey & Schubert, 2016).

Since its inception, the CIT model has had two overarching goals; 1) increasing officer knowledge, skills and attitudes, and 2) establishing a collaborative relationship with MH service providers and MH/substance use service providers. Similar to other locales, Allegheny County has had more difficulties achieving the second goal of establishing a vigorous working relationship of service providers and police departments. In interviews with police administrators and officers, there were a number of reports of positive working relationships with particular service providers, but a general acknowledgement of limited knowledge about how the BH service system works and what happens as a matter of course for individuals who go to these services. In addition, there did not appear to be any readily identifiable and organizationally recognized forum for sharing information or developments regularly about how police departments and service providers might work more constructively to divert individuals with MH problems. A further concern about CIT training is the strain that such

intensive training puts on smaller police departments. The 40-hour course often taxes available department resources (in terms of manpower and budget). Many smaller departments thus seek out less intensive training options, such as Mental Health First Aid. Meeting these challenges is necessary to capitalize on the investment and enthusiasm for CIT that is apparent throughout the county.

### ***9-1-1 Dispatch***

Allegheny County has a centralized emergency response system (9-1-1) that dispatches fire, emergency medical services and police response to reported incidents. This call center serves 91 different police agencies, with some smaller communities in the County maintaining their own direct line to their police departments. The 9-1-1 center dispatches approximately 4,500 calls per day, with a higher number of received calls. A single dispatcher working at eight-hour shift handles between 60-120 calls, using a Computer Assisted Dispatch (CAD) system. The CAD system provides any stored information regarding the address, a satellite and street view of the location, and the relevant department policies in that community.

The 9-1-1 center has two types of people working when a response is needed to a call - a call taker and a dispatcher. These individuals are on the call at the same time; the call taker talking to the reporting party and the dispatcher communicating with the police. The call taker has the responsibility to ask a set of structured questions, based on the type of call (e.g., threatened suicide), which follow a decision tree indicating subsequent questions based on the individual's responses.

The call taker and the dispatcher have access to a file that contains specific information (premise hazard flags) regarding conditions that should be considered at the address of the incident (e.g., history of assaults on officers). If an address has a premise hazard flag connected to it, a colored tab and a noise alert will come up to the dispatcher who is required to relay that information to the responding officer(s). The flags are included in the file when a written request (form available on a county website) is submitted by an officer or a citizen; officers must get the permission of their supervisor to submit such a form. Premise flags exist in the system for one year and are removed unless they are renewed at the end of that period by filing another form.

Identification of BH calls by dispatchers is inconsistent and unsystematic. There is a code in the dispatch system to indicate that a call involves an individual with a MH issue on scene, but this code is only applied if another code does not better capture the acute issue. For example, a caller with a MH disorder may be having a medical crisis related to diabetes, and the dispatch code will reflect the medical crisis. The impression of dispatch staff is that a call type of MH typically reflects a situation in which the caller is suicidal or in an acute MH crisis that is detectable in the phone conversation. Also, the impression is that this code vastly undercounts that number of calls that involve an individual living with a BH condition. The dispatchers sometime receive a premise hazard flag when an individual at the address for the call is known to have a BH problem, but this information will only be available if an individual officer or

citizen requests the inclusion of this information in this data base. In addition, the supervisors at 9-1-1 indicate reservations about expanding the ability of call takers and dispatchers to identify cases involving individuals with BH problems. There is a concern that such identification could promote a less prompt response to a call (e.g., a call taker attributes a medical complaint to the behavioral disorder rather than an actual medical crisis). The desire is for call takers to manage every situation based on the information communicated during the call.

There is no current system for matching a CIT-trained officer to a MH call. In addition, dispatchers currently have no indication of which officers have received CIT training, thus making selective assignments based on training reliant totally on informal knowledge. An officer on scene, however, can request a CIT-trained officer or a mobile crisis unit (from reSolve Crisis Services, the psychiatric crisis center) if, upon arrival and initial assessment, it is clear that some specialized intervention would be useful.

### ***Mental Health Crisis Services***

Police have a limited number of options for connecting individuals with a BH problem with appropriate services for diverting them from criminal justice system involvement. In Allegheny County, there is currently a single crisis response center (reSolve Crisis Services in the eastern part of the city) designated as the provider for these services. There was another crisis response center at Mercy Behavioral Health on the South Side of the city, but this site has discontinued general crisis response. It now provides limited crisis walk-in services, phone services generally for its own consumers, and some short-term residential support. Police in outlying jurisdictions report taking individuals to their nearest local hospital psychiatric unit (e.g., Jefferson Hills Hospital) to get treatment rather than to the jail for processing.

reSolve Crisis Services provides crisis evaluation, stabilization and referrals for a large number of cases from the community in general. During Fiscal Year 2017, resolve reported 6,414 walk-in services, 1,839 admissions to crisis residential, and 69,676 incoming and 26,136 outgoing calls through the crisis phone line. reSolve Crisis Services remains the regional affiliate for the National Suicide LifeLine, and calls to 800 number national lines received from the 412 area code are directed to the center.

reSolve also provides mobile crisis services, with 10,383 community-based mobile team responses reported in 2017. PBP and municipal officers report regular use and generally positive reviews of the mobile crisis team. The major limitation identified with the mobile response team is the amount of time that it takes for them to arrive on the scene (about 20-30 minutes) and the difficulties of managing the situation during this waiting period.

Police report often providing transportation to reSolve or Mercy Behavioral Health when confronted by situations involving individuals with BH problems, but this practice appears to be variable among officers. Data regarding the disposition of police calls in terms of when transportation to an MH facility occurs and the name of the facility used is considered

incomplete. However, it was frequently reported that a sizable proportion of city police officers feel that the voluntary nature of the services offered at crisis centers does not allow them to guarantee that the individual transported to the site actually receives appropriate attention; the person may instead simply appear in a short time back at the scene where they were first taken into custody.

PBP and municipal officers also report using psychiatric emergency rooms in incidents involving individuals with BH problems. This alternative is unattractive to officers and police supervisors for several reasons. First, in many locales, transport to the facility requires an ambulance or EMT on site. This incurs additional personnel involvement in the incident and possible cost for the individual being taken to the hospital. Second, it may take a considerable amount of time to triage or intake a person in a psychiatric hospital, and this is time that the officers will be unavailable to answer calls. This is particularly troublesome when the officers are still responsible for finding an alternative disposition of the call (e.g., jail) if the person is not admitted to the hospital.

### **Intercept 0/1: Gaps**

An examination of the current system for responding to crises of individuals with BH problems identifies several issues to consider in efforts to improve practice at Intercept #1 in Allegheny County. These are:

- ***Lack of an integrated data system to identify CIT-trained officers and to assess their impact on reducing arrest and increasing referral of individuals with BH problems to appropriate resources.*** While CIT training sessions are conducted regularly under the auspices of the PBP, information about who has been trained and their current employment status is not kept in a computerized, up-to-date form. In addition, reports of outcomes on calls handled by CIT officers are not entered into a computerized system. This lack of easily accessible information means that there is no method to determine which municipalities or areas of the city need additional CIT-trained officers or the potential impact of these officers on arrests or BH referrals. It also means that dispatchers have no accurate resource (other than personal knowledge) that can be used to assign a CIT-trained officer to an appropriate call.
- ***9-1-1 Dispatch personnel have no training in CIT and only very limited training in MH issues more generally (most training is focused on suicide prevention).*** Individuals taking calls have minimal training in the recognition or handling of BH issues and current protocols for gathering information from callers with a suspected MH concern are limited in terms of gathering the most relevant information for the resolution of crises (although these protocols are under revision). This means that opportunities for potentially useful information gathering at this initial point of contact are being lost. Some earlier attempts to involve 9-1-1 personnel in CIT training were not received well because the training took too long (40 hours) and had little direct relevance to the demands of the call receiving and dispatching jobs. There are specialized, successful curricula for training dispatch personnel, but they have not been implemented here.

- ***No regular forum for BH service providers and police officials to share information, to educate each other and to plan improvements.*** There is currently no planning group to examine issues, needs and successes of police officers and BH service providers in attempts to divert individuals from criminal justice processing. Limited information is shared between 9-1-1 dispatch and the CIT coordinator at PBP and between the CIT program and the service providers. 9-1-1 dispatch sends the PBP CIT coordinator a monthly list of all calls labeled as MH calls at the time of dispatch so that the Criminal Complaint Report (CCR) number for these incidents can be matched to the reports by CIT officers. However, the lack of a uniform definition by dispatch for defining an MH call, the nonsystematic matching of CIT officers to BH calls, and the selective filing of reports by CIT officers makes confident interpretation of these data problematic. In addition, the crisis service providers, police departments and the CIT program coordinator have no agreed-upon method for tabulating calls deserving attention or the appropriateness of response by different agencies.
- ***Limited BH crisis intervention resources to assist police officers in a timely manner.*** Police officers voice a willingness to work with MH crisis workers, believing that many of the situations that they confront could be resolved more effectively with consideration of the BH issues involved. Getting this expertise to the scene in a timely manner, however, is the major difficulty. Only walk-in crisis services are now offered by Mercy Behavioral Health, and they have no direct contact with the 9-1-1 dispatch center. Mobile crisis services operate out of the reSolve Crisis Center but their capacity to respond to the scene for assistance is limited and not timely.
- ***Variable level of adoption of CIT training across municipalities, as smaller departments find it difficult to free up officers for 40 hours of training and training slots are less readily available for these officers.*** Many municipal departments consist of fewer than ten officers and freeing an officer from patrol duties to attend training for a week places a coverage and fiscal burden on the department. As a result, many small departments simply put off obtaining CIT training. In order to assist the smaller departments in overcoming these obstacles, the PBP CIT Coordinator has altered the CIT training from five consecutive days to one day per month for five months, but smaller departments still rarely take advantage of this option. Finally, municipal departments often have the perception that CIT training is provided preferentially to PBP officers, since the PBP requires this training for all officers and class slots are first offered to PBP officers as a result. These factors produce the situation where many smaller municipal departments simply see CIT training as too resource-demanding and inconvenient.
- ***Few resources available to officers for handling the large number of cases that involve safe resolution of intoxication and later engagement in appropriate services.*** Many calls for police service involve acute intoxication with alcohol or illegal substances, and officers often see limited options for holding these individuals safely until a reasonable disposition can be determined. In the view of many officers, the most secure place for such individuals is in jail, since many services cannot hold individuals against their will and assess them medically.
- ***Limited secure, short-term housing arrangements for individuals for whom jail might not be necessary.*** While some proportion of officers regularly take individuals with BH

problems to reSolve Crisis Services, Mercy Behavioral Health Central Recovery Center or a local hospital with a psychiatric unit, another large proportion of officers opt to take these individuals to jail to resolve the legal issue at hand and to secure housing. In the words of one workshop participant, “[jail] is the housing when housing can’t be found.” Even in situations where involuntary civil commitment would seem justified, this might be left to the jail to pursue.

### **Intercept 0/1: Opportunities**

There are existing practices in Allegheny County that provide potentially useful building blocks for program development and improvements in current practice. These are:

- ***Broad law enforcement support for addressing issues surrounding BH calls.*** PBP, municipal departments and the Allegheny County police all express a level of frustration regarding BH situations and a clear commitment to do a better job in this area. There is a widespread desire to divert cases where further criminal justice system processing is counterproductive.
- ***An established, sound infrastructure for CIT training.*** CIT training is not new for police in the County. Departments are well aware of the potential benefits of CIT training and regularly take advantage of opportunities to have officers enroll. There is a certified CIT Coordinator in the City, the training curriculum is well established, and those involved in the training have learned from prior experience about what works and does not work in these sessions. Many departments have a large proportion of their officers trained already. There are improvements that could be made, but the current training provides a valuable resource.
- ***9-1-1 dispatch services currently use their capacity to link communications between officers on-scene with crisis workers.*** When dispatchers or officers in the field have a situation where an officer could use assistance from a trained MH professional (e.g., potential suicide), the call center can (and does) include a crisis service counselor on the conversation. This means that the crisis worker can provide input into the assessment and control of the situation. While it is unclear how often this situation arises, dispatch and officers report a positive response to the ready availability of this resource.
- ***Existing programs in some departments already use technology applications for certain specialized police response.*** The PBP has taken steps to equip officers with mobile computer applications that provide relevant information about resources for on-scene responses. Officers currently have an application to indicate nearby locations and information relevant for handling situations involving homeless individuals (e.g., nearest shelter, resources for free food). These applications have been received positively and used regularly (mostly by younger officers).

## **Intercept 0/1: Recommendations**

Several steps can be taken to build a more effective crisis response system for individuals with BH problems, one that operates more efficiently to divert individuals with BH problems from further criminal justice system involvement.

**1.1 Develop an up-to-date and accessible data base of CIT-trained officers currently working in PBP and municipal police departments and integrate this list with the 9-1-1 dispatch system so that the information is available in real time.** The current system for tracking who has received CIT training and where they are currently working is inadequate (i.e., there is no computerized list of CIT-trained officers and their current employment). Since officers regularly change employment among departments outside of and within the County, there is currently no system that provides accurate and up-to-date information regarding which CIT officers are on duty in a particular locale at any given time. This makes it impossible to do systematic assignment of CIT-trained officers to calls with known BH problems. Other major metropolitan areas (e.g., Norfolk, VA; see Norfolk Crisis Intervention Team <https://www.bja.gov/SuccessStoryDetail.aspx?ssid=76>) have successfully addressed this problem and their systems can serve as models. Dispatching CIT-trained officers to calls identified as exhibiting behavioral disturbances is a method to capitalize on sunk costs of specialized training as well as an efficient way to reduce arrests and jail processing.

**1.2 Provide specialized CIT training for 9-1-1 call takers and dispatchers and conduct cross-training exercises with behavioral crisis personnel.** Earlier attempts to provide CIT training for 9-1-1 staff did not materialize because of the lack of relevance of the current curriculum to dispatch personnel. This is a common problem that has been confronted successfully by several metropolitan departments (e.g., Madison, WI; Washington State; Miami-Dade, FL). Specialized, dispatch-focused training curricula have been developed and can be applied to Allegheny County. The most successful adaptations of this type of training have conducted the training in conjunction with BH crisis personnel (see, for example, <https://www.citwisconsin.org/training-calendar-1/2016/8/8/crisis-intervention-team-cit-dispatcher-training>; [https://fortress.wa.gov/cjtc/blog/index.php?option=com\\_content&view=article&id=411&Itemid=83](https://fortress.wa.gov/cjtc/blog/index.php?option=com_content&view=article&id=411&Itemid=83); and <https://www.tcbmds.org/cit-companion-for-dispatchers.htm>), and this approach should be taken here. This would involve cross-training personnel from both sites so that they share a common language and understanding of procedure as well as have an experiential feeling for the demands (and limitations) of each other's job.

**1.3 Expand and decentralize the administration of CIT training.** CIT training resources are currently controlled by the PBP and changes to operations and procedures are the purview of the City department. Moving the control of this training from one department to multi-agency leadership, having more than one site for conducting training (possibly integrating trainings with the Allegheny County Police training academy), and using a broader base of

trainers could increase enthusiasm and participation from municipal departments and promote inter-agency collaboration and cooperation. It would also promote more cooperative data collection across the city and municipalities to track the effects of training. A certified CIT Coordinator should be retained as a leader in this proposed reorganization.

As mentioned above, many small departments do not have the person power to send officers for a 40-hour CIT training. Increased cooperation among neighboring municipalities could help address this problem. Smaller police departments could pursue the possibility of establishing Memorandums of Understanding to allow officers from adjoining jurisdictions to patrol designated areas during periods when an officer would be attending CIT training. This approach has proven successful in several small departments across PA (e.g. Lackawanna County).

**1.4 Establish locally-based forums that meet regularly to examine the operations among MH crisis centers, police departments and social service providers.** Crisis centers and service providers need to have an ongoing dialogue with police departments across Allegheny County to respond effectively to trends and problems as they emerge in a community. Sharing information in regular meetings between field supervisors from both systems is an effective way to promote joint, coordinated responses to community safety issues. These forums need to be small enough to remain focused on issues that the participants feel they can affect, rather than being broad discussions of policy. As a result, they should map onto several adjoining municipal communities or a zone of the city, including only service providers who operate in that area. Such groups have been referred to as CIT steering committee or MH Response Advisory Boards and are a recommended component of any successful implementation of CIT in a locale.

This approach has implemented successfully in several locales. Examples can be found in materials from the Stepping Up initiative, particularly in Denver, Colorado. An exemplary model can also be found closer to home. Beaver County has conducted a successful, ongoing group with police and service providers, and initial consultation with officials there could provide valuable information for planning such forums (contact Heather Harbert at Markey Services).

**1.5 Allegheny County should identify and examine individuals who have frequent contact with the criminal justice and MH systems. Identifying and examining the characteristics of these individuals may provide clues for supporting them in a way that is both humane and cost-effective.** Many jurisdictions have noted that a small number of people with high BH and other needs often have repeated interactions with hospitals, law enforcement and public service systems (Chambers et al. 2013). Costs can be reduced, and the efficiency of services can be improved, if these high-need individuals can be identified and targeted for appropriate intervention (Culhane, Metraux, and Hadley 2002; Simon et al. 2001). The number of high-need, multi-service users in Allegheny County is unknown but many of the data elements necessary to explore this issue appear to be in place across service sectors.

With the sponsorship of a multi-agency leadership group (as described above), we recommend an analytic exploration of this issue in the County and, if the outcome of the analysis warrants, interagency policies for managing this group should be developed. By proactively identifying and reaching out to high users, later crises and costly services might be averted. A program of this sort exists in Chicago. There, a partnership between public and private agencies supports outreach groups that include a clinician and a CIT officer.

There are multiple groups/agencies that have taken on this population from different intercept points (e.g., police, jail, housing). For example, the Chronic Consumer Stabilization Initiative (CCSI) in Houston, TX is designed to identify, engage and provide services to individuals who have been diagnosed with serious and persistent mental illness and who have had frequent encounters with the Houston Police Department (<http://www.houstoncit.org/chiefs-message/>). The Familiar Faces initiative (King County, WA) is focused on creating a system of integrated care for individuals who frequent the county jail (defined as having been booked into jail four or more times in a twelve-month period) and who also have an MH and/or substance use condition (<https://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx>). The Familiar Faces initiative emphasizes the need for cross-sector collaboration and “putting the people and communities at the center of decisions about funding, policy and programs.” Finally, Frequent Users Systems Engagement (FUSE) uses a supportive housing framework to stabilize and end the costly revolving door of these frequent users. There are FUSE programs in over 30 communities (e.g., Houston, Los Angeles, Minneapolis, New York City) and formal evaluations of some of the programs have demonstrated reductions in the use of expensive crisis services and improved housing retention (<http://www.csh.org/fuse-map/fuse-overview/>).

Allegheny County, with the Data Warehouse resource, is well situated to complete a data-driven, cross-system examination such as this. However, we note that the Center for Data Science and Public Policy at the University of Chicago (<https://dsapp.uchicago.edu/projects/criminal-justice/data-driven-justice-initiative/>) offers resources and services to support counties engaged in this important effort.

**1.6 Expand the capacity of officers in the field to obtain MH consultation by increasing access to MH professionals.** As mentioned above, police officers feel that they could benefit from consultation with MH professionals while handling an incident involving individuals with BH problems. However, the amount of time currently needed to get a mobile crisis unit on scene often makes this option unwieldy. Three changes could make access more timely and useful.

First, the establishment of another mobile crisis team and increased integration of mobile crisis services with 9-1-1 dispatch would help. Currently, reSolve Crisis Services operates the only mobile crisis team in the County, and is responsible for all locales within the County,

responding to approximately 30-40 calls per day based on referrals from 9-1-1. reSolve Crisis Services operates its own dispatch service, responding to additional calls that come into its crisis line. The slow response to a scene involving the police is partially a function of coordinating with 9-1-1 dispatch and the challenge of covering so much geographic territory.

Having an additional mobile crisis team linked to 9-1-1 in another location in the County would alleviate some of this problem and potentially increase officer use of the service. In addition, integrating the 9-1-1 dispatch system with the mobile crisis dispatch could improve response time. Officers currently often avoid getting crisis services through 9-1-1 dispatch because it simply complicates the transfer of information about the situation; several people relaying impressions or reports of actions on the scene creates a hassle for officers. With a more highly trained dispatch service asking more detailed questions about BH issues (these are currently skeletal in the 9-1-1 dispatch service operating manual and are currently being revised), 9-1-1 dispatchers could send an MH mobile crisis unit at the same time an officer is dispatched to the scene. In this way, the responding crisis unit could be in direct contact with the officer on scene from the beginning of the call. Officers could still call for a mobile crisis team if they find relevant BH issues when they arrive on a scene, without having to route this request through 9-1-1 dispatch.

Second, officers could use an electronic tablet (or similar technology) to connect an MH professional with the scene (via Skype or a dedicated service). The MH crisis worker would be on call at a central location, available to officers throughout the County, and connected via computer to medical records. The professional on call would not have to be a psychiatrist; rather an experienced nurse or psychologist could serve the same purpose. This MH professional could provide guidance to the officers about approaches to take with the subject at the scene or conduct an interview with the subject to provide information about resources or strategies for addressing the current issues. These approaches have been used with positive results by several departments (e.g., Houston, TX; Springfield, MO), decreasing repeat calls and increasing use of appropriate services.

Our initial discussions with police and MH professionals uncovered a considerable amount of skepticism about this practice. Concerns ranged from increasing an individual's suspiciousness to having an individual steal the tablet from the officer. As a result, implementation of the use of this method would require efforts at the outset to educate police personnel regarding its potential benefits. Officers and supervisors would have to receive exposure to the substantial body of empirical evidence about the effectiveness of tele-psychiatry or tele-MH in varied settings (Ax, et al., 2007; Hilty et al, 2013) and the utility of this technology in other police departments (Thomlinson, Nuccio & Jackson, 2016; Ramsey, 2018). It would be advisable to bring in police officers from locales where this practice has been useful to engage in these discussions.

***1.7 Develop case processing and assessment centers where officers can take individuals in lieu of jail booking.*** The success of early diversion of individuals with BH problems by police

officers rests on the availability of attractive, well regarded alternatives to jail processing. In cases where arrest is justified and standard procedure, police officers are in the position of taking an individual to jail unless they can come up with a reasonable alternative. Expanding the domain of such alternatives increases the chances of successful diversion.

There are many challenges to setting up services that prevent a trip to jail for many individuals. Our recommendation is to set up regional processing centers that address the legal issues related to an arrest as well as present the individual with options for assessment and social services. These centers can have multiple functions and serve people at different points in criminal processing (e.g., short-term detoxification or stabilization facilities for arrestees, BH assessment sites, day reporting centers for probationers).

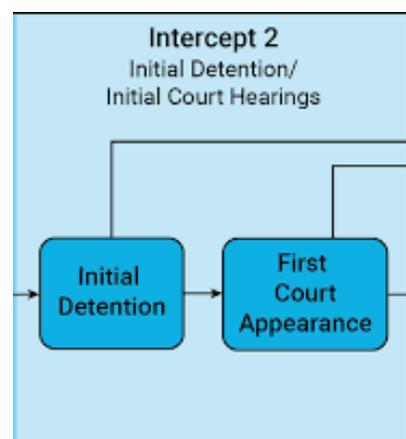
Multi-purpose regional centers of this sort exist in Arizona and Oregon. The Pima County Crisis Response Center (<https://www.behavioral.net/article/pima-countys-crisis-response-center-beautiful-and-functional-too>) and the Unity Center for BH in Portland (<https://unityhealthcenter.org/>) both include 23-hour observation facilities for short-term detoxification or stabilization and provide linkages to inpatient and outpatient BH care. The Pima facility incorporates recovery-oriented peer support specialists and system navigators to assist those at the Center and court proceedings are held at the Center as well.

The organization and functions of these centers will be discussed in detail in the recommendations section of the analysis of Sequential Intercept #2, since they will also fill a valuable role as a diversion service for Magisterial District Judges (MDJs). At this point, it is simply relevant to note that these centers may serve as diversion points for police officers at the point of arrest as well, providing individuals with a choice of going to the center for a resolution of the arrest or proceeding to the jail for booking.

## **Sequential Intercept 2 – Initial Detention/Initial Court Hearings**

### **Intercept 2: Overview**

The second sequential intercept where individuals with BH problems might be identified and diverted is at the point of initial detention and hearings. If an arrest occurs, the challenge becomes one of finding alternatives at the initial points of jail entry and court processing. This requires systems for identifying individuals with BH problems at the points of jail entry and prior to initial court hearings, the presence of alternatives other than jail, and a system for mobilizing these resources in a timely fashion. There are currently several components for identification and alternative service provision that can be augmented and integrated into an effective system in Allegheny County.



## **Intercept 2: Allegheny County Procedures**

Successful diversion at Sequential Intercept #2 requires integration of information and operations from several systems, i.e., pretrial services, service providers, jail processing and court personnel. The rapid integration of information from one system to another as well as the ability of these different systems to act upon prior and newly-acquired information are essential to successful diversion at this intercept. Individuals making decisions must have ready access to relevant information and a clear view of possible alternatives at their point of contact. Several aspects of the system currently in place in Allegheny County can be improved and linked together to promote diversion at this intercept.

### ***Pretrial Services***

Allegheny County Pretrial Services was formed in 2007 by combining the county bail agency, behavior clinic, accelerated rehabilitation diversion (ARD) program and alcohol highway safety program. The Pretrial Services entity created at that time now performs a variety of functions to support informed decision-making about the most reasonable disposition of arrested individuals. These services include:

- Interviewing all charged defendants (by bail investigators), using a locally validated standardized pretrial risk assessment to inform bail and bond decision making.
- Supervision of released defendants awaiting trial (by pretrial supervision officers), including referrals to prospective employers and BH and drug abuse evaluation services.
- Maintenance of a computerized case management system, used to generate a bail report and bail recommendations for the court prior to an individual's preliminary arraignment in Pittsburgh Municipal Court; more recently expanding to various district courts.

These services have been refined over the last decade and currently serve as a valuable platform for providing verified, comprehensive information to court personnel prior to preliminary arraignments.

Bail investigators work in teams, with one staff member interviewing the arrestee and the other verifying the individual's criminal history and other background information. Data on employment status, home ownership, health and personal life stability, along with the defendant's criminal record, are verified. Inmate interviews are conducted with every defendant brought into the jail on new charges or bench warrants. All investigations are conducted face-to-face and information is entered into a central case management system. This information is used to complete the risk-assessment tool.

Pretrial Services is currently using a locally validated pretrial risk assessment tool in Pittsburgh Municipal Court for all arrestees and bench warrant cases. This tool was locally validated in 2006 and revalidated in 2012. In 2016, Pretrial Services partnered with the Laura and John Arnold Foundation to begin using its nationally validated pretrial risk tool in the district courts for preliminary arraignments that are done in Pretrial Services' offices during normal business hours. Pretrial Services is currently providing pretrial risk assessments for 15 of the 32 district judges with plans to expand to the other 17 over the next year. The two pretrial risk

assessments being utilized provide separate likelihood scores for failure to appear and involvement in new criminal activity for each defendant. The score is then applied to a decision-making framework that makes a release recommendation based on the pretrial risk presented.

Pretrial Services also has a bail supervision unit. Bail supervision staff monitor individuals who have conditions of their bail, including reporting by phone or in person and electronic monitoring. As of December 31, 2017, the Pretrial Supervision Unit was actively supervising 814 defendants through phone-in supervision, 1,371 through in-person reporting supervision and 78 through pretrial electronic monitoring. Staff also review the status of defendants in the jail on unpaid bond only, and determine whether there should be a court filing for a bond modification. In 2017, the Pretrial Services Bail Court Unit advocated for 1,875 bond modifications, a twelve percent decrease over the prior year, and they presented 2,937 bond forfeiture cases in the Court of Common Pleas.

In addition, Pretrial Services has responsibility for coordinating several diversionary programs that can be used by court personnel. These programs can be recommended at different points in court processing, beginning at the preliminary arraignment (for some of the services). These potential services include:

- *Alcohol Highway Safety Program (AHSP):* AHSP is an umbrella program (serving approximately 5,000 individuals annually) that administers all Court Reporting Network (CRN) evaluations (required of all defendants charged with a DUI offense), the DUI Hotel, and PA Department of Transportation-mandated DUI education programs. Pretrial Services AHSP contracts with four local hospital-based treatment programs to provide this latter service. All first- and second-time offenders are ordered to attend a mandatory educational program, with the orientation of the program related to the severity of the offender's alcohol problem. Some offenders may also be sentenced to additional treatment and attendance at Alcoholics Anonymous meetings. In addition, the AHSP operates the Ignition Interlock Program, which requires offenders to have a breathalyzer installed on their vehicle and provide a negative breath sample prior to starting the vehicle.
- *Court Reporting Network (CRN):* This unit of Pretrial Services, under the AHSP, is responsible for evaluating anyone with a DUI conviction or an Accelerated Rehabilitative Disposition (ARD) for a DUI offense (see description of the ARD program below). The information obtained during the CRN evaluation is entered into the Department of Transportation information system and is used for linking county DUI programs into a statewide network. This allows the DUI Coordinator for each county to obtain information to assist in planning and monitoring programs. Anyone with a DUI conviction or an ARD DUI disposition must take a CRN evaluation. In 2017, the CRN Unit completed 4,240 evaluations.
- *Alternative to Jail Program (also referred to as the DUI Hotel):* This program allows first conviction second and third tier DUI offenders to complete their sentence, classes and treatment during a four-day residential program. Participants are sentenced to a local hotel

and receive all court- and state-mandated DUI treatment over an intense, four-day stay. Sessions are divided between DUI classes and group therapy. This programming is facilitated by one of four providers — Western Psychiatric Institute and Clinic (WPIC), Mon-Yough Community Services, Alternatives or Mercy BH. In 2016, 323 individuals completed the program and court personnel estimate that this saved the county the cost of 1,292 jail days.

- *Accelerated Rehabilitative Disposition (ARD)*: The ARD program is a pretrial diversion program that oversees offenders' completion of all court-ordered requirements. The Allegheny County District Attorney has established policies governing the types of crimes that the office will recommend to the court for admission into the ARD program. The District Attorney has the discretion to deny eligibility into the ARD program. Of the 1,954 defendants entering the program in 2017, 1,727(88%) of them were charged with DUI, while the remaining twelve percent (n=227) were charged with various other non-violent offenses. Once participants have fulfilled all court-ordered requirements, the criminal charge is dismissed and the record is expunged from their criminal history. The criminal record is not expunged, however, until all court costs are paid and court-ordered stipulations are met. Approximately ninety percent of cases admitted to ARD result in successful completion of the program and the dismissal and expungement of charges.
- *Behavioral Assessment Unit (BAU)*: The primary function of the BAU is to assist the court in the determination of a defendant's competency to stand trial; i.e., ability to meaningfully assist defense counsel, participate in his/her legal defense and understand the charges against him/her. The BAU Psychiatrist sees defendants who have pending legal matters in the Allegheny County court system and are ordered by a judicial authority to undergo a competency assessment. The BAU psychiatrist makes recommendations to the Court regarding the individual's competency to proceed in the pending court case. Behavioral assessments may also be done to assist in sentencing decisions.

BAU forensic psychiatrists completed approximately 1,270 evaluations in 2017 of which the majority (69%, n=881) were new evaluations. Of those individuals assessed by the BAU, eight percent (n=108) were found by the Court to be incompetent to stand trial and were involuntarily committed to Torrance State Hospital. The BAU also employs social workers who work with the psychiatrists to refer and attempt to connect defendants with appropriate services through DHS and private agencies.

The procedures for conducting competency-to-stand-trial assessments are currently undergoing changes in Allegheny County and throughout the state of Pennsylvania. Because of a lack of resources and oversight statewide, an unacceptably high number of individuals were waiting in jail for long periods to receive either a competency evaluation or treatment to restore competency. The American Civil Liberties Union filed a class action suit on behalf of these individuals, necessitating the state to devise methods for providing competency evaluations and competency restoration services beyond their singular reliance on available state forensic hospital resources. As a result, locales (Allegheny County

included) are currently designing and implementing methods to conduct competency evaluations and restoration services in the community and in the jail setting.

Allegheny County conducts competency assessments within 72 hours of receiving a court order. The delay in having a defendant that is incompetent to stand trial lies in the transfer to the state forensic hospital. In response to these transfer delays, Allegheny County has been working on a plan for the past year to restore competency locally. Funding to implement a jail-based competency restoration program was just secured from the PA Department of Human Services, with an expected start date of January 2019.

- *Programs to reduce failure to appear warrants:* Pretrial Services has established two programs that are aimed at safely clearing an existing failure-to-appear bench warrant and increasing appearance rates at court proceedings. The *Pretrial Safe Surrender Program* allows defendants with active failure-to-appear bench warrants to turn themselves in to Pretrial Services and appear the same day in motions court for a bond reinstatement hearing. The *Court Reminder Notification System* provides defendants messages via email, text or phone calls to remind them of upcoming court events. In 2017, 35,667 reminders were sent for all hearing types including formal arraignment, preliminary hearing, pretrial conference and trial.

Pretrial Services clearly fills an important, and evolving, function in the criminal justice system in Allegheny County. It serves as a conduit of information about the characteristics and processing of cases through the successive stages of early court involvement. In addition, it manages a number of programs to divert people from further court involvement and promote the smooth processing of cases requiring special attention by the courts.

### ***Jail Intake Processes***

The initial assessment of an individual entering the ACJ provides an opportunity to identify and intervene with individuals with BH problems. It is important to recognize, however, that the primary goal of initial jail processing is to document the occurrence of an individual's jail stay, the reasons for the stay and the condition of the individual at the time. At jail intake, the primary concerns are ensuring safety of the jail staff and the arrestee, with background information collected mainly to determine if there are immediate issues that have to be dealt with before the person is sent to a particular unit (e.g., acute medical conditions, intoxication), the most appropriate housing unit for that individual, given their history (e.g., prior victimization), and level of risk to others or self.

A range of law enforcement officers can take a person to the ACJ, including those from PBP, police officers from any of 130 municipalities in the county, parole/probation officers, constables, sheriffs, bail enforcement agents or federal officials. The highest proportion of individuals are transported to the ACJ by PBP officers. Information is collected about the delivering agency and the reason for holding the individual.

The ACJ does systematic data collection and processing, beginning when an arrestee arrives at the *sally port* (the secure, controlled entryway to the jail). At initial entry, a medical examination is conducted by a medical assistant or nurse and a determination is made if an individual requires treatment at a medical facility before being cleared for entrance into the jail. Signs of florid psychosis (e.g., active hallucinations, disorientation), intoxication and suicidal thoughts are assessed.

The arrestee then proceeds through a series of stations that gather information or assess different aspects of the individual's history and current situation. Initial screening is done to identify any urgent health needs, language issues, gender identity, sexual orientation, incarceration history, chronic conditions, current medications/treatments, hospitalizations, general MH substance use and insurance coverage. These determinations are based on the arrestee's self-report. Any necessary consents or access-to-care forms are then presented to the arrestee. Arrestees are also fingerprinted, and their records are checked for any additional legal obligations (e.g., outstanding warrants). Information obtained is provided to Pretrial Services staff on site.

During the initial jail screening, additional efforts are made to see if the arrestee is currently involved with MH services. A diversion specialist from Justice-Related Services (JRS) is present in the intake area Monday through Friday during daylight hours. This individual checks three data bases (eVOLVE, OnBase and CIPS) to see if the arrestee is currently or has been a client of JRS (a service coordination agency operating in the ACJ and courts). If the person is an active client of JRS, the service is notified of his appearance at the ACJ.

A preliminary arraignment is then held within approximately 10 hours. At this stage in processing, a determination is made whether an individual will be released from the jail (e.g., sent to a psychiatric hospital for possible involuntary commitment) or proceed to preliminary hearing. If the outcome of the arraignment hearing indicates a jail admission, the arrestee's information is entered into the Offender Management System (OMS), and he is assigned a Department of Corrections (DOC) identification number. In addition, a booking observation questionnaire is administered by a correctional officer and this information is entered into OMS. The questionnaire consists of 28 "yes/no" questions, some of which ask about suicidal thought, history of self-harm, substance use and hospitalization for "emotional problems."

A more in-depth physical assessment (completed by a registered nurse) and a MH screening is then conducted after booking. The MH screen is meant to identify serious MH needs, deficits in intellectual functioning and/or need for immediate further assessment. The screening is done by a qualified MH professional, usually a MH Specialist. The screening covers a wide range of topics and is used to determine whether an individual should be assessed in greater depth and/or housed on a MH unit in the ACJ.

As part of the current evaluation, we compared the jail screening instrument developed for use in the ACJ to several more commonly-used instruments. The instruments used for comparison were those that received support in the GAINS Center 2015 report on *Screening and*

*Assessment of Co-occurring Disorders in the Justice System* as well as a 2013 systematic review article of MH screening tools for correctional settings (Martin, Colman, Simpson, & McKenzie, 2013). In addition, because of the broad scope of the Allegheny County instrument, we compared it to measures used to assess several specific domains beyond simply MH and substance use. We included screening tools for co-occurring disorders, suicide risk, motivation for change and trauma/PTSD; all areas of concern in the Allegheny County instrument. We limited the comparison tools to those that could be administered by jail staff with minimal MH training (i.e., extensive clinical experience would not be required to administer any of the tools examined). The 15 tools used for comparison are listed in the full report in Appendix A (the summary memo regarding this examination of the MH screen that has been shared with ACJ personnel).

Our overall strategy for this review involved first identifying the general constructs (not specific questions) included in the County screening process. We then examined the comparison tools for those same constructs as well as other constructs not assessed in the ACJ tool. Admittedly, there could be debate as to the definition of specific constructs and question items included. However, the purpose of this exercise was to provide a broad picture of the overlaps of the instruments, not to construct a strict scientific test of comparability. We are comparing the type of content covered in the instruments, not the comparative psychometric quality or clinical utility.

Our review (aspects of which are presented in more detail in Appendix A) led to several conclusions. These are:

- The ACJ screening instrument is comprehensive, covering a major proportion of the content included across a range of other screening tools. There are a wide range of clinical concerns asked about in the screening interview, but this screening instrument is not simply an amalgam of other existing scales. As a result, there are several clinical issues that are covered in other instruments that are not included in the Allegheny County instruments. The table in Appendix A indicates which of the possible areas of inquiry overlap or fail to overlap with the commonly used instruments. No single tool can or should cover every conceivable dimension of potential problems. What areas of clinical concern are most useful for inclusion in the instrument is ultimately a matter of balancing what others have found valuable for analysis of overall population trends and the utility of certain types of information to the clinical providers in the jail.
- The ACJ screening instrument has no scoring system. Many screening instruments allow for a tally of endorsed items and derived subscales. The scores can then be used for identifying cases with extreme or concerning levels of BH problems. This information can then be used to see if higher need cases receive appropriate services or to prioritize individuals for scarce resources. The current system provides a general indicator of the need for a comprehensive assessment or a recommendation for placement on a MH unit.
- There is no centralized, accessible data system for ongoing analysis of the clinical profiles or services provided to incoming arrestees. The collection of comprehensive information on the clinical issues of people entering the jail provides a valuable opportunity for assessing how individuals with BH problems are diverted and/or treated subsequent to this level of

involvement in the criminal justice system. While the introduction of the electronic health record into the jail procedures (approximately a year ago) has been a major advance, the large potential of this system to provide information that could be used for systemic analysis has not been tapped. The capability of the ACJ to produce data sets that can be used for identifying and following individuals with BH issues appear to be nonexistent. Given the lack of psychometric data on the jail screening instrument and the lack of data analytic resources at the ACJ, there is currently no sound method for identifying these individuals in the jail population or following them forward in the criminal justice or service provision process.

### ***Preliminary Arraignment Process***

The preliminary arraignment is the first time that an arrested individual appears before an MDJ or Common Pleas Court judge to determine the charges that will be filed and the possible bail conditions to ensure the appearance of the individual at the subsequent preliminary hearing or Common Pleas Court hearing. If the defendant was arrested without a warrant (for a crime greater than a first- or second-degree misdemeanor), the MDJ will make a determination of probable cause (i.e., a reasonable basis for believing that the suspect committed the alleged crime) based on the specific circumstances of the arrest. If the defendant was arrested pursuant to a warrant, the MDJ will provide the defendant with a copy of the warrant and any of its supporting affidavits.

All preliminary arraignments for criminal cases that occur within in the City of Pittsburgh are held at Arraignment Court (located in the Municipal Courts building, also referred to as Pittsburgh Municipal Court or PMC). Preliminary arraignments for criminal cases that occur outside the City of Pittsburgh are held at either the local Magisterial District Court or at Arraignment Court/PMC, depending upon the circumstances. PMC operates 24 hours a day, 7 days a week, including weekends and holidays. MDJs are assigned to preside over PMC on a rotating basis allowing for continuous coverage. ([https://www.alleghenycourts.us/pmc/arraignment\\_court.aspx](https://www.alleghenycourts.us/pmc/arraignment_court.aspx)). There are currently 48 Magisterial District Courts (inclusive of Pittsburgh Municipal Court) in Allegheny County.

The largest proportion of preliminary arraignment hearings occur at PMC. General practice, until recently, was for an arrestee to appear without defense counsel or a representative of the district attorney's office present. The information and recommendation from Pretrial Services is available to the MDJ to assist in determining the charges to be filed as a result of the arrest and whether a conditional bond can be set, based on the judged likelihood of an individual committing a crime before the next hearing or failing to appear at that hearing.

The preliminary arraignment must occur "without unnecessary delay." To comply with the timing requirements, Pennsylvania law permits the preliminary arraignment to take place over video, so long as there is an audio-visual connection between the defendant and the MDJ. This location is determined by the arresting officer and may fall outside of the boundaries of the MDJ's judicial district.

The MDJ will also schedule the defendant's preliminary hearing during the arraignment. In Allegheny County, the preliminary hearing will be scheduled not later than 14 days (if person in custody) and not later than 21 days (if the person is not in custody) after the preliminary arraignment (Pa.R.Crim.P.5420(g)(1)). The defendant is given oral and written notice of the date, time and location of the hearing, and is notified that an arrest warrant will be issued if he/she does not appear for the preliminary hearing. In addition, bail is also set for the defendant's release at the preliminary arraignment. The defendant will be given the opportunity to post bail, retain counsel and inform others of the arrest. If the defendant does not post bail, he/she will be booked in the ACJ until bail is posted or the preliminary hearing occurs.

This hearing provides the first event after arrest where an individual can be diverted from further processing by the imposition of conditions to promote involvement in treatment or avoidance of certain situations. Several programs and reforms (e.g., the Misdemeanor Justice Project, see <http://misdemeanorjustice.org/our-work/>; reforms promoted by the District Attorney's office in Philadelphia, see Lucas et al., 2017) have been successful in reducing jail populations by limiting the types of charges that will be pursued past this point in processing. Most of these programs summarily release people from jail at the point of preliminary arraignment if the charge is a designated low-level misdemeanor (e.g., marijuana possession). The preliminary arraignment, however, also presents an opportunity for an individual with BH problems to be engaged in services and diverted from further involvement in the criminal justice system. Few programs, however, have used the point of preliminary arraignment hearing for this latter purpose (Heilbrun et al. 2015).

### ***Preliminary Hearings***

After being arraigned or receiving a summons, a defendant will appear before an MDJ for a preliminary hearing. At the conclusion of the preliminary hearing, the MDJ will determine, based upon the evidence, whether a criminal offense has been committed and whether the defendant was the individual who committed it. This is called a *prima facie* case.

The Commonwealth must prove the *prima facie* case by a preponderance of the evidence (i.e., more likely than not). If a *prima facie* case is established, the individual will be held for court. If no *prima facie* case is established, the individual will be discharged. The defendant always has the option of waiving the right to a preliminary hearing. This will result in the criminal charges being held against the defendant as if the MDJ had heard the case and found that the Commonwealth had established its *prima facie* case. If a *prima facie* case is established, the defendant will be held for trial in Common Pleas Court and the court will set bail (if not done at preliminary arraignment), continue an existing bail order, advise the individual of the need to submit to administrative processing (e.g. fingerprinting) and inform him/her of his/her rights regarding future hearings. If setting bail at this stage, MDJs often use the setting of conditions at the preliminary hearing as a method to nudge individuals with BH problems to obtain an assessment or enroll in services. In our interviews with MDJs and others, it was consistently

estimated that this practice occurs in approximately 30-40 percent of cases seen for a preliminary hearing.

### *Preliminary arraignments and preliminary hearings in BH cases*

An innovation related to preliminary arraignment was implemented and evaluated in the Pittsburgh Municipal Court recently, producing promising results. Starting in April 2017, the Public Defender's Office provided counsel at preliminary arraignments taking place at PMC during business hours. No additional resources (financial or otherwise) were provided by the County for this effort. Court and DHS personnel compared the outcomes for cases receiving this representation (through September 2017) to cases handled in the prior six months without this representation.

Analysis showed decreases in the use of money bail and jail bookings, with the effect stronger for black arrestees (DHS, unpublished data, 2018). The observed effects were:

- 19 percent decrease in the use of money bail
- 18 percent decrease in jail bookings at the time of arraignment, with a 21 percent decrease in jail bookings for black defendants compared to a 14 percent decrease for white defendants
- seven percent increase in concurrence with the recommendations from Pretrial Services, including a 15 percent increase in concurrence for Release on Own Recognizance (ROR) for black defendants

These shifts in arraignment outcomes are impressive and expected to endure.

The Public Defender's Office is planning on extending the times of coverage for appearing at the preliminary arraignment in stages over the next year. Data analysis on the impact of this increased representation will be ongoing, including cost estimates of savings in jail bed days. The extension of this practice could hold promise for identifying and intervening earlier to divert individuals with BH problems.

Another analysis, done as part of this evaluation, indicates that those individuals with BH problems may be particularly likely to be affected positively by changes in the procedures for setting bail and bond conditions at the preliminary arraignment. A sample of individuals who appeared at a preliminary hearing in Allegheny County from January 1, 2014 through September 27, 2017 was identified in the court data bases (n = 114,017) and variables about their court processing were pulled. Individual identifying information for these cases was then cross-checked against the service history data bases kept by DHS to determine who in this group had received BH or substance use services in the prior three years. This allowed for an examination of differences between those with and without an indicator of receiving services on several relevant court processing outcomes (i.e., the types of charges filed at the arraignment, bail conditions at arraignment and outcomes from the preliminary hearing).

A sizable proportion of the sample of people coming up for a preliminary hearing at this time had some indication of BH or substance use service involvement. The following proportions of the sample had the listed indicator:

- 33 percent had received MH services
- 24 percent had received drug/alcohol services
- 30 percent had a MH diagnosis
- 24 percent had a drug/alcohol diagnosis
- 21 percent had a prescription for a MH/substance use medication
- three percent had an involuntary (302) commitment

When looking at the entire sample, 41 percent of those coming up for a preliminary hearing met at least one of these criteria. Although it would be preferable to have a more refined, psychometrically sound indicator of BH problems at the point of arrest and preliminary arraignment, one is not readily available currently in the county data bases (as noted above). These prevalence rates, however, are generally congruent with those seen in other locales (Broner et al, 2002-2003).

Analysis indicated several notable differences between the group with a history of receiving services (BH services group; 41%) and those not identified as receiving services (non-BH services group; 56%). First, the profile of charges differed between the two groups. More of those individuals in the group with service histories were charged with felony property offenses (15% vs. 9%) and misdemeanor property offenses (14% vs. 10%). Closure examination of the specific charges in these categories indicates that these differences were overwhelmingly the result of different patterns of retail theft charges. Given that a third retail theft charge is, by statute, a felony regardless of the value of the stolen object, it seems that those with BH are being processed for repeated patterns of this offense. In addition, the rate of being charged with DUI is over three times higher in the group without BH service histories than in those with service histories (15% vs. 4%). This differential probably indicates a difference in level of monetary resources between the groups (i.e., those with BH histories may be less likely to have cars and to drive regularly). It also means that programs targeted at DUI offenses are likely ineffective at reaching individuals with BH problems.

Second, the outcomes of the arraignment hearings and the preliminary hearings follow different patterns in each group. Table 2 shows the most common types of bail condition set at the preliminary arraignment and the most common disposition at the preliminary hearing for each type of case (BH service user or non-BH service user). It is worth noting that decisions to move a case to "traffic/non-traffic" status, thus making it a summary offense, is made by the District Attorney's office.

**Table 2: Most common bail conditions set at preliminary arraignment and disposition at preliminary hearing by crime type\***

	BH/SU Case (n=46,733)		Not BH Case (N=67,284)	
	Most common bail condition at arraignment	Most common disposition at preliminary hearing	Most common bail condition at arraignment	Most common disposition at preliminary hearing
<b>M Drug</b>	ROR (44%)	Moved to traffic/non traffic (51%)	ROR (55%)	Moved to traffic/non traffic (55%)
<b>M Person</b>	Monetary (52%)	Withdrawn/dissmised (52%)	Nonmonetary (46%)	Withdrawn/dissmised (58%)
<b>F Property</b>	Monetary (71%)	Sent to CP (68%)	Monetary (59%)	Sent to CP (63%)
<b>M Property</b>	Monetary (45%)	Moved to traffic/non traffic (39%)	ROR (34%)	Moved to traffic/non traffic (39%)
<b>M Public Order</b>	Monetary (52%)	Moved to traffic/non traffic (50%)	ROR (42%)	Moved to traffic/non traffic (50%)
<b>F Person</b>	Monetary (82%)	Sent to common pleas (59%)	Monetary (73%)	Sent to common pleas (58%)
<b>M DUI</b>	ROR (65%)	Sent to CP (96%)	ROR (77%)	Sent to CP (98%)

\* For the seven most common types of charges

There are two patterns worth noting in this table. *First, the BH cases are much more likely to be given monetary bail across five of the seven crime types.* Even when the most common bail given is monetary for both groups of cases (felony property and felony person), the BH cases are appreciably more likely to receive this condition (71% to 59% for felony property; 82% to 73% for felony person). *Second, the dispositions at the preliminary hearings for each group are essentially identical for each group for each crime type.* These findings indicate that there is little difference in the disposition of the case at the point of the preliminary hearing for a BH case or a non-BH case, but there certainly is at the point of the preliminary arraignment; a BH case is more likely to receive monetary bail conditions.

The regularities observed above are still present even when we examine cases for the most common crime types with the sample limited to cases heard by MDJs who are currently conducting hearings. This analysis was done to see if the patterns seen over the last four years were still likely to be present today. Table 3 indicates the prevalence of cases of each crime type that received a monetary bail condition and the average amount of the monetary bail set at the arraignment. As seen in the table, monetary bail is more common for BH cases and the amount of bail is consistently higher in these cases.

**Table 3: Use of bail for four most common charges by BH status**

	BH/SU Case (N=23,139)		Not a BH case (N=34,432)	
	% cases with monetary bail	Average amount of bail	% cases with monetary bail	Average amount of bail
<b>M Drug</b> (most serious in 14% of these cases)	25	\$13,499	15	\$12,144
<b>M Person</b> (most serious charge in 17% of these cases)	48	\$18,288	28	\$16,821
<b>F Property</b> (most serious in 13% of these cases)	68	\$21,975	54	\$21,054
<b>M Property</b> (most serious in 11% of these cases)	41	\$13,432	28	\$10,653
				15

These two analyses do not provide a detailed picture of the processes underlying the initial decision-making regarding cases with BH problems in Allegheny County. Nonetheless, they do highlight the potential importance of the preliminary arraignment as a point of intervention for diverting individuals from further criminal justice system involvement. Individuals with recent service histories for these problems constitute a sizable proportion of those individuals seen at the preliminary hearing stage and these individuals are being treated differently at their preliminary arraignment. They are more likely to receive higher monetary, rather than nonmonetary, bail, and can thus be assumed to be at greater risk to spend time in jail prior to their preliminary hearing.

### ***Justice-Related Services***

JRS offers a number of services for qualifying individuals with BH problems throughout all levels of the criminal justice system. JRS works in collaboration with the courts, ACJ staff, state hospital and community services providers. JRS staff are active in county and state support services, diversion services, Mental Health Court (MHC), Drug Court and DUI Court. The first point of contact with JRS occurs at Intercept 2 through the JRS Diversion program (see earlier description).

JRS has been an established service within the county service system since 1994. From inception, JRS was tasked with the overall goal to systematically provide “a comprehensive continuum of justice-related services and supports for persons with mental illness and/or co-occurring substance use disorders involved in the criminal justice system.” Currently, JRS is

housed in a contracted agency (Human Services Administration Organization) working with DHS to provide case coordination and management services to individuals with BH problems in the justice system. It works across the DHS Office of Behavioral Health (OBH), the Allegheny County Court of Common Pleas, the Office of the Public Defender, the Office of the District Attorney, the Office of Probation and Parole, ACJ Medical and the DHS Office of Intellectual Disabilities to provide access to services at multiple points in the criminal justice system.

As part of its service, JRS staff can coordinate services for individuals released from the ACJ. JRS staff conduct comprehensive assessments and develop plans for treatment that are then presented at an individual's hearing (preliminary hearing, trial, probation violation hearings). The plan encompasses housing and treatment needs, along with community referrals. The judge must review and approve the service plan. JRS remains open with individuals from 60 days to as long as six months; with cases generally closing at 90 days or upon jail entry. Some cases require extended staff involvement until resources and services (e.g., housing, medical assistance) are in place. JRS staff may also have cases open for a longer time period if the individual is enrolled in MHC, Drug Court, DUI Court or Veteran's Courts (JRS remains involved with these clients for the duration of their time in specialty court). Finally, JRS also provides service coordination for persons with mental illness referred from the Pennsylvania Department of Corrections at the expiration of a maximum prison sentence or an individual eligible for parole after release from a state correctional institution.

JRS involvement with a client can be initiated in several different ways:

- To qualify for JRS services, a potential client must be an adult ( $\geq 18$ ) resident of Allegheny County, have an active pending criminal court case within Allegheny County and/or a pending probation violation within Allegheny County, have a qualifying documented diagnosis of an Axis 1 mental illness or co-occurring substance use disorder and have a qualifying charge (e.g., not homicide). Individuals who meet these criteria are given the option to participate in JRS services; involvement with JRS is totally voluntary. If the individual is involved with a Community Treatment Team (CTT), he/she will not be involved with JRS, since CTT services are considered intensive case management services (and therefore JRS services would be redundant).
- *An individual is identified at jail entry as a current or potential JRS client.* On a daily basis, JRS receives a list of new jail admissions from Pretrial Services and a JRS staff member stationed at the ACJ searches four databases (Onbase, CIPS, Client View and EVOLV) to determine if the newly-admitted person qualifies for JRS services. The JRS staff member will then do a quick assessment and referral. If a new admission does not appear on the list from Pretrial Services, he/she will not be reviewed for JRS services. It is worth noting that the JRS staff member is present at the jail during daylight hours, Monday – Friday. This jail-based position was to end in June 2018 at the close of a Pennsylvania Commission on Crime and Delinquency- (PCCD)-funded pilot project; however, the position has been extended with funding from DHS.

- *Individuals can be referred to JRS Services (diversion, support, MHC) by anyone.* If the person is appropriate based on diagnosis, as well as criminal charges, then the referral is processed and passed to the appropriate unit within JRS.
- *The individual appears for a preliminary hearing and has a history of BH services.* It may become known prior to or during a preliminary hearing that an individual has had a history of service involvement and the MDJ or judge, the individual, an attorney or a family member may request involvement with JRS by submitting a referral.
- *An MDJ or judge may submit a referral.* Through prior contact with this individual or a review of the facts of a case, a judge may submit a referral to JRS Diversion, Support and MHC at any time during court processing.
- *A referral from MHC, DUI Court or Drug Court that has been vetted and accepted by the specialty court teams.* Referrals often come for individuals appearing in specialty courts because of the primary mission of these courts to coordinate care for individuals with BH problems.

Within 24 hours of a referral receipt, JRS will complete a preliminary assessment to establish that the individual will qualify for JRS services. If enrollment criteria are met, the referral is passed to the appropriate unit for monitoring. Within 48 hours of the referral, notification will be sent back to the referral source via emailed letter regarding the outcome of the referral. Referrals are assigned to staff based on court dates. In most instances, JRS staff can complete an assessment and develop a plan for treatment prior to court, as long as they are given sufficient notice.

The need for JRS services is greater than the capacity, and enrollment criteria have been established to keep the case flow to a manageable rate. On any given day, JRS is providing services to over 1,150 people. Tracking and managing service coordination for a group this size is a complicated administrative task, particularly in light of some perceived limitations on information sharing. Also, many of the tasks performed by JRS are tied to court processing (e.g., MH referral completion by next court date, presentation of a service plan at a court hearing) thus target dates for particular tasks are subject to changes in court schedules. JRS staff currently must search court records manually on a daily basis to determine the next court date for each client. Identifying a MH service history and/or past diagnosis requires a review of four distinct databases (Onbase, Client View, CIPS and EVOLV).

In past years, JRS provided input at the preliminary arraignment (pre-booking diversion). This practice stopped about eight years ago for two main reasons: 1) the enrollment rate was low, with only a few cases per month entering their caseloads and 2) a lack of clarity about what agency had responsibility for transportation of individuals to diversion sites. Taken together, these operational issues made continuation of the service problematic and impractical (the cost of a person on duty at all hours exceeded the yield). In addition, at the time, there was not

strong political support for diversion at the early stages of criminal processing. Separate from Pre-Booking Diversion, from 1994 to 2017, JRS had a night-time staff person housed in intake at the ACJ who had the ability to process referrals to JRS, coordinate with arraignment court and provide technical assistance on 302s to the ACJ as needed.

Three things delimit JRS service delivery. First, the service is limited to service coordination. JRS is not a treatment provider, meaning that it does not deliver direct service such as medication or group therapy. JRS's involvement with clients is limited to finding appropriate services, enlisting a client's willingness to engage with these services, and overseeing the client's initial stages of service involvement. JRS has no direct control over the quality, intensity or timeliness of the services provided by community services providers or the availability of appropriate beds for their individuals (drug and alcohol inpatient, MH Residential). Second, JRS has to make sure that clients meet the eligibility of the service providers, which can be involved, requiring considerable documentation and delays in approval of program acceptance. Moreover, the JRS Support Unit has to meet the requirements of a supplemental services program to be reimbursed by Community Care Behavioral Health, the BH managed care agency that reimburses JRS on a fee-for-service basis. One of these requirements is that JRS serve only individuals with an evaluation on file that meets the diagnostic criteria of JRS. Ascertaining the appropriate diagnosis or obtaining one can take a considerable amount of time and effort, slowing down or blocking acceptance into the program and subsequent jail release. Finally, involvement with JRS is voluntary. Justice-involved individuals who do not want to be involved with the service cannot be forced to be so. Individuals refuse JRS services most often due to an expectation that they may remain in jail (longer than without JRS services) to wait for a specific treatment and/or residential program after the disposition of their charges.

Individuals needing a drug and alcohol assessment for inpatient treatment usually must wait for the prospective provider agency to complete the assessment. For example, Pyramid receives the most requests for D&A assessments for individuals at the ACJ and it may take two to three weeks (at a pace of 5-10 assessments per week) to complete this assessment. JRS staff work to have individuals assessed for inpatient treatment prior to court. There can be a delay in assessment based on when the referral is received by JRS, when the court is scheduled and the availability of the provider in the community.

### **Intercept 2: Gaps**

- **Pretrial services has taken the initial steps toward developing and implementing a sound risk assessment instrument, but getting this instrument into widespread use by MDJs is still a formidable challenge.** The development of the Arnold Pretrial Risk Assessment Instrument allows for the use of a recently validated and sophisticated way to assess both risk of criminal involvement and risk of not showing up for a later court appearance. In addition, the production of these risk scores and risk profile has been integrated successfully into the pretrial assessment information available to MDJs in selected locales (including Pittsburgh Municipal Court). However, this development is only part of the challenge; getting this instrument used regularly and relied upon by MDJs at preliminary

arraignments and preliminary hearings is the remaining task. The acceptance of this scale and its integration into everyday practice are essential for systemic change toward more uniform and effective sorting of cases at the front end of the County's criminal justice process.

- **A large amount of relevant information on arrestees is gathered upon entry to the ACJ, but some information is redundant and the data systems are not integrated.** The jail intake process screens arrestees for a variety of issues, and one of them is the presence of BH and/or substance use problems. There is, however, some redundancy in the data collection process (e.g., questions about suicidality). In addition, the information is stored in several different data systems and these systems are not linked together electronically. As a result, the information collected at one point in the intake process cannot be integrated easily with information collected at another point. This creates a burden for jail staff in terms of data entry and retrieval; there is no single source of information to assess an arrestee's BH and/or substance use treatment needs and the potential for conflicting information increases. This also prevents the development of a single metric for monitoring and tracking outcomes for individuals with BH needs. There is no single accepted source of information for determining who has particular intervention needs.
- **The MH screening instrument at the ACJ, while comprehensive, is not a standard measure and therefore has no scaled scores or subscales that can be compared over time.** The BH screening instrument is scored and entered into an arrestee's electronic health record. There is much information collected as part of this screening interview, and the consideration of the information leads to a determination of whether the individual appears to need further assessment and treatment while in the jail. This determination is based on the assessor's weighting of the information obtained, thus introducing potential variability related to individual global judgments about the suitability of possible actions. The use of this instrument in this fashion misses a chance to develop a scaled score that could be used for monitoring the prevalence of consistently-defined BH problems and the outcomes for these cases. There is a need for a consistent case identification system, not just a classification and placement decision tool.
- **There is limited information about individuals' BH problems, their treatment history or possible treatment options available to MDJs at the points of arraignment and preliminary hearing.** MDJs regularly see individuals whom they believe have BH issues, but they feel ill-equipped to assess the severity and impact of these issues on the individual's criminal behavior. They are open to trying to "push" these people to services as part of their court involvement. However, mental health evaluations in the community are often difficult to obtain and expensive, with the cost borne by the offender. These factors often frustrate the efforts of the MDJs. As a result, the MDJs often feel that their only alternative is to send an individual with BH issues to the ACJ for their lack of compliance with the conditions of their bail. This dynamic would seem to contribute to the patterns seen in the data presented above, with little differential processing occurring at preliminary

arraignments or preliminary hearings for people with BH issues and people with BH problems more likely to receive a monetary bail condition at preliminary arraignment.

### **Intercept 2: Opportunities**

- **Pretrial services is a well-established service within the County with a variety of services that can be integrated into a system for pretrial diversion efforts.** Pretrial Services currently operates a range of programs for identifying individuals who might be candidates for diversion. In addition, it oversees programs monitoring adherence to court-mandated conditions. This division of the court might therefore work well as an intact platform for future innovations in this area.

There are two aspects of Pretrial Services that could be assets in future efforts to divert individuals with BH issues. First, staff from Pretrial Services see and interview individuals face-to-face shortly after arrest about a range of topics. They are the only individuals at this early stage of processing who gather a broad domain of information with the explicit intent of determining a reasonable course of future court action. Other court or jail personnel who interact with an individual after arrest have a restricted set of concerns, i.e., the public defender looks for information to build a reasonable argument for release, the jail nurse is primarily concerned with present health issues, the jail entry port staff need information to determine classification and appropriate unit placement. Second, by design, Pretrial Services integrates computerized information from multiple sources. This service has an established infrastructure with methods and protocols for drawing down and combining information from a range of entities, such as criminal justice agencies, social service providers and the courts. Pretrial Services is an existing portal for information that knows what it takes to provide a comprehensive view of an individual in a timely fashion.

- **The presence of a new electronic health record (EHR) and a comprehensive system for assessing BH issues makes such information more complete, consistent and manageable than it had been in previous efforts to increase diversion at the ACJ.** The introduction of the EHR into jail operations has been a notable improvement, providing more consistent information, quicker access to BH information and potential for transfer of that information into practice. This relatively new process has yet to be implemented to its full capacity. It can be a valuable resource for information on treatment or social history for consideration at court hearings and, as such, can become the backbone of collaborative efforts to support the management needs of these individuals. Prior efforts to gather information on recent arrestees faltered partially because of cumbersome processes related to the collection and integration of relevant information.
- **The expanded presence of public defenders at preliminary arraignments at Pittsburgh Municipal Court presents an interested party to introduce BH information into the factors considered by the MDJ.** The expansion of public defender services at preliminary arraignment has increased the concurrence of MDJ's decisions with the recommendations made by pretrial services and has reduced the use of monetary bond. This change in process

could be used as a platform for altering bail determinations for individuals with BH problems. The presence of the public defender at the preliminary arraignment increases the chance that BH information could be introduced and weighed in consideration of possible bond conditions.

- **MDJs see JRS and DHS Resource Specialists as valuable resources at preliminary hearings.** Some MDJs have had DHS Resource Specialists or JRS staff as resources in their courtroom during hearings involving individuals with BH issues, and they almost unanimously report that such input is valuable in their consideration of alternatives. However, it is also generally recognized that having these specially trained people present as an “on call” resource would be expensive and inefficient. The MDJs (and Common Pleas judges) lack adequate training in BH issues and treatment approaches, and access to this knowledge is seen as a way to address some of the most frustrating cases coming before them.

## **Intercept 2: Recommendations**

**2.1 Integrate the ACJ data systems and link them to the DHS computer systems.** The process of identifying individuals with BH problems could be made more efficient by finding and eliminating duplicate questions, data entry and data retrieval operations in the multiple data systems currently operating at the ACJ, particularly at the point of intake. Similar questions about a particular presenting problem (e.g., the presence of suicidal ideation) are asked at several points in initial processing and entered into one of several data systems operating on site. These systems, however, have a limited amount of integration, i.e., there are only a small number of instances where they automatically “talk” to each other to exchange information. This increases the possibility for conflicting information, depending on which system one uses to draw down the data. Thus, these databases should be systematically examined for content and distinct purpose. To the degree possible, redundancies should be eliminated and information merged to facilitate more efficient use and better output. In addition, we recommend that the ACJ hire more skilled personnel to manage and work with the data and/or form partnerships with local universities and/or DHS analytic staff. These changes could potentially enlighten jail management, promote efficiency and inform practices.

Perhaps most important for the purposes of diversion of BH cases, it would be useful if the ACJ data systems had a limited and restricted real time connection to the data at DHS. It could be valuable to explore how to develop methods for conveying the level of BH needs without violating the protections of HIPAA. A live, protected connection with DHS could, at the very least, provide a flag for individuals who have a history of MH or substance use treatment for consideration at the preliminary arraignment hearing. Such a system works effectively for the enhanced pre-arraignment screening unit in New York City (<https://www.vera.org/publications/the-enhanced-pre-arraignment-screening-unit>) and is explained in more detail below (see Recommendation 2.4).

On a related note, the use of an EHR at the ACJ significantly advances the possibilities to more effectively and efficiently manage the criminal justice and BH needs of inmates. It would be

beneficial for DHS personnel involved with the EHR data to track innovative uses of the information in counties throughout the country. Monitoring blogs and attending meetings such as that of the OpenMinds Strategies and Initiatives Institute (<https://strategy.openminds.com/>; <https://www.psychu.org/future-ehr-collaborate-connect-communicate/>) would keep Allegheny County abreast of innovative practices.

**2.2 Allegheny County should expand its assessment of inmate homelessness at jail intake and re-entry.** Individuals without stable housing are a special needs population. These individuals are often “frequent flyers” who cycle in and out of the ACJ and County shelter systems, and MH and substance use disorders are common. Identifying these individuals early will maximize the time that can be devoted to addressing the issue. We recommend that the ACJ add a series of questions to assess housing stability at the time of intake. It has been suggested that this assessment not rely on a single item, but rather multiple questions such as the following (Jones, 2007):

- Where did you live prior to your arrest?
  - Living on the street or some other space not meant for human habitation (e.g., car)
  - Living with others without a lease (family or friends).
  - Living in SRO (single room occupancy).
  - Living in a shelter (emergency, transitional or drop-in center) continuously for four months or used shelter 14 days non-continuously within the last 60 days.
  - Living in an institutional/correctional facility without a permanent address.
  - Was homeless in the past but is now housed and in danger of being evicted.
  - Now housed but in danger of being evicted.

**2.3 Simplify the MH assessment process, devise a system for scoring aspects of the screening and assessment, and keep a database of the codified information.** The development of a uniform and comprehensive MH screening and assessment procedure at intake has been an extremely important and impressive recent development. The challenge for this system now is to serve purposes beyond documenting the presence of a diagnosable disorder, need for medication or likelihood of deterioration under certain conditions in the ACJ; this system may be useful beyond managing the population while they are in the jail. It is certainly critical to determine which in-house unit is most appropriate and which services are important to put into place while the person is in the jail. These issues cannot and should not be downplayed or ignored.

The resources spent screening and conducting BH examinations could be generating information that could also serve broader purposes. Currently the structure of the jail MH screen yields a series of information bits that are not easily translated to a score that is then connected with a set of possible actions (e.g., the assessment score generated by the Pretrial Services risk assessment). There are analytic techniques that can be applied to the jail data to generate a reliable scoring method which could then be used to identify individuals with particular needs and the severity of the need. A single or multiple scores of this sort can

provide information needed to monitor how well the BH and criminal justice system is providing for these individuals. Currently, there is no systematic way to see if individuals with the highest risk of recidivating and the highest MH needs are receiving the most resources, and if those resources are appropriate for the cases that are receiving them. Systematically and consistently identifying risk and need levels is the building block of demonstrated efficient and effective criminal justice/BH service systems (see Stepping Up Initiative framework for targeting resources or Council of State Governments service matrix; <https://stepuptogether.org/wp-content/uploads/2017/11/Stepping-Up-November-9-Webinar-Slides.pdf>, and <https://csgjusticecenter.org/wp-content/uploads/2017/01/Louisiana-Service-Matrix-General-WITH-DEFINITIONS.pdf>). This could start at the level of ACJ entry with some extensions of these recent advances (see Recommendation 4.1).

**2.4 Establish a computerized service to automatically alert JRS and relevant BH providers when an active or recent client has entered the ACJ.** Having a smoothly operating, real time connection of computer systems between the ACJ and DHS would allow for identifying information about arrestees entering the jail to be sent to DHS at time of initial processing. A system at DHS could then search for the status of that individual with BH providers, determining if the individual is an active client or has a recent history of service receipt. Notification of the individual's entry into the ACJ would then automatically be sent out to the identified providers and a file for logging actions taken by the provider would be created. By contract, service providers could be required to respond with certain actions within a given time period with specified actions (e.g., contacting the individual within a specified time period, contacting identified family members or agencies). The actions taken would be logged by the service provider, indicating the timing and outcome of whatever efforts were undertaken.

This is not a totally new or untested approach. There is currently a JRS staff person at the ACJ during daylight hours Monday through Friday, reviewing social service records of arrestees entering the jail and contacting JRS staff when a current or former client enters the jail (see above description of JRS). The manual searching of multiple data bases and personal contacting of staff is a labor-intensive task, however, and the proposed system would expand and automate this effort. In addition, such a system has been sustained and effective in other sites. For example, Maricopa County (Phoenix, Arizona) has had an automatic notification and service tracking system in place at its jail for over a decade (their "You've got Jail" system) and reports increases in service connections for identified arrestees.

An automated system like the one proposed has several advantages. First, it increases the likelihood that an arrestee with a BH problem will be contacted by JRS or a provider known to them within a reasonably early stage in their jail stay (a current gap as noted at Intercept 3). Such contact should promote early planning for release or coordination with the Courts to provide achievable conditions for release. Second, it widens the net of providers who have a responsibility to respond to an individual being in jail. Service providers would not be in the position of only finding out about a jail stay after the person returns to their agency after an unexplained 60-day absence. Finally, such a system would provide a method to promote accountability for service providers. One of the persistent issues facing individuals trying to

coordinate services for arrestees in jail or being released from jail is the slow response, or lack of response, from some previous providers about approval of continued or new program involvement (a gap noted at Intercept 4). An automated system like the one proposed would move those discussions up further in the individual's jail stay. Moreover, tracking of service provider response would provide data that could be used by DHS in ongoing monitoring efforts and future contract discussions.

### **2.5 Increase the likelihood of conditional bond being used at arraignment and preliminary hearings by identifying BH cases for which alternative plans may be appropriate and feasible.**

If accurate and timely information about an arrestee's BH status and treatment history can be accessed, it can play a part in determining appropriate conditions in which involvement in treatment can be imposed in lieu of being held in jail after an arraignment or preliminary hearing. As reported earlier, identification of the types of BH issue and the best approach to take with it are judgments that MDJs struggle with regularly, often feeling ill-equipped to make these judgements. Resources and changes in presumed practices are required to make this process function more effectively. There are several practices that have to be in place in order to allow MDJs to make informed and confident diversionary decisions.

First, as noted above, information about the type of BH problem and prior treatment history must be available prior to the hearing and there must be a conduit for its introduction at the hearing. Assuming that an effective computerized link can be established between DHS and the Pittsburgh Municipal Court and regional MDJ offices, a simple identifier check could be run with DHS prior to the hearing to see just if the person has a BH record. If the individual does, the public defender (who is projected to be at more arraignment and preliminary hearings in the future) can approach the client for consent to see the details of the record and to use it in the formulation of a proposed set of conditions to present to the Court. The public defender may also want to obtain consultation with an MH professional prior to the hearing (see recommendation #6 below).

Second, the MDJ must have some assurance that the district attorney's office would be agreeable to the granting of a conditional bond requiring treatment involvement. Unfortunately, the representatives of the district attorney's office do not regularly attend arraignment hearings but do attend much more regularly at preliminary hearings. In order to clarify the viewpoint of the district attorney's office on the practice of diverting individuals with BH problems at these points in the criminal process, a set of criteria could be provided to the justices to indicate when this practice would be acceptable. This statement would be most useful if it were stated as a presumption of the acceptability of a conditional bond including treatment in the absence of an assistant district attorney at the hearing. It would seem to be a reasonable policy for the district attorney's office to define the category of cases meeting this presumption. Specifically, they would be those with a documented history of a BH problem, a low risk score for recidivism and for missing the next hearing (as indicated by the pretrial assessment screening instrument), a misdemeanor or felony retail theft charge (a charge disproportionately represented in cases with BH histories), and no personal victim. The provision

of guidelines by the district attorney's office would keep the MDJ from having to infer what that office's judgment might be and thus avoid the risk associated with any conditional release.

Third, there must be an enforcement mechanism to ensure attendance at assessment or treatment sessions. Some individuals will agree to a conditional bond at a hearing, and then ignore its conditions once the threat of jail is removed. This situation is faced regularly by other pretrial programs (e.g., Accelerated Rehabilitative Disposition, Court Reporting Network) and these programs provide experience in making this diversion strategy work successfully. The District Attorney's office has to be willing to hold charges in abeyance at the point of arraignment, with the option to file the charges at a later date. There has to be a person assigned to check on the individual's compliance with the court order in a short time period after diversion, enforcing the return to jail if the conditions are not met, as done in other pretrial programs.

**2.6 Expand the role of the probation Day Reporting Centers/Community Resource Centers (DRCs/CRCs) to provide services to individuals on conditional bond.** Effective enforcement of court conditions is only part of what is needed to make the proposed system of early diversion work. There must also be service providers who are accessible, have appropriate skills, and can refer to needed ancillary services readily and successfully. The likelihood of a person complying with the need to take part in assessment or treatment, and their attitude about those services, rests partially on the convenience and appropriateness of the mandated services.

An expansion of the types of services offered at DRCs/CRCs to include assessment and services for BH cases on conditional bonds could provide the needed types of services to support this diversion approach. These centers already have many of the services that might be needed (e.g., substance use programs), and they would provide access to offices for other services in the same building. There are certainly operational hurdles to address to achieve this goal (e.g. working through the PA Department of Drug and Alcohol Program legalities for providing services on site, concerns about the probation department's ability of enforce building and/or program rules, inclusion of pre-trial services personnel onsite). These challenges notwithstanding, the location of the DRCs/CRCs in high-utilization communities creates a promising possibility for expansion into the broader role. The utility of these centers as a resource is touched upon again in the section on Sequential Intercept #5.

One expansion of services that could be particularly valuable for these centers is to integrate forensic peer support services into their operations. Forensic peer support specialists have a unique perspective that they can share constructively with individuals with BH problems in the midst of their criminal justice involvement. One of the major goals of service providers at this early stage of criminal justice system involvement is to promote engagement with services. Forensic peer support specialists can be a valuable resource for the flexibility and empathy needed to promote that process.

**2.7 Use telepsychiatry to provide assessment and consultation at arraignments and preliminary hearings.** As noted earlier, MDJs often feel at a loss regarding how to think about

and plan for the range of BH problems that confront them. Although having MH professionals assist in the courtroom is often valuable, it is simply too costly and inefficient to have these professionals regularly staffing the large number of courtrooms throughout the County. Having these staff more intensively involved with specialty courts is a better use of a limited resource.

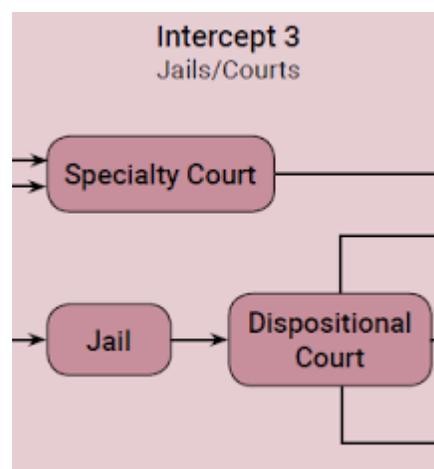
Telepsychiatry (or tele-“MH professional”) is an attractive option to provide the needed assessment and consultation services. Having a centralized location where a BH professional can respond when needed can ensure that this resource will be accessed more broadly across the County and across times of day or night when arraignments or hearings may be held. Also, there is considerable (and growing) research indicating the effectiveness of such services for professional consultation as well as interventions with clients (some of this is covered in the section on Sequential Intercept #4). Giving access to such a service to MDJs could help make these justices more comfortable in formulating conditional bonds and better educated about the nuances of BH services.

Based on the skeptical reactions of participants in our two workshops, though, the introduction of this technology into courtroom practice will require careful staging in order to be successful. Criminal justice professionals in general appear to place great stock in a person’s nonverbal presentation in assessing the likely success of possible actions. This is not unique to criminal justice professionals, however, and these issues have been addressed systematically in other applications. Resources devoted to introductory education and experiential exercises would be well spent if the goal is widespread use and acceptance.

### **Sequential Intercept 3 – Jails/Courts**

#### **Intercept 3: Overview**

Intercept 3 covers the criminal justice system processes after the determination that a case will be held for trial. This is a point in criminal justice case processing where case disposition by the Court can be directly tied to involvement with treatment services (using such strategies as specialty courts). In addition, there is potential for reduction in the duration of a jail stay if appropriate BH plans can be formulated. It is also a point in processing, however, where the seriousness of the charges may give the Court pause regarding its ability to effectively monitor an individual in the community.



#### **Intercept 3: Allegheny County Processes**

At Intercept #3, individuals with BH issues face the possibility of involvement with multiple court hearings. In this section of the report, therefore, we briefly describe the court processing

system past the preliminary arraignment/hearing. There are several opportunities for diversion along the way.

### ***Court Processing***

In Allegheny County, if a case advances to a trial, it will proceed to the Court of Common Pleas, Criminal Division (see <http://alleghenycountyda.us/criminal-procedure/>). The stages of case processing at this point are described briefly below.

- ***Criminal Information Filed***  
The MDJ will send notice to the Department of Court Records, which notifies the District Attorney of the charges that were held for court. The District Attorney's Office will then file a formal charging document, which lists the counts and offenses charged against the defendant. At this stage, the District Attorney can terminate the prosecution or add or delete charges.
- ***Formal Arraignment***  
This proceeding will usually occur without the presence of the District Attorney or Judge. The defendant is provided with information about the charges and advised of his/her rights. Pretrial motions might then be filed, and the District Attorney's Office must respond to these. In addition, the defendant is given notice to appear for the pretrial conference.
- ***Pretrial Conference***  
Generally, the defendant and his or her lawyer and an Assistant District Attorney will appear before the assigned Judge and a trial date will be set. At this time, the defendant will plead guilty or proceed to trial.
- ***Guilty Plea, Jury Trial, Non-Jury Trial***  
A defendant may waive the right to a trial and enter a guilty or *nolo contendere* plea. A defendant entering a plea of not guilty may choose to be tried by a jury or by the Judge alone. At trial, the defendant's guilt must be established beyond a reasonable doubt. If a defendant is found not guilty, he or she will be immediately discharged. If found guilty, the defendant may be sentenced immediately or sentencing may be deferred pending a pre-sentence investigation into the defendant's background. If a defendant elects to plead guilty, a plea date will be scheduled, when it will be determined that the defendant is knowingly and voluntarily entering a plea of guilty to the charge(s). Once the Judge accepts the plea, the defendant may be sentenced immediately or sentencing may be deferred pending a pre-sentence investigation into the defendant's background
- ***Pre-sentence Investigation and Report***  
The Probation Department prepares a report for the Judge summarizing the crime and the defendant's personal and criminal backgrounds. Generally, in cases involving a victim, the victim is asked to make an impact statement.
- ***Sentencing***  
Sentences are largely at the Judge's discretion. However, there are a number of mandatory minimum sentences that must be imposed if a defendant is convicted of a specified crime. At sentencing, the Judge will consider the pre-sentence report, any additional relevant evidence presented and any victim impact statement(s). The Judge will also consult the

sentencing guidelines and facts surrounding the commission of the crime and the defendant's criminal background. Sentences can include alternatives to confinement, including a fine, probation, restitution, community service, alternative housing, house arrest, electronic monitoring or work release.

There are additional legal processes related to appeal and post-conviction relief, but these are not directly relevant to consider as systemic issues with potential for increasing appropriate diversion for individuals with BH problems.

Obviously, moving through the many phases of court processing can take an extended period of time, depending on the specifics of the case and the individual charged. Over the past several years, the fourteen Judges in the Criminal Division have worked with Court administration to reduce the time from filing to disposition. The average time to disposition has decreased from a median of 261 days in 2010 to 173 days at the close of 2016.

### ***Specialty Courts in Allegheny County***

Cases with BH issues can be identified and possibly diverted to a number of specialty courts in Allegheny County. Some of these courts are charge-driven and others are diagnosis-driven. Each offender entering a specialty court is screened and discussed with the applicable court personnel to verify eligibility. Importantly, victims must agree to the offender's participation in a specialty court and the DA retains the final "say" as to who is ultimately accepted into the specialty court (the DA retains "veto" power over court admission). The seven specialty criminal courts are: 1) Mental Health Court (MHC), 2) Drug Court, 3) Veteran's Court, 4) Domestic Violence Court, 5) Program for the Re-Integration, Development and Empowerment (PRIDE) Court, 6) Driving Under the Influence (DUI) Court and 7) Sex Offender Court . Additional information is provided below for each specialty court. We also include a note in this section about "Phoenix court," an expedited docket available in Allegheny County (and not technically a specialty court).

It is important to note that all the specialty criminal courts above operate post-plea—meaning that only people who have pled guilty to the charges brought against them are eligible for processing by that court. If specialty court participants fail to fulfill their requirements, they will be required to serve the sentence attached to the crimes to which they have pled guilty upon entry to the court. In addition, the conviction remains on their criminal record, even if they do complete court involvement successfully. As such, these courts serve largely as a structured alternative to jail, rather than as strictly defined diversion courts (exclusive of Drug and DUI court which can serve as a diversion from state prison).

While Allegheny County Court of Common Pleas is not unique in this regard, not all specialty courts operate with these conditions. The District Attorney's office in the Seattle Municipal MHC, for instance, offers different case resolution options depending on the circumstances surrounding the charges (see recommendation 3.1 for more details).

### ***Mental Health Court***

Allegheny County MHC represents a partnership between the District Attorney's Office, the Public Defender's Office, DHS-JRS and Adult Probation. Judge Lazzara presides over MHC. This court provides intensive supervision and treatment for individuals with substance use and MH issues, using a team approach.

The MHC "serves to ensure the maintenance of or increase in MH and substance use treatment in order to reduce the likelihood of criminal recidivism and to improve both MHC participant and community safety." The MHC is open to adult residents of Allegheny County with mental illnesses who have pled guilty (or were convicted by non-jury trial) to one or more misdemeanors or non-violent felonies in the county. About 95 percent of MHC participants in Allegheny County have both a MH and substance use disorder (personal communication, D. Barnisin-Lange)

Whereas anyone can refer an individual to MHC, in order to qualify for supervision by this court the defendant must have a current (i.e., within the past twelve months), documented, qualifying MH Axis 1 diagnosis (not Axis 2). Upon referral, JRS meets with and assesses defendants to learn about their background and history of BH issues. If the referred defendant consents to participate, the application is vetted by JRS and discussed in a weekly meeting among the District Attorney, the public defender, the JRS service coordinator(s) and probation officer(s). At that meeting the team comes to a consensus about the appropriateness of the case for MH court. This group rejects cases if: 1) the person doesn't meet the possible sentencing protocol (i.e., could qualify to be sentenced to probation); 2) the person isn't willing to participate; or 3) defense counsel objects because court participation would result in appreciably longer supervision than would result from standard court processing. The District Attorney has absolute discretion in accepting MHC referrals and, therefore, each MHC participant must receive the approval of the District Attorney.

Involvement with MHC means involvement with treatment conditions. When an individual agrees to participate in MHC, he/she agrees to accept mandatory community-based BH treatment. Participants must submit to regular drug testing and must follow-through with all components of their individual service plan, including taking all prescribed medications. Refusal to be involved with treatment results in standard court processing.

MHC has five or six probation workers and an administrator, all with specialized training, whose caseloads consist of individuals coming before the MHC. There are also three JRS workers and a JRS manager who work exclusively with the MHC. If a person is on the MHC docket, JRS is involved for the entire length of court supervision.

The progress of MHC participants is monitored closely. Progress meetings regarding MHC participants occur weekly, involving the MHC district attorney, the MHC public defender, the MHC JRS service coordinators, the MHC probation officers and the MHC Judge. Participants are present before the MHC Judge at least four times per year during which their progress is

labelled positive, negative or neutral. The in-court reviews occur once every 30 days and gradually become less frequent (i.e., once every 60, 90 and 120 days). If a negative review is given, participants will have more frequent reviews, which can be as often as twice per week. The typical minimum sentence for an individual in MHC is two years of probation supervision (see Barnisin-Lange & Van Keuren, 2011).

Given this intense level of involvement and resource commitment, the reach of the MHC is necessarily limited. Consider that there are approximately 2,400 individuals in the ACJ on any given day and that approximately 12 percent of these individuals, or 288, have a serious BH issue (using prevalence estimates from Steadman, et al, 2014). Also consider that the ACJ processes approximately 15,000 individuals a year and, using the same prevalence estimate, this means that about 1,800 of these stays involve an individual with a serious BH problem. These figures indicate a potential pool of over 1,000 people who might be eligible for MHC. Yet our conversations with County stakeholders indicate that on any given day (in early 2018) there were about 160 people involved with MHC. MHC thus provides alternative court processing to a small proportion of individuals coming before the court with significant BH needs.

Whether MHC serves those individuals who are most likely to benefit from this type of Court involvement is an open question. It is difficult to know exactly which cases with BH problems get to MHC and which do not. It is clear that offenders with particular types of offenses are not going to be included in the MHC docket. For example, most sex offenders and those charged with serious violent offenses are excluded from participation. Individuals with active symptoms and service histories would seem to be more likely to be referred and accepted to MHC; these individuals are more likely to be noticed and referred. An undiagnosed individual who commits a crime but has less clear symptoms or history (e.g., during an unrecognized manic episode), probably has a lower chance of being referred to MHC.

There is some limited evidence that MHC has a positive impact. The recidivism rate for MHC participants three years after their graduation was 17 percent, compared to 52 percent of the population at the ACJ. However, it is difficult to ascertain how much of this difference is attributable to the selectivity of the cases on the docket, compared to the impact of court involvement. In addition, the RAND Corporation (2007) used administrative data to study the fiscal impact of costs for MHC participants as compared to those with typical supervision. In the course of this evaluation, they found that entry into MHC increased the use of MH treatment services in the first year as well as a decrease in jail time for participants without substantial short-term incremental costs over status quo processing. In their view, the decrease in jail expenditures mostly offset the cost of increased MH treatment.

### ***Veteran's Court***

Allegheny County was one of the first in Pennsylvania to institute a specialty veteran's court. The Veterans' Court (VC) was established in 2009 to identify and serve "offenders who currently serve in the military or who have been discharged from military service but have a documented Axis I MH diagnosis, served in combat, or have substance abuse issues." Similar to

MHC, the VC is available to adult veteran residents of Allegheny County who have been charged with a misdemeanor or non-violent felony. It offers community-based MH treatment instead of jail time.

A 2015 article (Santoni, 2015) indicates that 180 individuals entered the VC program between 2009 and November 2015, with 100 completing the program. Participants are referred to the VC and must plead guilty or be found guilty by bench trial before being accepted into this specialty court. Eligible defendants must consent to be involved in the court, and if a victim is involved, that person must consent to the veteran's participation in the VC. The district attorney has absolute discretion regarding entry into the VC.

VC participants are paired with peer mentors and probation officers who encourage and monitor their progress throughout the program. VC participants are expected to stay in regular contact with these individuals as well as with their JRS service coordinator. An individualized treatment plan must be followed, all prescribed medications must be taken, and appearances for appointments and court dates are monitored. Participants also appear regularly before the VC Judge, currently Judge Zottola, and progress is reviewed and rated as negative, neutral or positive.

VC involvement is divided into three phases: Honor, Courage and Commitment. Each phase must be successfully completed in order to be eligible for graduation from the court. Successful completion rests on the participant's demonstration of insight about each of the phases' meanings and goals. Early termination of the participant's supervision and sentence can be achieved through successful completion of the phases. Santoni (2015) reports a two percent recidivism rate for graduates of the Allegheny County VC, but the time frame for the outcome is not clear.

### ***Domestic Violence Court***

The Allegheny County Court established the Domestic Violence Court to manage repeat domestic violence offenders. Defendants who are processed through the DV Court are under heightened supervision and involvement in programs for batterers. Specialists in the District Attorney's office handle these prosecutions.

### ***Program for the Re-Integration, Development and Empowerment (PRIDE) Court***

The Program for the Re-Integration, Development and Empowerment (PRIDE) Court is designed as a treatment alternative to jail for those convicted of prostitution charges. These individuals are given a probation sentence. People with accompanying violent offenses are, generally, ineligible for participation in PRIDE Court, and the district attorney's office has to approve entry into the program. Also, eligible individuals must consent to participation in the program.

Offenders in the program must submit to random drug and alcohol tests, participate in weekly Post-Traumatic Stress Disorder (PTSD) meetings, and abide by an 8:00pm to 8:00am curfew.

Programming is also provided regarding the skills needed to live free of substance abuse, sexual exploitation and violence. PRIDE Court participants are also able to receive psychiatric services, if necessary.

To graduate from PRIDE Court, participants must successfully complete drug and alcohol treatment, attend weekly programs (on topics such as parenting, housing, nutrition, healthy relationships and fact vs. fiction: prostitution), and engage in PRIDE's employment and education services. Participants must attend regular PRIDE Court review hearings where sanctions can be given for failure to comply with the program's expectations. These sanctions include three, ten, 20 or 30 days in jail depending on how many prior rule violations the participant has.

The use of PRIDE Court in the county is unclear. Reports from some individuals interviewed indicated that the PRIDE Court model was originally designed in conjunction with the Pittsburgh Bureau of Police but has not been used by the police as it was intended. These reports suggest that this court has evolved into an Adult Probation program that is directed by the PRIDE Court service provider. Other reports indicate that it is in full operation. Official reports do not indicate the number of cases processed annually in this court or evidence of its effectiveness.

### ***Driving Under the Influence (DUI) Court***

DUI Court is a program for offenders with two or more DUI convictions within ten years. Entry into the program begins with identification by the District Attorney or a recommendation by the defense attorney. If selected, the offender is given a drug and alcohol evaluation and a treatment plan is developed.

Program participants receive an alternative sentence. Instead of being sentenced to serve a state prison term, participants are given a restrictive intermediate punishment (i.e., drug and alcohol treatment) lasting 18 months, followed by a five-year period of probation. Attendance at Alcoholics Anonymous or Narcotics Anonymous meetings are required along with 40 hours of community service. Finally, participants must hold a full-time job throughout their participation in the program, agree to sobriety monitoring and follow the treatment plan established by the DUI Court specialist.

DUI Court uses a five-step program, and each step must be completed before entering the subsequent phase. Progress hearings are held in DUI Court. If positive progress is made, the DUI Court judge may reduce the participant's sentence; if the participant regresses, the judge may impose temporary incarceration, community service hours or additional restrictions on house arrest. If the offender does not complete DUI Court successfully, the mandatory sentence for the charges is imposed.

### ***Drug Court***

Allegheny County's Drug Court (DC) is designed for individuals who have multiple prior convictions and are facing a potential sentence of at least twelve months incarceration under the PA Sentencing Guidelines (see <http://www.pbpp.pa.gov/About%20PBPP/Documents/County%20PP%20Programs%20and%20Services/02-%20ALLEGHENY%20COUNTY.pdf>). Potential participants must display an apparent need for substance abuse treatment to be sentenced to participate. On average, participants are sentenced to 23 months of DC involvement.

The program requires participants to attend drug and alcohol treatment and have electronic monitoring. Additionally, participants must attend Alcoholics Anonymous or Narcotics Anonymous meetings and either attend school or find employment. The offenders attend monthly progress hearings in the DC to review their recent successes and failures. If a participant fails out of DC, he/she is given the traditional sentence for the crimes already pled guilty to.

The Allegheny County DC is different from almost all other drug courts in that the participants are required to be abstinent from all drugs, including Suboxone and Methadone. Judge Nauhaus, the current DC Judge, views medication-assisted treatment as the use of "chemical crutch[es]." This is contrary to the recommendations of federal government agencies and the National Association of Drug Court Professionals, thus limiting the outside support that can be used for this court.

DC participants recidivate at nine percent in the first year following their graduation from the program. Again, however, it is unclear how much of this low rate is the product of strict case selection or involvement with the court's programs.

### ***Sex Offender Court***

The Sex Offender Court (SOC) promotes the use of effective, evidence-based practices to supervise sexual offenders whose crimes would require Megan's Law registration. Participants can avoid jail time and be sentenced instead to attend treatment, follow all Sex Offender Registration and Notification Act (SORNA) registration requirements, and attend regular SOC reviews. Offenders are assigned a probation officer trained in sexual offender management who aids in ensuring participants' compliance with the conditions of their supervision. All offenders have specialized conditions, tailored to their individual circumstances. These conditions include mandatory sex offender treatment, no contact with minors and no alcohol use. Treatment providers and probation officers are in regular communication, which includes discussing polygraph results, treatment goals and how well the offender's goals are being met. Judicial reviews occur monthly; two SOC judges discuss the program, supervision and issues that the offender is facing.

Each of the specialty courts described above have certain features in common. As mentioned earlier, these courts all require an individual to plead guilty to the offense(s) charged. Court involvement, therefore, provides an entry into services, but it does not avoid the long-term consequences of a recorded conviction. Also, in general, the courts determine whether a participant has successfully completed requirements for release from supervision on an individualized, case-by-case basis. As a result, compliance with the court can produce variability in the treatment requirements, severity of sanctions, and length of court involvement. In short, there is a heavy reliance on the discretion of the treatment team regarding both admission and acceptable program completion.

A more general caution about specialty courts in any locale (Allegheny County and beyond), is their focus on a particular BH problem or criminal offense. There is an implicit judgment that the identified problem (e.g., drug use) or type of offense (e.g., sexual offense) is the primary issue that must be addressed to keep this individual from future offending. This logic is certainly limited, since most offenders present with a range of factors that contribute to their offending and many problems co-exist in an individual's life (e.g., MH and substance use issues). It is often a challenge for court and service personnel to determine which risk factor is most salient, and the impact of any therapeutic jurisprudence efforts by the court may be limited by being solely focused on the criteria that determined court involvement.

### ***Phoenix Court***

The Phoenix Docket (also known as the Phoenix Court) is a case management process to expedite “a defined list of criminal charges—primarily Driving Under the Influence (DUI) cases with no accident or personal injury, drug-related offenses with no mandatory penalty, and other non-violent misdemeanor cases.” Once identified, Phoenix cases are processed differently from other cases, beginning at the preliminary hearing. Generally, at the preliminary hearing, an MDJ makes a determination that the defendant is more likely than not the person who committed the accused acts. Then, at the formal arraignment, in addition to formally presenting the charges against the defendant, the judge will also provide the defendant with the discovery packet, sentencing guidelines for the charges, and the District Attorney's plea offer. In four weeks, the defendant will return and either accept the plea offer or request a trial on the matter. This court thus avoids using court resources on cases that can be readily diverted from the court's docket with alternative dispositions, rather than identifying individualized BH services for an individual. Individuals participating in Phoenix Court are supervised by probation staff with no dedicated court team or specialized supports as are offered in the seven specialty courts described above.

### **ACJ**

In this section of the report, we summarize current practices in the ACJ for the management of individuals who screen positive for a BH problem during the ACJ's health services screening process. The information was gathered from interviews with jail personnel and from a 2014 document, *Data Brief: Behavioral Health Services in the Allegheny County Jail*, published by

DHS. Jail personnel confirmed the accuracy of the 2014 data brief but indicated that they are currently making changes to their procedures. All new procedures, therefore, may not be reflected here.

ACJ data indicate there were 14,797 jail admits between January and December 2017. These individuals were

- predominantly male (77.8%) and either white (n=7,079; 47.9%) or black (n=7,373, 49.9%) with less than three percent of admissions of individuals of some other race
- fewer than half (44%) are admitted for a new arrest (22%) or an arrest warrant (22%), according to the classification in the OMS system; the remaining admissions were for a variety of reasons (e.g. failure to appear, probation detainer related to a new charge)
- the majority (82%) have been committed by either an MDJ (49%) or Criminal court (33%) (personal communication, T. Cassisi, 4/9/18)

The ACJ's screening process was presented in some detail in the earlier section of this report regarding Sequential Intercept #2. There is no need to repeat this information here, other than to note that there have been marked improvements over the last year in identifying individuals with BH problems. There are, however, clear ways to improve this process that are presented in the earlier section of the report. The current system of assessment at the initial stages of jail processing are focused on problem identification, assignment to an appropriate living situation and contact with services while at the jail, rather than on opportunities for diversion.

### ***Assignment to Units within the Jail***

As of January 2018, the ACJ employed two full-time psychiatrists and three master-level MH professionals. These individuals are central to the process of managing individuals with BH problems who are on the jail units, determining the type and intensity of care that these inmates will receive during their jail stay. If an individual screens positive for a BH problem in the health services area, several alternative actions to manage the individual may be taken, depending on the issues presented.

- If detox is needed, individuals will go to the medical unit or be sent out of the ACJ for detox services until they are medically stable enough to be admitted. If individuals are unsafe in the general population but do not need detox, they are sent to unit 5D or 5F. These units have 24-hour coverage by an RN and daily accessibility to a psychiatric consultation.
- If the person is safe in general population and does not need detox, he/she is sent to 4A (males), 4B (males) or 4D (females). If an individual needs medication for support for a non-acute BH problem, a psychiatrist is available to do a medication check. Two registered nurses are also available to see individuals if they request a sick call for medication problems. Master's level social workers are available to provide informal support, and individuals can participate in voluntary classes regarding drug and alcohol issues or MH wellness issues.

- If medication or support for a non-acute BH problem are not needed, the person may be eligible for alternative housing. The provider completes an intake assessment, arranges for medication management (from a community psychiatrist or through the jail medical staff), provides a combination of individual and group therapy and classes, arranges for services if not provided by house staff, and facilitates transition to less intense and more community-based treatment/aftercare.
- If an inmate's BH problem is not acute but requires medication and/or support, he/she may be eligible for specialized programs/pods. Women may go to the Hope Program for Women (on 4E), with drug and alcohol, education, MH wellness classes and an aftercare meeting with a social worker one month prior to release. For men, this can be the Hope Program for Men (on 2C), unit 5E which has an unlicensed drug and alcohol program, or to 5MC for a licensed outpatient drug and alcohol program. After completing the 5MC program, men can return to jail unit 5E or 1B, possibly with outpatient treatment from Renewal. They may also go to alternative housing (e.g., a transfer to the Pyramid halfway or three-quarter-way program, or be released with outpatient group sessions at the Allegheny County Health Department).

### ***Alternative Housing***

On a weekly basis, ACJ personnel review the criminal history of all individuals entering the ACJ to determine eligibility for community-based alternative housing. A request for a review for alternative housing eligibility may be made by the Court, an attorney or an inmate. The only cases excluded from this review are those for which the judge states that alternative housing is not an option. Alternative housing is reserved for inmates who meet a set of criteria developed by the warden of the ACJ regarding the level of threat to public safety (e.g., no aggravated assault or robbery in the prior five years). In addition, jail personnel coordinate with Pretrial Services, using the pretrial risk assessment to assess the wisdom of transferring an inmate from a bond to alternative housing. Approximately 65 percent of cases reviewed are deemed eligible for alternative housing,

The ACJ contracts with three providers for alternative housing: Renewal, Inc., The Program for Offenders and Goodwill. Individuals are assessed for drug, alcohol, medical and MH issues and placed into the housing alternative that meets their identified needs. Each of these programs has a slightly different capacity and orientation. Relevant points about each one are provided below:

- Renewal, Inc.
  - capacity to house 30 women and 150 men, with separate facilities by gender
  - can provide substance use treatment (has an appropriate license)
  - has both an inpatient and outpatient substance use program
  - provides inpatient and outpatient MH treatment, and educational, vocational, recreation and employment programming
  - medication management provided by a staff or consulting psychiatrist.
- The Program for Offenders

- capacity to house 56 women and 50 men (The West Homestead Center/WHC is the woman's facility and Allegheny County Treatment Alternative/ACTA is for men)
- can provide substance use treatment (appropriate license)
- ACTA has drug and alcohol treatment and MH treatment through a collaborative arrangement with UPMC Mercy
- Goodwill
  - capacity to house 49 men
  - supported by Pyramid Health Care
  - outpatient group services provided
  - medication management provided through staff or consulting psychiatrist
  - clients are referred to community-based services (e.g., 12 step program) upon discharge
  - Pyramid Health Care also supports a partial hospitalization program, a halfway house and a three-quarter-way house
  - Pyramid Agencies providing alternative housing also sometimes provide step-down services for individuals who do not have BH problems, have completed the re-entry program (described later in this section) and have not yet been released.

Expanding the criteria for the assignment of alternative housing to target individuals with BH problems would have a sizeable impact and be cost-effective. Let us walk through our logic for this statement.

Summing up all the available beds for these three programs indicates that there are potentially 335 beds available for alternative housing on any given day. Information provided to us, however, indicates that about 75% of the beds are filled on any given day, meaning that there are about 250 beds utilized on any given day ( $.75 \times 335 = 251$ ). This would mean that there are approximately 16,351 jail bed days saved annually ( $251 \text{ beds per day} \times 365 \text{ days per year}$ ) by using the currently available alternative housing. Finally, it is also important to note that current estimates are that the cost of alternative housing is less than the daily cost of having someone in the ACJ (approximately \$75 per day versus over \$90 per day). In terms of just gross costs of housing, this means that the use of alternative housing is approximately \$245,265 cheaper annually than keeping these individuals in ACJ ( $\$15 \text{ per jail bed day savings} \times 16,351 \text{ jail bed days of alternative housing}$ ).

It is also estimated that individuals spend an average of 80 days in alternative housing, meaning that these programs can "turn over" each bed approximately 4.6 times per year ( $365 \text{ days per year} / 80 \text{ day stay per person} = 4.65$ ). This means that about 1,155 individuals are served in alternative housing in a year ( $4.6 \text{ "spells" of use annually} \times 251 \text{ beds} = 1,155 \text{ individuals served}$ ). Using the above prevalence estimate (12%) cited above (page 57 for the number of individuals with a serious BH problem in the jail population, it is then possible to estimate how many individuals with serious BH issues could be served with the current level of resources. If all the individuals currently served in the alternative housing program annually (1,155) had a serious BH problem, this service would then be provided to about 64% of the BH population passing through the jail in a year ( $1,150 \text{ individuals served in alternative housing in a year} / 1,800 \text{ people with serious BH problems entering the jail annually} = 64\%$ ).

Of course, the reality is that not all of the beds in alternative housing are going to be assigned to individuals with a serious BH issue (i.e., the current crimes or histories of these individuals might disqualify them for alternative housing, other individuals without serious BH issues will be assigned to alternative housing). If one assumes, however, that even one quarter of the beds were occupied by individuals with serious BH problems, this level of service provision would touch the lives of about 16% of those with serious BH problems in the ACJ.

### ***ACJ Diversion***

In contrast to alternative housing, the ACJ diversion program is for individuals with a substance use problem who are in pre-trial status or jailed for a probation violation. These individuals may be released to a substance use treatment program under a set of conditions requiring them to enter residential/inpatient substance use treatment. Recommendations for jail diversion are initiated by the Court (judge or hearing officer at the Gagnon I hearing) and are typically triggered by the nature of the charge or a request from the defendant (e.g., if the defendant requests services, the judge is likely to give them the chance). A warrant for arrest will be issued if the individual does not complete the treatment program.

ACJ personnel assess the individual for the appropriate level of care, and a high percentage of individuals successfully complete their assigned treatment program. There are approximately twenty different service providers involved with this program. Program involvement can range from three weeks to six months. There are currently 145 individuals in the ACJ diversion program.

Having a sufficient number of available beds and turning these beds over quickly are continuing issues for the jail diversion program (as it is for other programs as well). Part of the issue is the delay related to getting an individual to the diversion site; it takes approximately two to three weeks to get a person from the point of recommendation for diversion to release from the ACJ. The length of the process is largely attributable to the time required to activate medical assistance (typically seven days) coupled with the few days it takes to obtain signatures from the Court and physicians. Providers used for jail diversion do not turn down people for program entry because of their criminal justice history; indeed, many proactively seek out jail clients. Diversion for MH reasons is handled by JRS (see Intercept 2: Allegheny County Procedures section of this report).

### ***Classes and Services in the ACJ***

An array of services is provided to ACJ inmates from multiple providers. The list below reflects descriptions of services for Fiscal Year 2018 listed by the ACJC. It includes services offered to inmates in the general population as well as those in the re-entry program.

- Cognitive Behavioral Therapy
  - *Thinking for Change* (Provider: Mercy Behavioral Health)

Thinking for Change is a 12-week evidence-based program designed to help clients address the habits of “criminal thinking,” moving to more positive ways to solve problems and handle stress. It includes structured cognitive behavioral treatment (CBT) modalities, and addresses thoughts and beliefs that lead to antisocial and criminal behaviors. While still incarcerated and in a controlled and monitored environment, participants have the opportunity to model and practice problem solving skills, and report back to a group on their pro-social behavior choices. The curriculum contains 22 lessons, and it can be expanded to meet the needs of the participant. A separate group is available for veterans, with facilitators who are veterans.

- *Sage: CBT Maintenance Group* (Provider: Mercy Behavioral Health)  
This is a follow-up to the Thinking for Change curriculum for men on the re-entry pod. There is also a Sage program for women.
- *Breaking Free: The Power of Choice* (Provider: Mercy Behavioral Health)  
The Power of Choice is an eight-week CBT program. Curriculum is based in part on Thinking for Change, the CBT program provided in the ACJ, and is offered in the community to clients referred by the ACJ, Probation, and through self-referral. It is offered at Probation DRCs, Renewal (men only) and in the jail on the Re-Entry Pod (men only).
- Drug and Alcohol Services
  - *Drug and Alcohol Program Pod* (Provider: Allegheny County)  
This is a drug and alcohol education pod for women. Clients stay in the program for 12 weeks and are eligible for a 30-day extension pending successful completion. Four hours of drug and alcohol intervention groups and one-on-one individualized care are provided as needed.
  - *Drug and Alcohol Education Pod* (Provider: Allegheny County)  
This is a drug and alcohol education pod with a structured living environment, triage, education and aftercare. Clients recommended to drug and alcohol education in the re-entry center (see below) will stay on the pod until space is available. Clients referred to in-house drug and alcohol education on the program pod (see above) will complete their 12-week program and then be discharged to 5E. A 16-week drug and alcohol aftercare curriculum is provided on 5E for clients who have completed either a drug or alcohol education program. Those who complete the 16-week program will stay on 5E as a graduate participant or return to general population.
  - *Re-entry Drug and Alcohol Education* (Provider: Allegheny County)  
This program focuses on topics such as relapse prevention and the effects of addiction on family functioning. It consists of 12 weeks of group education; four days per week for 1.5 hours per day.
  - *Addiction and Trauma* (Provider: Allegheny County)  
This is a 12-week program for woman which meets three hours per week.
  - *Moving On* (Provider: Allegheny County)  
This program for women is designed to address common issues women face as they return to society.
  - *Outpatient Drug and Alcohol Treatment*

Individual and group drug and alcohol therapy sessions are offered on a weekly basis. Each participant receives one hour of individual and one hour of group therapy per week. Outpatient services begin in the ACJ and continue in the community.

- **Employment and Training**
  - *Job Placement Services* (Provider: Goodwill Industries)  
These services are provided at the Probation DRCs/CRCs. This consists of one-on-one assistance with resumes, interview preparation, job search and soft skills development.
  - *Vocational Training* (Providers: Phillip Randolph Institute, Burns & Scalo, Trane Institute of Pittsburgh, Community Kitchens of Pittsburgh)  
Goodwill administers funding to these training sites and monitors enrollment and completion of training curricula.
  - *Vocational Training Precision Manufacturing 2000* (Provider: New Center Careers)  
This program provides hands-on job training in the manufacturing and machining industry and job placement services following completion. Male clients may enroll while still incarcerated in the ACJ and will continue after release at the Southside location.
  - *Training to Work* (Provider: ACJC)  
This is a partnership with PA CareerLink to provide vocational training opportunities.
- **Family Support Services**
  - *Family Support Services* (Provider: Mercy Behavioral Health)  
Participants in Parenting Classes are eligible to receive additional structured contact with their families through Structured Family Contact Visits and Family Phone Calls.
  - *Parenting Classes* (Provider: Mercy Behavioral Health)  
This program provides a class for men and women called *Parenting on the Inside*, which is an evidence-based, cognitive behavioral parent management skills training program.
  - *Relationship Classes* (Provider: Mercy Behavioral Health)  
*Walking the Line* (for men) and *Within my Reach* (for women) are classes offered to inmates. The classes use an evidence-based curriculum.
  - *Batterers' Intervention Program* (Provider: Family Services of Western PA, Family Resources, Renewal Center, Inc., Women's Center and Shelter)  
Allegheny County contracts with Batterers' Intervention Program providers to offer classes on understanding how abusive behaviors develop and progress and developing healthier ways to deal with emotions.
- **Education Services**
  - *General Education* (Provider: Allegheny Intermediate Unit). All clients referred for education services are screened and pre-tested prior to placement in a class. Clients may participate in multiple classes either simultaneously or consecutively. Class options include: Literacy Workshop, Adult Basic Education, Pre-GED, GED, Computer Literacy, Pre-Apprenticeship Prep and Pre-Apprenticeship.
  - *Creative Writing* (Provider: Chatham University)
- **Mentoring and Aftercare**
  - *HOPE Pre-release Program* (Provider: Foundation of HOPE). This program provides 120 hours of group work addressing a variety of themes. Participants may remain in the HOPE program after completing the group work. Additional support service

coordination and post-release service planning is available through the Hope Pre-release service coordinator.

- *HOPE Aftercare* (Provider: Foundation of HOPE) This includes community-based services such as a mentor program, support services once per week, free counseling once per week and aftercare office services

### ***Data Collection and Management at the ACJ***

ACJ personnel report that there are currently 11 data systems operating within the jail:

1. OMS (*Offender Management System*)
2. ASAP (*Allegheny Standardized Arrest Program*)
3. IRES (*MH Information Referral and Emergency Services*)
4. CIPS (*Client Information & Payment System*) DHS Based Website
5. ClientView (*DHS Based Website; Allegheny County Client View provides insights to DHS clients and their involvement within DHS. Information such as client demographic information, services provided across multiple DHS Program Offices, eDocuments, Service Plans and Assessments are all made available in order to help better serve our clients through integrated service delivery*)
6. KIDS (*Key Information Demographic System*) – AKA ACJC
7. CERNER (*Medication History Report Program*)
8. Application Center Library (*Former system created by Allegheny County Health Department*)
9. TechCare (*Electronic Health Record utilized by ACJ Healthcare Department*)
10. OnBase/Unity Client (*Indexing/Data System*)
11. EVOLVE (*Justice Related Services – JRS Specific program to which only JRS has access*)

ACJ personnel indicate that these systems are not linked to one another and there are restrictions on access to certain data systems. While, on one hand, the reliance on data systems to track information is admirable, it also is laden with concerns such as a) the labor intensity for staff to search multiple databases, b) reliance on staff to consistently and thoroughly check all possible locales for certain data elements and c) the consistency of information across data systems. This situation also has implications for the data management and analytic skill level of ACJ personnel who manage the data systems and points to the need for thorough training and oversight for those entering data into each system.

### ***Competency Restoration***

An examination of issues related to criminal justice processing for individuals with serious mental illness is not complete without special attention to the policies and procedures for competency restoration. However, a study focusing on state-wide policies as well as a closer examination of Allegheny County practices was completed in 2017 (Steadman & Callahan, 2017). We defer to the recommendations made in that report.

### Intercept 3: Gaps

- **There is limited information about, or guidelines for, the screening process for specialty court admission.** Each of the specialty courts addresses a particular subset of offenders (e.g., mentally ill offenders, veterans, sexual offenders) and each court has stated inclusion criteria. However, it is not clear how case characteristics beyond the specified court minimal admission criteria contribute to the Court's decision to admit individuals to the court's program. It is clear that involvement with any of the specialty courts require the consent of the victim. There is no indication, for example, whether any consideration is given to the connection between the individual's presenting problems (e.g., co-occurring substance use and MH condition) and criminal behavior.

In each court, there appears to be a group process involving at least the court personnel, the referring agency or individual, and the District Attorney's office. The guidelines for these decisions, though, are not clearly articulated and the reasons for admission or denial for court involvement are not documented. It is difficult to assess whether these courts are systematically ignoring some set of cases or inadequately judging the potential effectiveness of any interventions without information about the initial filtering process for court enrollment. Furthermore, the degree to which the specialty courts work together to identify, screen, refer and monitor participants is unclear.

- **The logic and benefits/drawbacks of having the specialty courts only available as post-plea options for individuals with BH problems have not been examined.** There are potential benefits and costs associated with requiring individuals to plead guilty to a particular offense before being eligible for a specialty court. For example, individuals with less serious offenses might not volunteer for an extended period of court involvement and monitoring if the sentence they received is relatively short (or appreciably shorter than the period of specialty court monitoring). Yet, many of these individuals might be successful in the specialty court within a short period of time. The range of options and incentives for court involvement and completion is constricted in the specialty courts; there might be other ways to tying sentencing in with court involvement that could increase the range of cases involved and the consequences of program completion.
- **The reach of the specialty courts, particularly MHC, is limited, given the size of the population that might benefit from involvement.** A successful specialty court requires considerable resources and effort for each client, and court systems are usually wary of significantly investing in these efforts. As a result, the proportion of individuals who are positively affected by a "therapeutic jurisprudence" approach is usually small compared to those who might benefit from it. The Allegheny County Courts are no exception. As pointed out in the document, only a small percentage of the individuals with BH problems being processed by the courts are involved with these specialized services. This disparity is often overlooked, however, and stakeholders might too easily assume that the simple existence of a specialty court adequately addresses the problems of a particular subset of criminal offenders.

- **The evaluations of the County specialty court programs are not extensive or coordinated.** The portfolio of specialty courts in the county is impressive. Yet there seems to be only a few evaluations of the functioning or impact of these efforts. The existing evaluations are short term undertakings mostly limited to documenting recidivism rates. Coordinated assessments of the Courts could provide valuable information about the effects of certain processes on client retention, successful outcomes and service involvement.
- **Identification of individuals with BH problems in the ACJ is inconsistent, with service providers often unaware that a client is in the ACJ until they are nearing release.** There is no systematic identification and notification process operating from the ACJ to service providers. An inmate can be picked up as a client by JRS during a jail stay, but reporting of jail admission to a known service provider is not done regularly. Several agencies and all County service coordination units have forensic liaisons whose job is to make contact with clients of the agency who have entered the ACJ. Even in these situations, though, forensic liaisons report being unaware of a client being jailed because of missed opportunities (e.g., no immediate cross-system checking in the ACJ) or delays in communication (e.g., not notified when an individual is being discharged from an inpatient setting directly to jail).
- **There appear to be insufficient BH treatment resources in the ACJ.** As mentioned in the assessment of Intercept #2, the number of psychiatrists and master's level professionals devoted to BH treatment seems inadequate for the likely level of need in a daily population of over 2,000 individuals. In addition, while impressive for its ongoing operations, the number of alternative housing arrangements for individuals with BH problems seems to fall well short of meeting the potential needs of this group.

### Intercept 3: Opportunities

- **The EHR system at the ACJ holds potential as a source of information for designing systemic change in the provision of BH services in the ACJ.** As mentioned in the analysis of Intercept #2, the successful integration of the EHR into jail operations can be an opportunity for collecting information about systemic regularities regarding services and processing of individuals with BH problems. This system can be used to identify relevant groups of inmates with specific BH problems and to document what types of services they are or are not receiving as well as their subsequent community adjustment. This system can be tied into existing DHS data bases to address specific questions about the likely impact of particular interventions and the extent of certain inmate needs.
- **Specialty court personnel and service providers have developed generally positive, collaborative working relationships.** The process of mounting and sustaining specialty courts requires that legal, administrative and social service personnel become educated about each other's views and practices. This is a valuable building block for continued innovation and quality improvement. Furthermore, the existence of a range of specialty

courts in Allegheny County provides an opportunity to weave together functions of these courts, particularly given that the individuals served by these courts typically have multiple and complex needs that cross specialty court domains (e.g., a veteran with MH and substance use issues).

- **There are many programs in place at the ACJ to address criminogenic needs.** Numerous evidence-based programs (e.g., CBT) are already operating at the jail; there is an extensive menu of such programs already in place as part of the Re-entry Program. This is an important feature of this environment, since effective interventions for inmates with BH problems have to address both BH needs *and* criminogenic risk factors. Simply increasing BH services alone does little to reduce the likelihood of recidivism in this group of individuals (Mulvey & Schubert, 2016).
- **The ACJ diversion program provides a model for processing individuals to alternative services.** Allegheny County already has a diversion program (the ACJ diversion program mentioned above) that keeps qualifying individuals from serving time on a jail unit prior to conviction. This program has methods for monitoring individuals for program involvement and processing their cases to provide alternative dispositions. It has an established framework that could be extended to include a more diverse population and set of service providers.

### **Intercept 3: Recommendations**

**3.1 Consider allowing individuals in pre-plea status to enter specialty courts. There may be ways to integrate a deferred prosecution model into the specialty court practice with certain subgroups.** The primary purpose of specialty courts is to use a court's authority to reduce crime by changing defendants' behavior of concern (substance use and/or offending behavior related to a MH condition). There are generally two models for specialty courts: deferred prosecution programs and post-adjudication programs. In a deferred prosecution or diversion setting, defendants who meet certain eligibility requirements are diverted into the specialty court system prior to pleading to a charge. Defendants are not required to plead guilty and those who complete the specialty court program are not prosecuted further. Failure to complete the program, however, results in prosecution. Alternatively, in the post-adjudication model, defendants must plead guilty to their charges, but their sentences are deferred or suspended while they participate in the specialty court program. Successful completion of the program results in a waived sentence and sometimes an expungement of the offense. However, in cases where individuals fail to meet the requirements of the court (such as a habitual recurrence of drug use), they will be returned to the criminal court to face sentencing on the guilty plea.

In 2012, nationally, 35 percent of specialty courts accepted a case at filing or prior to a plea, while 64 percent accepted a case after a plea was entered (Strong, Rantala & Kyckelhahn, 2016). Allegheny County falls in line with the majority of specialty courts in their post-adjudication orientation. There seems to be room to expand the reach of these specialty courts,

however, for individuals on a pre-trial basis as a condition of their bond and for a limited time frame. A model such as this would require the support of the District Attorney's office and would necessitate careful planning that considers both the legal and practical implications (e.g. impact on probation supervision) of this change.

There are models of successful courts of this type that Allegheny County could examine and potentially modify to fit local needs. The *Intervention Program for Substance Abusers* (IPSA) in Montgomery County, MD, diverts certain first-time offenders charged with misdemeanor drug crimes out of the court system and into programs that provide an opportunity to change behavior through drug testing, education, treatment and community service, and to assist offenders in avoiding a criminal record. In Seattle, WA, the District Attorney's office offers different case resolution options depending on the circumstances surrounding the charges. These can include (1) the charges being continued with the possibility of having them dismissed upon successful completion of MHC requirements; (2) the participant pleading guilty to the charges but given the opportunity for their dismissal upon successful completion of MHC requirements (i.e., deferred sentence); or (3) the participant pleading guilty to the charges, which will remain on the individual's criminal record independent of success or failure in MHC (i.e., suspended sentence).

Options for more flexible and responsive methods for promoting diversion could be explored and integrated into the operations of the specialty courts in Allegheny County. The current system operates with a restricted set of criterion and requirements about plea status as well as a non-transparent system for case selection. These factors limit the potential reach and effectiveness of the County specialty courts. Consideration should be given to the possibility of coordinating efforts between courts as suggested in the Behavioral Health Treatment Court Collaboratives program (SAMHSA, 2014; <https://www.samhsa.gov/gains-center/grants-grantees/behavioral-health-treatment-court-collaboratives>).

**3.2 Expand the criteria for involvement in the ACJ diversion program beyond just those with substance use disorders; include MH clients as well.** As pointed out above, the jail diversion program has procedures and assessment processes that allow individuals with substance use problems to be diverted to treatment programs instead of spending time on a jail unit. The current jail diversion program, however, is designated only for individuals who might benefit from involvement in a substance use treatment program. The program policies and practices could be altered to accommodate individuals with MH problems, with treatment programs for MH rather than just those with substance use problems. The platform for a true diversion program, however, seems to exist; one that could supplement (but certainly not supplant) the ongoing efforts of JRS to move people out of ACJ to appropriate services.

An expansion of this sort would require an investment in personnel to manage the process. Currently there are a total of three jail staff and one court coordinator who manage the diversion program (among other job responsibilities). Under present procedures, individuals awaiting a diversion bed sit in jail; a situation that needs to be solved rather than exacerbated

by adding additional clients and responsibilities. Furthermore, such an expansion would require the approval and support of the District Attorney.

An expansion of the ACJ diversion program to include those with MH problems would also make assessment and monitoring more nuanced. Having individuals with any one or combination of MH problems (alone or in addition to substance use problems) would require a more individualized specification of what constitutes appropriate treatment and successful program completion than currently used in the jail diversion program. However, it is important that we reframe the importance of the disorder and the reason for the intervention. In this instance, the MH disorder is treated because it is a factor that affects the individual's adjustment to an institutional setting or community rather than as a risk factor to be controlled to reduce reoffending (as is the case for substance use). In the terminology of the risk-need-responsivity model for targeting interventions to reduce recidivism in the criminal justice system, MH problems should be thought of as "responsivity" rather than "risk" factors (Andrews, Bonta, & Hoge, 1990). After all, the most influential factors related to recidivism in non-mentally ill individuals are the same as for mentally ill individuals. Mental illness has to be considered in relation to the use of appropriate criminal risk reduction interventions (Mulvey & Schubert, 2016)

Finally, inclusion of individuals with significant MH problems would also require an expansion of the pool of services providers working directly with the ACJ. A proactive effort would have to be made to recruit new social service agencies and practitioners, to provide incentives for them to participate in serving justice-involved individuals and to involve them in a "learning community" of service providers entering service provision in this arena. More information about possible methods for expanding the pool of service providers for justice-involved individuals is presented in the recommendations section for Intercept #4.

**3.3 Expand the alternative housing program.** Similar to the ACJ diversion program, the alternative housing program already operates in the ACJ with a reasonable level of efficiency and effectiveness. However, the program as it presently operated has a limited reach into the pool of individuals with BH problems currently in the jail. This could also be expanded to include more individuals with BH problems and to accommodate the expected issues accompanying such an expansion (e.g., the addition of a crisis team available for providers). The pool of possible alternative housing providers would also have to be expanded and the skills and commitment of these providers would have to be reinforced (see Recommendation 4.3).

**3.4 Re-examine the guidelines and operations of the Drug Court.** Drug treatment courts are an increasingly important tool in reducing the census of those incarcerated for non-violent drug offenses. In the midst of a growing opioid crisis, it seems opportune to examine the practices and effectiveness of the current drug court's role. The current drug court guidelines appear to have a limited set of endorsed treatment alternatives. There is a large literature on effective drug court practices, and an analysis of the County drug court in light of this information would probably be useful.

In particular, it would be useful to examine the practice of not endorsing the use of medication-assisted treatment (MAT). The use of MAT is not universally accepted by drug courts. Only 56 percent of drug courts report that their opioid dependent participants were receiving some type of MAT, but the inconsistent use of MAT is observed to be rooted in cost as well as political, judicial and administrative opposition (Mausow, Dickman & Rich, 2013). This appears to be the case in Allegheny County. It would be useful to examine the potential for MAT, since it is endorsed by the National Institute of Drug Abuse and the National Association of Drug Court Professionals.

## **Sequential Intercept 4 – Re-Entry**

### **Intercept 4: Overview**

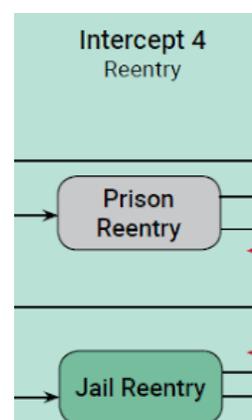
Intercept 4 covers the possibilities for diversion at the points of re-entry from jail. It considers the adequacy and potential of available services to address the BH needs of releasees as they make the transition back into the community. Several programs in Allegheny County that provide these services are described below.

### **Intercept 4: Allegheny County Initiatives and Processes**

#### ***Allegheny County Jail Collaborative***

ACJC (<http://www.alleghenycounty.us/Human-Services/About/History/Jail-Collaborative.aspx>) was created in 2000 in response to a perception by County leadership that services to support former inmates during their re-entry into the community were inadequate. ACJC was formed as a joint effort between the ACJ, DHS, the Allegheny County Health Department and the Allegheny County Courts. The goals of ACJC are to promote public safety, reduce recidivism and promote successful reintegration for individuals leaving the ACJ. The ACJC focuses on providing services for comprehensive re-entry planning, including family reunification, housing, substance abuse and MH treatment, employment, and community engagement. The partners of the ACJC meet monthly and work to plan all in-jail, transitional and post release services.

In 2009, the ACJC was reorganized and a Jail Collaborative Cabinet was formed. The Cabinet has representation from DHS, Public Health, Judges (president and administrative), ACJ Warden, head of Probation and County Administration; no representatives from the District Attorney's or public defender's offices are on the cabinet. The Cabinet is still operational and the administrator for the ACJC calls the meetings. There is also a Jail Collaborative Operations meeting which is run by the Warden and the Criminal Court Administrator, and these meetings include representatives from Probation, Pretrial services, DHS and the County Executive's



Office. Underneath the Operations committee are ACJC providers (e.g., Mercy Behavioral Health, Goodwill, Wesley Family Services). These individuals meet bimonthly.

The ACJC providers are up for new contracts in the fall of 2018. Prior to the current time, the providers were given money each year, but they were not held strictly accountable. The Jail Collaborative Operations committee members believe that, while some services are good overall, they could still improve. As a result, the contracts will be changed from a simple annual payment to provide the contracted services to a fee-for-service system. The new requirements will also include the use of evidence-based programs and pre/post-tests to demonstrate impact. The providers will be given 60 percent of the negotiated payment for enrollment and 40 percent of the payment when an enrolled individual completes the program. This arrangement will ensure that inmates are following through on the program (i.e., makes the provider expend more effort to engage and retain them). In addition, a new contract with Wesley Family Services will include a part-time person for MH/DA coordination.

### ***Jail Re-Entry Services***

In 2010 and 2011, the County launched a set of re-entry programs under the auspices of a federal grant provided by the Bureau of Justice Assistance Second Chance Act Adult Offender Re-Entry Demonstration Programs initiative. These programs were focused on improving services for a delimited group of releasees; men and women who had completed a county sentence in the jail or an alternative housing facility and who also had a high likelihood of coming back to jail. The re-entry program, while voluntary, is offered to all individuals who met the following criteria:

- serving a county sentence of at least three months
- recommended for the program by probation because the individual has minor charges and a probation detainer
- medium or high risk to recidivate based on a validated risk assessment tool
- on probation or parole status following sentence
- not involved with a specialty court (these individuals are supervised by specialty court staff).

The re-entry program is supported by multiple service providers, including Mercy Behavioral Health, Goodwill, Allegheny Intermediate Unit, Phillip Randolph Institute, Trade Institute of Pittsburgh, Community Kitchens of Pittsburgh, New Century Careers, Wesley Family Services of Western PA, Renewal, Inc, The Woman's Center and Shelter, and Carnegie Library of Pittsburgh.

Each week, ACJ personnel receive a list of individuals who were sentenced in the prior week. The list is reviewed and all clients who meet the criteria are offered the opportunity to enroll in re-entry services unless they are experiencing an acute MH condition (and housed on the MH pod). Individuals may refuse to participate in the re-entry program, but inmates are informed that the refusal will be reported to the judge handling the case; as a result, most eligible inmates (estimated at 85-90%) enroll. There have not been any official assessments of whether those with a BH condition are more likely to refuse, but the impression of program staff is that

they are not. Participants are allowed two chances to take advantage of the services in the program.

### ***Re-entry Pods***

The ACJ has one pod for males and one pod for females focused on getting inmates prepared for re-entry to the community. While on this re-entry pod, residents live in a structured living environment while participating in classes and social services provided in the ACJ Re-Entry Center and Classrooms. Group sessions and guest speakers are also offered. Clients receive service coordination through a Pod Coordinator. The goal is to prepare an inmate to take on the challenges of more freedom of choice and responsibility. As a result, upon completing the re-entry services identified on a needs assessment, a resident may be eligible, with the recommendation of the re-entry program staff, to transfer to a work pod where regular employment is part of the daily routine.

Inmates must meet certain criteria to be eligible for placement on the re-entry pod. These are:

- medium or high risk to recidivate based on a validated risk assessment tool
- approved by the ACJ classification department for housing on this unit.

In June 2018, there were 65 individuals residing on these two re-entry pods. There were 62 male inmates on the male Re-entry pod and 3 females on the Female Program Pod. The Female Program pod also contains females that are in the HOPE program and females who are awaiting beds on the women's drug and alcohol program pod.

### ***Re-entry Program Description***

Individuals residing on the re-entry pods are required to be involved in a range of re-entry services; re-entry clients not residing on these specialized pods can also be involved in these services. Whether on a re-entry pod or another unit within the ACJ, though, participants in the re-entry program complete two phases of services.

Phase 1 begins with a need's assessment and the development of a Phase I Service Plan. The assessment and the recommendations and the Phase I Service Plan is completed within 10 days of entering the Re-entry Program. The jail service coordinator works with the inmate, as the inmate takes the required classes to complete the Phase 1 Service plan.

The development of the service plan involves identification of the issues that need to be addressed and then mapping out a plan of service involvement that can target these issues prior to release. The jail service coordinator (JSC) completes the Montgomery County Risk and Needs Assessment, which identifies the strengths and needs of the individual in the realms of criminal history, education, employment, finances, family relationships, drug and alcohol use, trauma and behavioral health. A service plan is then developed with the client, specifying the classes and treatments the individual will complete while in the ACJ or alternative housing. If the individual is transferred to alternative housing during this time, the Alternative Housing JSC

is assigned and the plan is adjusted to include equivalent services available at the new location. The JSC meets regularly with the individual to monitor progress and to address other needs such as therapeutic support, participation in workshops and driver's license reinstatement.

The Phase 2 of the Re-entry plan begins 60 days before the inmate's minimum release date and usually ends six to nine months after release to the community. At the outset of Phase 2, a meeting is held with the individual, the administrator of the re-entry program, the JSC, SCS, PO and all instructors and therapeutic staff who worked with the person in Phase 1. All these individuals review the client's progress and make recommendations for programming in the community, and the client provides feedback.

A community services coordinator (CSC) works with the inmate to get the appropriate services into place prior to, and for up to nine months after, release. The JSC does a "warm hand-off" of the client to the CSC. This involves all three individuals (JSC, CSC and client) discussing concerns and needs going home as well as accomplishments in ACJ. The CSC develops a service plan with the clients that includes services during the last 60 days of their jail stay as well as after. This plan corresponds to the supervision plan that the re-entry probation officer will follow. In addition, the re-entry probation officer conducts a home visit to verify the individual will return to a stable, structured environment with no apparent barriers to successful return to the community. The CSC and the re-entry probation officer meet with the client regularly during the last 60 days of the inmates stay in the jail. They then meet every two weeks or monthly with the client for the next 6-9 months depending on the progress of the client in the community.

### ***Services/Classes Available with the Re-entry Programs***

Inmates may be referred to re-entry and education classes by court order, program staff, jail staff or self-referral. The ACJ policy for enrollment of inmates in re-entry and education classes is to give first priority to individuals who have been targeted for services based on risk and need. The extensive list of services and classes is provided in the presentation of available resources in the section on Intercept #3. It is simply worth noting that all of these services are potential resources for inmates in the re-entry program and that program participants are given top priority for enrollment.

### ***Additional Services***

Several other services are available to individuals leaving the ACJ. A benefits counselor can assist individuals who are being released with enrollment in Medicaid or other health care options. This initiative is particularly helpful for individuals with BH problems, since continuity of care and timely access to care are important for successful management of numerous disorders. In addition, in 2016, DHS, Community Care Behavioral Health and Allegheny Health Choices, Inc. issued a joint position statement indicating that Medication Assisted Treatment (MAT) was to be the standard of care for individuals with an opiate disorder. Subsequently, the number of MAT slots available to the re-entry population has been increased, and the ACJ has begun providing a non-narcotic medication option combined with substance use treatment for

eligible offenders upon release. Narcan is also provided to anyone leaving the jail who requests it. Finally, according to the Community Human Services plan for fiscal year 2017-2018, transportation assistance in the form of bus passes and gas cards are provided to participants for up to two months upon release from jail. This assistance promotes access to community resources and attendance at treatment, employment and training programs (DHS Bulletin 2017-1, page 61).

### ***Comparison of Allegheny County Re-entry with Best Practices***

It is difficult to obtain perspective on the adequacy of services provided at the point of re-entry to the community from the ACJ. Obviously, a wide range of services and supports are necessary at this transition point for individuals with BH problems, but assessing the adequacy of a network of oftentimes independent programs is not a straightforward task. In the existing literature, however, there is a model specifying the general components of what should be present in a re-entry system (the “APIC Model;” see Osher, Steadman & Barr, 2003). In this formulation, a re-entry plan would align with best practice guidelines if it includes the following components:

- Assessment of the inmate’s clinical and social needs and public safety risks
- A plan for treatment and services to address the inmate’s needs
- The identification of the community and correctional programs responsible for post-release services
- Coordination of a treatment plan to ensure continued services in the community

These rather general prescriptions have been translated into more specific terms. These components serve as the framework for a Jail Re-Entry Checklist put forth by the GAINS Center (2004; see also SAMHSA, 2017).

We compared the ACJ re-entry program against these guidelines. Table 4 provides an overview of how County practices line up with these generally accepted standards for re-entry services.

Table 4: GAINS Jail Re-Entry Checklist compared to Allegheny County Jail Re-Entry Program

<b>Recommendation</b>	<b>Allegheny County Practice</b>
MH needs assessed within 48 hours of arrival facility	Health services personnel identify those in need of acute MH care and those need further assessment (see intercept 3)
Information should be shared with the detainee, as well as medical and MH personnel	Information gathered in the health services area, including the MH needs of the client, are accessible to Medical staff only.
<p>Discuss areas of potential need with each client to determine areas for services/supports. Areas assessed include:</p> <ul style="list-style-type: none"> <li>MH Services</li> <li>Psychotropic Medications</li> <li>Housing</li> <li>Substance Abuse Services</li> <li>Health Care</li> <li>Health Care Benefits</li> <li>Income Support/ Benefits</li> <li>Food/Clothing</li> <li>Transportation</li> <li>Other</li> </ul>	<p>A five-person team consisting of a designated Re-entry Probation Officer and four Re-entry Specialists works with eligible inmates pre-release to assess needs and link program participants to appropriate pre-release services and programming available through the ACJ's Re-entry Center. The needs assessment (Montgomery County Risk/Needs Assessment) explores strengths and needs related to criminal history, education, employment, finances, family &amp; relationships, drugs &amp; alcohol, trauma and behavioral health.</p> <p>The LSI-R (Level of Service Inventory) is completed in Phase 2 of the re-entry program, closer to the time of release. The LSI-R includes an assessment of criminal history, education &amp; employment, family/marital relationships, accommodations, leisure/recommendation, companions, drug &amp; alcohol problems, emotional/personal problems and attitudes/orientation.</p> <p>These assessments do not include food/clothing or transportation.</p>
Jail staff should document steps taken to set-up the identified services and the dates this was done.	<p>All information, including contact notes and referrals are recorded in the ACJC Database.</p> <p>Re-entry Specialists maintain regular contact with clients in the ACJ, ideally meeting with clients at least twice a month to monitor participation and progress in designated re-entry services and addressing emerging needs or issues.</p> <p>Re-entry Specialists work with inmates in the ACJ to facilitate enrollment in and completion of targeted interventions and services</p>
A final plan should be identified in terms of appointment times, next steps and person to contact for each identified need.	A Phase II service plan is provided to the client. This plan includes specific next steps, appointment dates and contact information.
A full re-entry plan is completed and discussed with the detainee.	Following assessment, the client's Re-entry Team— designated Re-entry Specialist, Re-entry PO and Family Support Specialist— meet with the client to review the assessment results and develop a Phase 1 plan,

	<p>including referrals to re-entry programming and services and re-entry goals.</p> <p>Phase 2 begins between 30 and 60 days before the inmate's release and involves a needs assessment with the LSI-R conducted by the Re-entry PO. A transition and home plan are discussed with the client.</p>
<p><b>Ensure continuity of treatment for people with MH needs as they move between settings (Vera Institute of Justice, 2012)</b></p>	<p>Community Service Coordinators are in place to assist with this process.</p>

The above comparison indicates that the Allegheny County Re-entry Program incorporates the practices recommended by national experts.

We applaud the ACJC for supporting an evaluation of the re-entry program in 2012 (Willison, Bieler & Kim, 2014). The evaluation found that the program prolonged the time to re-arrest and reduced the overall re-arrest rate. In addition, the re-entry program was found to align with core correctional practices. Our understanding is that the current policies and practices of the re-entry program have benefited from the recommendations made in this prior evaluation.

### **Community-Based Forensic-Focused Services**

Allegheny County has a number of community-based services with a forensic component. These services are described below.

**Forensic Liaisons.** DHS works collaboratively with eight agencies to assist adults and families with linkage to and coordination of services. These agencies are: Chartiers MH/MR, Family Services of Western PA, Mercy Behavioral Health, Milestone Centers (county-wide), Mon-Yough Community services (county-wide), Staunton Clinic, Turtle Creek Community Services, and Western Psychiatric Institute and Clinic. Each of these agencies (or service coordination units) has a jail forensic liaison (FL).

When operating according to the program guidelines, the FL provides information to the ACJ treatment team (e.g., an individual's medication regime when in the community), meets with consumers from their agency in the ACJ, and serves as a link across probation, JRS, MHC and Service Coordination teams. Specifically, the FL is notified by ACJ personnel, a provider or family member when an individual receiving services from the respective agency is admitted to the ACJ. As an authorized provider, the FL can look at the electronic health record of the individual and provide the ACJ with a synopsis of the available clinical information and order bridge medication if necessary. The FL will also visit the individual and provide information about how to connect with the provider, if necessary. This FL is only called if the individual is not involved with a Community Treatment Team (see below) and has no other service coordinator, in which case this role is assumed to be taken on by these individuals. The FL has

no role with the client after his/her release unless the client reaches out. Reports are that there is considerable variability in the timeliness and responsiveness of the FL suggesting an opportunity to review the standards and practices of the program for possible improvement.

**Community Treatment Teams.** Community Treatment Teams (CTTs) provide comprehensive, community-based services to people with serious mental illness who have very complex needs. Unlike other community-based programs, a CTT is not a linkage or brokerage case-management program that connects individuals to MH, housing, or rehabilitation agencies or services. Rather, it is meant to provide individualized services directly to consumers, working with the idea of multiple disciplinary providers focused together on a small set of frequent service utilizers.

In Allegheny County, CTTs follow the Assertive Community Treatment (ACT) model, and the services are organized according to present standards for ACT teams. MH professionals within ACT teams include psychiatrists, vocational/education specialists, master's level professionals with expertise in dually diagnosed clients, psychiatric nurses, forensic specialists, peer counselors, therapists, intensive service coordinators and social workers. Services are expected to be provided on an average of three- to five times a week for each individual and staff is available 24 hours a day for crisis intervention services. To help divert individuals from the hospital, people served by CTTs are encouraged to first contact their team in times of crisis. However, there are situations when people might use other crisis services (e.g., reSolve).

There are nine CTTs operating in the County: Mercy Behavioral Health (four), WPIC (two), NHS Human Services/Merakey (two, NHS is now called Merakey), and Family Services of Western PA (one). These teams receive oversight as well as training and technical assistance from Allegheny HealthChoices, Inc. in collaboration with DHS and Community Care Behavioral Health (Community Care).

Referrals for Allegheny County to a CTT come through Community Care or DHS. Intake requirements are:

- 18 years of age or older
- diagnosed with a severe and persistent mental illness
- a Global Assessment of Functioning score of 40 or lower
- meeting two or more of the following:
  - at least two psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months; can include admissions to the psychiatric emergency services
  - Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal)
  - co-occurring mental illness and substance use disorders with more than six months duration at the time of contact
  - literally homeless, imminent risk of being homeless, or residing in unsafe housing
  - residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or

requiring a residential or institutional placement if more intensive services are not available

The overriding mission of CTT is to provide an integrated set of services for individuals who have difficulty effectively using traditional case management or office-based outpatient services; that is, individuals who require a more assertive and frequent non-office-based service to meet their clinical needs. Individuals with BH problems who are involved with the criminal justice system may have prior involvement with CTT services, but involvement with the criminal justice system is not an active portal to these services. An ancillary service of CTT is to have a forensic coordinator who can help an individual with a BH problem navigate the criminal justice system and formulate and monitor a community treatment plan that can be approved by the court.

***Integrated Dual Disorder Treatment (IDDT).*** Integrated Dual Disorder Treatment (IDDT) is an evidence-based practice that addresses a person's substance use in the context of the treatment of their mental illness. Mercy Behavioral Health has one IDDT team that includes a physician, nurse, therapist, case manager, peer, and other professionals who assist persons who have a mental illness and an addiction (dual disorders). Although an evidence-based practice for people with co-occurring mental illness and substance-use disorders (Drake et al, 1998; SAMHSA, 2009), IDDT has experienced limited adoption in Allegheny County, and there appears to be no systematic collaborative relationship with the local criminal justice system. Clearly, a single IDDT team is not sufficient to meet the needs in Allegheny County.

***CORE (Capitalizing On a Recovery Environment).*** Capitalizing On a Recovery Environment (CORE) is a 16-bed facility for JRS clients in need of extended treatment and support (i.e., 45 days to six months program involvement). The facility is located in Homestead and is operated by Resources for Human Development, a Philadelphia-based agency. Individuals sent to CORE require sustained substance use treatment but also have significant MH problems. These are usually individuals who have not done well in other facilities and/or have a significant criminal history. CORE replaced CROMISA, a past program for state parolees that had insurmountable zoning and institutional acceptance problems.

***Forensic Peer Support.*** Forensic peer support is a specialized form of the more common peer support model used in many BH intervention programs, including service coordination. Peer support is particularly attractive to many BH service providers because of its synergy with a recovery model and its potential for increasing client service engagement. Forensic peer support involves peer counselors and specialists with experiences in the criminal justice system working with individuals with BH problems while they are encountering such issues (Davidson & Rowe, 2008).

It is difficult to obtain a definitive assessment of the number or effectiveness of forensic peer support specialists currently working in the county. Many of the organizations that foster the development of these specialists work at the state level (e.g., programs offered in Department of Corrections facilities), and only a limited number of local agencies appear to have integrated this service into their ongoing activities. Perhaps not surprising, then, reports about the

prevalence and success of forensic peer specialist in the County are mixed. Some service providers and criminal justice professionals report that this is a widely used and developing resource and others indicate that there are only a few such individuals actively working in the systems (particular in the substance use area). A forensic peer specialist is listed as a member of every CTT team in the County and some private agencies (e.g., Resources for Human Development) have a clearly defined forensic peer support program as part of their available services. However, no centralized and systematic information appears to exist about this service resource. For example, since these programs are not County-funded, DHS has no reliable gauge on the range of private agencies with a forensic peer support program and/or the number of available forensic peer support specialists. The general impression of providers and criminal justice personnel is that forensic peer support services offer considerable potential, but are underused and not integrated with existing services in Allegheny County.

***Telepsychiatry.*** In 2001, more than half of the correctional systems in America were delivering services to offenders via telehealth, with MH services being one of the most frequently used applications (Larsen, Stamm, Davis, & Magaletta, 2004). This technology is used in many locales to evaluate offenders and prescribe psychotropic medications to patients where appropriate (Ax, Fagan, Magaletta, Morgan, Nussbaum & White, 2007). In addition, a body of research now indicates that telepsychiatry (also referred to as tele-MH and other variations) is effective and increases access to care (Hilty, Ferrer, Parish, Johnston, Callahan & Yellowlees, 2013). MH providers in Allegheny County (e.g., WPIC) have used it effectively, particularly in partnership with rural communities in Pennsylvania. DHS has been exploring this method of service delivery and WPIC and Community Care are currently working to develop telepsychiatry standards.

Given its established record of acceptance and effectiveness in numerous locales, it is notable that there is limited use of these types of services with the justice-involved population in the County. Currently, telepsychiatry is used on a limited basis for assessments in the ACJ, and there seems to be little enthusiasm for more widespread use for screening and assessment, diagnostic consultations, or service planning (e.g., outside service provider interviews with prospective clients upon release). Part of this reluctance seems to be based on a general skepticism about the impersonal nature of the interaction with an inmate. When we presented the possibility of using telepsychiatry to address some of the difficulties of obtaining speedy access to MH providers, the reaction was generally dismissive. If such approaches were to be introduced into the ACJ assessment, treatment or referral processes, it is clear that a substantial amount of preparatory work with staff would have to be done to achieve acceptance and use.

### **Residential Treatment Services**

Allegheny County supports a range of residential treatment services available to individuals with BH disorders, and these form the largest pool of possible options for housing available for individuals with BH problems in the criminal justice system. These generally vary along a

continuum of security, treatment intensity and available support services. The different types of facilities are:

- Residential Treatment Facilities for Adults (RTFA)
- Long-term Structured Residences (LTSR)
- Community-based Extended Acute Care
- Community Residential Rehabilitation (CRR)
- MH Comprehensive Personal Care Homes (small specialized groups homes and bridge housing)
- Domiciliary Care

The admission criteria for these facilities differ and not all accept justice-involved individuals

According to a presentation regarding County policy and practices available from DHS (Aranyos & Johnson, undated), the following residential treatment options are available for justice-involved individuals:

- Dual Residential:
  - MISA CRR
  - Half way house
  - ¾ House
  - Recovery Housing
- MH Residential:
  - CRR
  - Group homes
  - Personal care boarding homes
  - Supportive housing
  - Forensic LTSRs (with two planned for people needing criminal competency restoration; one run by Resources for Human Development (12 beds) and one by Merakey (8 beds).

At any given time, there are approximately 250 individuals on a waiting list for residential services.

Recently, DHS has taken two steps to address the limited pool of residential treatment services. The first is the development of an electronic application (MH Residential) with real-time assessment of the availability of County-funded, MH residential beds (e.g. LTSR, CRR, apartment CRR, short term supportive housing). DHS maintains an electronic database reflecting real-time information regarding the status of MH residential beds. Agencies are required to enter real-time data about their bed status and expected discharge dates related to filled beds. Agencies have an incentive to keep this information updated and accurate because it reduces the lag time for a new admission (and they are not reimbursed for empty beds). This system will not include drug and alcohol service beds; drug and alcohol service providers track their own agency's bed availability.

In addition, DHS has instituted a weekly meeting about bed availability and assignment in an effort to assign available beds to those individuals with the highest needs. Referrals for residential service beds come from multiple places (e.g., JRS, CTT) and there are always more referrals than available beds. The strategy of a weekly meeting was thus chosen as a way to formalize the distribution of this scarce resource. During this meeting, beds are assigned via group consensus, based on a consideration of the referral date, level of need, the associated level of care needed and case priority status (e.g., the individual is currently homeless). Individuals from priority areas may advocate on behalf of their clients during the weekly meeting. If there are multiple referrals with equivalent high need, the group will consider the referral date. Regardless of the groups' decision, however, providers are able to decline referrals but are expected to provide an explanation for the decision.

It is worth noting that individuals who are currently involved with the criminal justice system are listed as priority cases for bed assignments. However, this list indicates 27 possible prioritization areas (of which criminal justice system involvement is one), and open beds are assigned based on a combination of need and referral date, not on a ranking of the priority areas. In addition, the referral staff provide information about the individual's priority status, meaning that there is no advocate for those who are in jail, unless JRS or CTT are involved in the referral.

### **Housing**

Like many counties, Allegheny County has a shortage of affordable housing and beds for homeless individuals. This reality disproportionately affects County residents living with a behavior health disorder. A 2013 DHS analysis found that 62 percent of clients in the homelessness system also had a MH diagnosis and 47 percent struggled with substance abuse (DHS Bulletin 2017-1). The prevalence of homelessness among ACJ inmates is currently unclear because there is no single indicator of homelessness in the ACJ data system. However, we can assume the need is substantial. In 2015, as many as 58 percent of probationers (n=2,832) met criteria for medium or high risk associated with housing (ACJC Strategic Plan 2016-2019), and we speculate that this would be no less of an issue in 2018.

The housing needs in the County exist despite a centralized access system (Allegheny Link), a "Housing Portal" designed to give users quick access to housing options. This system, a collaborative initiative of DHS and ACTION-Housing, has multiple functions. Allegheny Link is designed to find housing for individuals with varying disabilities (housing connector), provide access to a continuum of services to help people who are homeless or at risk for homelessness (e.g., case management, drop-in programs, emergency shelters) and promote multiple supportive housing initiatives.

### ***Supportive Housing Initiatives***

The Allegheny County Human Services Plan FY 2017-2018 (DHS Bulletin 2017-1) indicates that DHS has several ongoing supportive housing initiatives for at-risk county residents. These include:

- Capital projects for behavioral health (financing to create targeted housing units)
- Bridge rental subsidy program (short-term tenant-based subsidies until permanent housing subsidy is available)
- Master Leasing program (leasing units from private owners and then subleasing/subsidizing the units to consumers)
- Housing Clearinghouse (an agency that coordinates and manages permanent supportive housing)
- Housing Support Services (used to assist consumers in transition to supportive housing and/or services needed to assist individuals in sustaining their housing)
- Housing contingency funds (flexible funds for one-time and emergency costs such as security deposits)
- Project-based operating assistance (partnership with PA Housing Finance Agency in which the County provides operating or rental assistance to specific units then leased to eligible persons)
- Fairweather Lodge (Evidence-based practice where individuals live and work together and share responsibilities)
- CRR Conversion Projects

Clearly, Allegheny County has numerous projects to supply resources to individuals trying to make a transition from one type of housing situation to another or facing obstacles to stable housing (e.g., BH problems).

Beginning in 2017, an additional program called Heathy Housing Outreach (“H2O”) was added to the county resources. The goal of H2O is to provide access to BH treatment and other supports to homeless individuals and families living with a BH need. The distinct aspect of this program is that it “combines the efforts of four providers to provide outreach, engagement, screening, treatment and supports to people experiencing homelessness in locations where they live and are comfortable.”

This expansive list includes many of the best practice approaches to difficult housing challenges. None of these efforts, however, target justice-involved individuals with BH disorders who present a distinct range of difficulties related to ongoing criminal justice system involvement and need for ongoing services of varying intensities. While these individuals may qualify for housing assistance under one of the existing inclusion criteria, explicit consideration of the challenges of dealing with the criminal justice system is not recognized in any of the existing programs.

This is certainly recognized by both service providers and criminal justice personnel. In nearly every individual interview conducted or group meeting held as part of this evaluation, the issue of ensuring housing stability was identified as a key to success with justice-involved individuals with BH disorders. It was also identified as one issue where solutions were not immediately apparent. In this regard, Allegheny County is similar to many other Pennsylvania counties. In recent mapping exercises done by the Pennsylvania Mental Health and Criminal Justice Center of Excellence, an insufficient supply of stable housing options was consistently identified as a major barrier for supporting justice-involved individuals with a BH disorder as they return to the community (Heilbrun, et. al, 2015).

#### **Intercept 4: Gaps**

- **There are limited residential treatment beds with the appropriate level of care for individuals with BH problems leaving the ACJ.** Individuals with BH problems leaving the ACJ present complex treatment challenges, oftentimes requiring well-coordinated care from both substance use service providers and MH care service providers. These individuals also have substantial material and social needs that must be addressed if they are to adjust positively to the community. Unfortunately, these individuals—and their case managers—are often frustrated with the simple lack of potential, accessible resources in the community to address the range of issues that arise.

There is a shortage of substance abuse treatment providers as well as few beds in residential treatment facilities that can address both MH and substance use problems effectively. The need for substance use treatment greatly outstrips the availability. DHS estimates an average daily waiting list of 261 slots, with the greatest need for inpatient rehabilitation beds, halfway house slots and outpatient treatment (DHS Bulletin 2017-1, pg. 52). As a result of cumbersome (and sometimes conflicting) licensing requirements, residential treatment facilities with expertise in both substance abuse and MH treatment are very limited and in high demand. Gaining acceptance into the existing facilities can take a considerable amount of time, with admission almost exclusively at the discretion of the service provider. Individuals with more extensive criminal histories and more complicated service needs can often wait in jail for an extended period before finding an appropriate placement.

**There is no consideration given to justice-involved individuals as a class of special concern (and requiring special re-entry planning) in decision making about assignment of residential treatment resources.** In addition to the reality that there are simply too few residential treatment beds, individuals coming out of jail are not given any unique priority for receiving a residential treatment slot. The fact that an individual has a criminal history or may currently be in jail may be considered in the meeting to determine the allocation of residential treatment slots, but this is only one of many considerations (and sometimes, one that may work against placement with some providers). A large number of possible priority considerations, of which current justice system involvement is one, are all treated equally. Prioritizing justice-involved individuals would require the identification of qualified

providers (see recommendation 4.1 and 4.2) and the cooperation of the DA's office. If these efforts were successful it could reduce length of jail stays for those with BH problems.

- **Obtaining and maintaining housing remains a constant challenge for many individuals re-entering the community after a jail stay. There are, however, few collaborative efforts that target housing for justice-involved individuals with BH problems.** DHS has numerous initiatives to promote affordable housing for its clients. However, very few of these housing options are targeted specifically for justice-involved individuals with BH problems. The availability of housing for these individuals is limited, the waits are long, and the incentives for taking a justice-involved individual with BH problems are few. The lack of stable housing, however, is regularly cited by service providers and consumers as one of the critical factors in a successful adjustment back in the community.

#### **Intercept 4: Opportunities**

- **A capable structure exists for promoting and organizing re-entry services.** As shown in the comparison presented earlier in the text (Table 4), the re-entry system for Allegheny County stacks up favorably with national guidelines. In addition, the ACJC is an exemplary initiative that has been in operation since 2009. This is a forward-thinking structure, with both an operations and providers committee, that is already in place to promote improvements in the re-entry process.

In 2012, researchers at the Urban Institute's Justice Policy Center conducted a 12-month process and outcome evaluation of re-entry programs in Allegheny County. This evaluation demonstrated the effectiveness of the ACJC's efforts in reducing recidivism in program's participants (Urban Institute, 2014). This evaluation also highlighted several areas for improvement (e.g., difficulty accessing some of the re-entry services and inconsistencies in assessing client needs), providing a map for improvements. In addition, the ACJC has continued to push for positive changes, e.g., recently reformulating the funding structure for service providers to promote more accountability.

- **The DHS Data Warehouse has integrated service records of individuals with BH problems who have had ACJ stays.** As mentioned previously in this document, Allegheny County has a valuable resource in the DHS Data Warehouse. There is the capacity to integrate this information with data from the ACJ to identify individuals who make up the group of individuals with BH problems in contact with the ACJ. Individual careers of service involvement could be constructed across a variety of agencies using the information currently stored in this combined information.

#### **Intercept 4: Recommendations**

**4.1 Analyze existing data to estimate the system's capacity to meet the service needs of justice-involved individuals with BH needs and to identify barriers to continuity of service for**

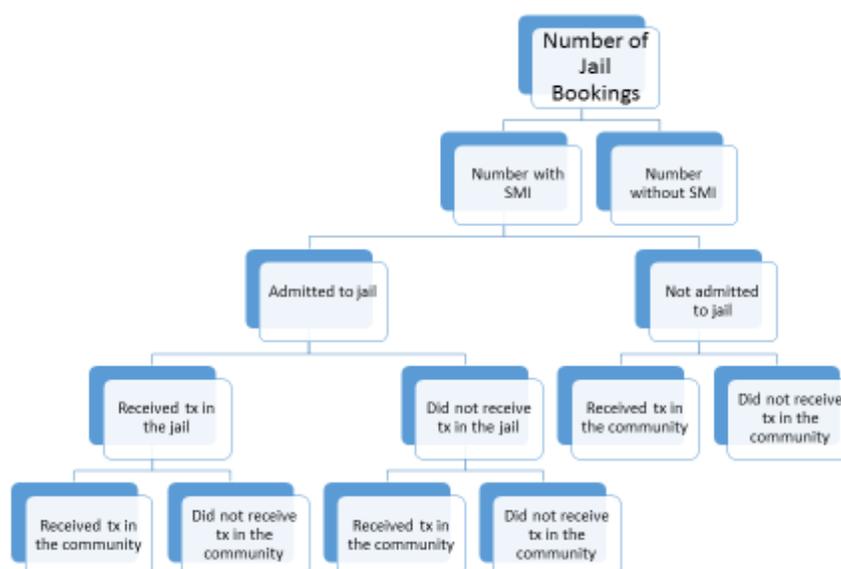
**ACJ releasees.** Communities that offer an accessible array of evidence-based BH services to the criminal justice population in a timely manner are likely to also have better criminal justice outcomes (Ray & Goldman, 2013). There is a general consensus among stakeholders in the County (including DHS) that there is a clear shortage of some services (e.g., residential treatment beds). What is unclear, however, is the extent to which justice-involved individuals with BH disorders as a whole are or are not disproportionately affected by these shortages and/or if certain subgroups within this population (e.g. transition age youth) are particularly underserved (CSG, 2015). Currently, it is difficult to know the volume of individuals with BH needs exiting the ACJ, the frequency with which they are linked to services in the community, and whether or not their wait times for resources are longer than the general population. Empirical information about the current state of affairs is essential to plan resources effectively and to set the stage for holding providers accountable to specified levels of performance.

Fortunately, the County is positioned well to conduct informative analyses without a major investment. The data are there; the EHR in the ACJ, the County BH service records, and court processing data are accessible and usable. Given the different “owners” of these data sets, memoranda of understanding may be needed, but this is not an insurmountable problem. The Data Warehouse could act as the repository for this exchange, and specialized analysts could be hired on a contractual basis.

Several types of analyses would be useful. These could include:

- *Developing estimates of the volume of needed services by tracking cases with and without a BH problem forward from booking in the ACJ.* Such analyses would be enriched by adoption of earlier recommendations in this report urging improvements in the scoring and storing of information from the initial ACJ screening and assessment data collection. Figure 2 shows the types of prevalence estimates that might be obtained to inform service planning. This product would be analogous and complementary to the analyses done regarding the County system’s treatment capacity for substance use treatment (DHS Bulletin 2017-1, page 53).

**Figure 3. Flow chart of relevant prevalence rates needed for planning**



- Determining if services are going where they have the most impact.* Similar analysis could be done incorporating risk level, allowing for a determination of whether services were being targeted to those with the highest criminogenic risk and need, as recommended by the Council of State Governments (Osher, et al 2012; see also Stepping Up Initiative Key Resources: <https://stepuptogether.org/key-resources>; Jonson & Cullen, 2015). In addition, an analysis of who gets re-entry services would be useful, since addressing criminogenic needs as well as BH needs is particularly important for inmates. Our conversations with stakeholders indicated that re-entry services are provided to a subset of inmates participating in the re-entry program, and that not all inmates are eligible for the re-entry program (e.g., those in an acute MH crisis at the time of jail admission, those with a sentence less than 90 days, those who choose not to participate). It is important to know how this selection filter lines up with risk and need. The Jail Administrators Re-entry Toolkit (Mellow, et al., 2008) suggests a hierarchy of re-entry service delivery based on level of need and expected length of stay, and it would be useful to see how much re-entry services are currently targeted appropriately.
- Mapping out service delivery patterns for this population.* Analyses could examine delays and shortages by examining the time between ACJ release and the date of the first services received in the community. It would also be useful to see how long the spells of treatment are, especially for individuals with substance use issues. The National Institute on Drug Abuse (NIDA, 2006) has produced guidelines for drug treatment for criminal justice populations, noting that treatment must last long enough (at least three months) to produce stable changes for those with more severe problems. Results from the above

analyses could be compared to these guidelines for different providers and subpopulations to set reasonable accountability measures.

- *Consolidating these analyses into specific program solicitations.* More focused analyses of subgroups or patterns of use could identify gaps in service provision. Solicitations could be formulated in line with accepted guidelines for developing effective services for this population, specifically the National Institute of Health standards set forth in the National Institute of Drug Abuse 2014 publication, “What works for offenders with co-occurring substance use and mental disorders.”

**4.2 Establish Forensic Communities of Practice, (similar to the Communities of Practice model being used in child welfare) and a “learning collaborative” model for forensic community service providers.** A *Community of Practice* is defined as a group of specialized providers that share a concern, capacity and passion about an issue or a population, and who deepen their knowledge and expertise by interacting on a regular basis. The idea is to develop an invested group of providers who develop a shared practice by working together on problems, solutions and insights, and building a common store of knowledge (Wenger, 2002). In 2015, the County used this model to elicit providers who were interested and prepared to work with families at risk of losing custody of their children to the child welfare system.

We propose a similar approach to building a group of providers for justice-involved individuals with BH problems. We expect that DHS personnel have learned a considerable amount from their experiences in trying to establish a group of providers in child welfare, and that these lessons could be translated to forensic service providers. As already noted, the group of forensic service providers for these individuals is rather limited and disjointed, and has remained static for a number of years. Participating agencies would be expected to engage in specialized training, take part in meetings and other events related to the Community of Practice, and partner in evaluation related to their work. In addition, it would be expected that these service providers would have both a higher rate of reimbursement for services and a contractual obligation to take specified clients. This approach could bring a renewed sense of mission, expanded horizons and new faces to the task.

A suggested addition to this Community of Practice would be the integration of some of the practices used in “learning collaboratives” or “quality improvement collaboratives.” In this approach, agencies or organizations learn from each other by sharing ideas, methods and experiences, using a structured process focusing on data and shared concerns. These types of collaboratives have been shown to be effective for implementing and sustaining change in a variety of public health areas (Wells, et al, 2018; Joly, et al, 2012). This approach has also been used successfully by the Community Care in several health initiatives. Community Care could be a collaborative resource for DHS efforts to expand and enrich forensic services.

**4.3 Expand the amount and type of supportive community housing dedicated to serving justice-involved individuals with BH problems, including the establishment of a step down facility for individuals moving from the ACJ to a more permanent housing arrangement.** An

individual's housing arrangement plays a major role in successful adjustment back to the community. Disrupted or disruptive housing can jeopardize any recovery gains made during incarceration; periods of homelessness significantly elevate the risk of recidivism for new convictions, revocations and readmission (Lutze, Rosky, & Hamilton, 2014). The reality, however, is that there is not enough stable or supportive housing for individuals with BH disorders, whether they are coming out of jail or otherwise. The further reality is that justice-involved individuals are not given priority for a supportive housing placement, partially because they have no mandated special status in the determination of treatment bed assignment and partially because their criminal record makes them less attractive to treatment providers (on top of their MH and/or substance use problems).

It seems apparent that there has to be an effort to increase the chances of justice-involved individuals with BH problems ending up in supportive, treatment-oriented housing. Here we define supportive housing as permanent, affordable housing linked with services that meet the needs of the individuals (see, for example, Housing First). Services are coordinated across a range of areas such as health, MH, substance use, vocational services, benefits advocacy and other supports necessary to help people succeed. Important features include tenant contributions toward rent (e.g., 30% of income, most often coming from public benefits such as SSI payments), often coordinated by neighborhood-based housing organizations.

There is evidence that supportive housing models work. In projects serving mentally ill individuals experiencing homelessness and substance addiction across several sites, supportive housing has yielded more stable housing (81% of participants housed after one year and 63% remained housed after two years), fewer emergency room visits (56% decrease) and hospital admissions (45% decrease), a 76 percent reduction in days spent in jail/prison, a 57 percent reduction in the rate of prison incarceration, a 30 percent reduction in the rate of jail incarceration among those with mental illness, and a decreased recidivism rate from 50 percent to seven percent (Corporation for Supportive Housing, 2009). The best programs are those with a mission to serve this population and those which begin to engage and provide services to the individual while still in jail.

Any expansion of supportive housing for justice-involved individuals with BH problems would require some specific policy changes. Recognition of current criminal-justice involvement (and current residence in the ACJ) would have to be recognized explicitly as a reason for moving someone up in the queue for a supportive housing assignment. It is an open question whether a certain number of available supportive housing assignments at different levels of care could be dedicated to justice-involved cases. If the above recommended Forensic Communities of Practice are successful, housing partners would certainly be part of this initiative.

It would also be useful to explore the possibilities for a step-down unit/facility to house individuals who are court ordered to JRS but are awaiting a residential or treatment bed. An option such as this would save the County the daily cost of jail beds and provide a more humane environment in which these individuals can await placement. This suggestion is in line with recommendations made by National Institute of Corrections officials in a 2013 technical report completed for McLean County, VA (Ray, & Goldman, 2013). In the report, National Institute of Corrections officials recommended that crisis beds could be an appropriate option to help prepare inmates with mental illness for service linkage and return to the community (page 45). In addition, such a program has been initiated by the Pennsylvania Bureau of Probation and Parole. Building this type of program on the existing structure of the alternative housing program in the ACJ might be advisable to capitalize on procedures and contacts already in place.

There are several locales that have done some variation of this suggestion and these may be worth a closer examination by Allegheny County stakeholders. In Hampden County (MA), men who are still under correctional jurisdiction upon release are relocated to a residential Prerelease Minimum Center (PMC) or the Western Massachusetts Correctional Addiction Center (WMCAC). Trained community-based staff work with the clients until they are ready for placement (SAMHSA, 2017). In Philadelphia, the Alternative & Special Detention (ASD) facilities house minimum- and community-custody men and women; primarily inmates serving sentences on weekends and work release inmates. These facilities permit access to the community and individuals with a job contribute 16 percent of their gross pay toward room and board. Local agencies are contracted to provide a wide variety of services, including vocational training and education services. Although we are not suggesting a work-release program, the basic model of a placement where a person with a BH disorder has access to support services in a less restrictive setting than a jail unit seems reasonable and potentially less harmful for individuals with BH problems (<http://www.phila.gov/prisons/Facilities/Pages/AlternativeSpecialDetention.aspx>).

**4.4 Revisit and revitalize prior collaborative efforts with the Housing Authority and the Probation Office to establish a policy allowing probationers into public housing.** It is our understanding that current policy prohibits individuals on probation from obtaining or living in public housing. In our discussions with stakeholders, we learned that there were previous discussions between DHS, the County Housing Authority and the Probation Office about probationer's access to public housing. These discussions ended without a revised policy and it is unclear why. We recommend that County officials revitalize discussions about this possibility.

Several locales, including a neighboring county, have policies in place to allow probationers into public housing and these can serve as templates for an Allegheny County policy. Beaver County, PA has a model for allowing probationers into public housing. In Ohio, the Cuyahoga Metropolitan (Cleveland area) Housing Authority reserves two floors of public housing (with an 18-month limit on the stay) for men who have recently been released from prison (Open Door Program; <https://www.clevelandymca.org/open-door.html>). Perhaps even more applicable to the local situation, the King County (Seattle area) Housing Authority provides project-based

Section 8 vouchers for a 46-unit transitional housing development. Participants can stay between 18 and 24 months, and can transition to conventional public housing without additional screening (<http://www.doc.wa.gov/information/policies/files/350210a1.pdf>).

**4.5 Integrate forensic peer specialists (FPSs) into the service network used to support community re-entry.** There is considerable value in having an individual with lived experience as part of a treatment team, particularly for justice-involved individuals with BH problems. An empathetic understanding of being caught up in the criminal justice system can help with engagement with services as well as support for goals in community reintegration. However, the specific role for this individual must be clearly stated at the outset of service provision, and the boundaries, contributions and expectations accompanying this role should be communicated to the team at the outset. Based on our stakeholder interviews and workshops, though, it seems that the exact role for FPSs has not been delineated in the County service system. As one participant put it, “We have just never figured out what to do with peer specialists.”

An FPS is an individual with a history of mental illness and/or incarceration, who has achieved a reasonable degree of stability in their own lives. After completing a certification process, these individuals can be employed by local government and nonprofit agencies to provide individualized support to others with psychiatric disabilities and criminal justice involvements. The involvement of certified FPSs has become an increasingly important aspect of integrated care.

A growing body of empirical research has demonstrated the value and efficacy of FPS services (Sells, et al. 2006; Rowe, et. al, 2007) and this has led to the professionalization of the role with formalized training (see, for example, PA Providers Association <http://www.paproviders.org/upcoming-forensic-peer-support-training/>) and qualification as a Medicaid reimbursable service (Blash, et al, 2015). The use of an FPS has been recognized as a best practice for the support of justice-involved individuals with BH disorders (Davidson and Rowe, 2008), and many states and local authorities have used these individuals effectively to support the needs of jail diversion and re-entry programs. Educating providers about the utility of FPSs and expanding their use in Allegheny County could alleviate some of the burden on more specially trained service providers who are in short supply. Moreover, for providers with County contracts, contract language could require the agency to offer forensic peer services as an option in recovery as well as specifying the training curriculum that is the accepted standard for this certification. This is an underdeveloped, but potentially very valuable, resource for promoting positive re-entry in justice-involved individuals with BH problems.

**4.6 Examine the possible utility of Assisted Outpatient Treatment (AOT) and convene a workgroup with court and law enforcement personnel to see if there are acceptable local procedures and resources to pursue this option.** Assisted outpatient treatment (AOT) laws allow courts to order certain individuals to comply with treatment while living in the community and gives the court the power to commit the MH system to providing the treatment. AOT orders have to include case management services or assertive community

treatment team services (<http://mentalillnesspolicy.org/aot/assisted-outpatient-treatment-guide.html>). Pennsylvania law permits such orders under certain conditions, but this option is rarely used. An effort to use it more broadly in Allegheny County could require ongoing consultations with state officials to work out an acceptable set of procedures.

Such efforts might prove useful for some of the most difficult cases of justice-involved individuals with BH problems. Multiple studies have examined AOT specifically or mandated treatment more broadly. In North Carolina, Swanson and colleagues (2013) found that AOT successfully reduced the number and length of psychiatric hospitalizations, decreased criminal justice involvement, and increased the use of outpatient and medication services. These improvements were observed even after the court-order for treatment had expired. Another California program, assessed using a randomized clinical trial, also showed a significant difference between the groups in the proportion returning to jail on a new charge within a year (Burke & Keaton, 2004). Other investigators (Broner, Mayrl & Landsberg, 2005) found that mandated diversion clients had less time in prison and more in the community, better links to treatment and decreased drug use.

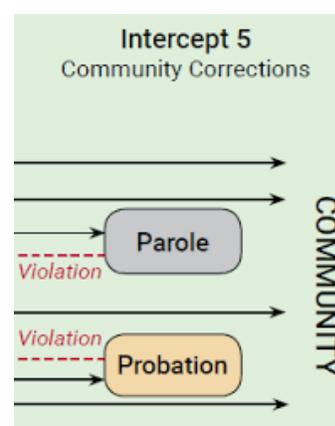
The issue with AOT is that it uses coercion in the form of court intervention for the limited number of cases where violence and community disruption are possibilities. Naturally, the use of coercion in some form as a means to secure treatment for justice-involved individuals with BH problems is controversial. On one hand, the idea of coerced treatment during a period of court supervision seems to be a natural fit and may be viewed as a promising opportunity to improve service utilization by individuals with BH problems. On the other hand, the infringement on civil liberties and the undermining of a patient's right to refuse treatment, as well as the erosion of the therapeutic relationship, are also concerns. As one set of commentators noted, "those that provide treatment under a threat of state action for client noncompliance rarely provide effective therapy but quickly come to serve social monitoring functions instead." (Mulvey, Geller, & Roth, 1987).

Consideration of this approach is a worthy exercise for two reasons. First, it addresses the issue that often undermines efforts to integrate potentially troublesome and stigmatized individuals (e.g., criminals with BH problems) back into the community, i.e., it assures that some legal process can remove these people when they start deteriorating. Second, AOT orders also have a coercive effect on providers. As noted earlier, MH providers sometimes resist working with justice-involved individuals (Massaro, 2004). The AOT model helps overcome this obstacle by "involuntarily committing the MH system to provide its services to these clients. The court order applies to both the patient and the provider." (Belluck, 2013). Thus, this approach may also represent an opportunity to pressure providers as well as individuals, ensuring that MH providers also meet their duties decreed by the Court. In the best outcome from this approach, a period of coerced treatment may be a conduit to continued involvement in care for both the client and the provider.

## **Sequential Intercept 5 – Community Corrections**

### **Intercept 5: Overview**

Intercept 5 addresses possible diversion points at the later stages of an individual's involvement with the justice system, after court processing or serving a sentence. This intercept is concerned with possible alternatives to incarceration resulting from violations or new offenses during periods of community supervision. It focuses on potential practices to ensure the provision of appropriate services in lieu of violating an individual's probation or parole status and returning that individual to jail or prison.



In this section, we address issues related to supports for successful probation. Probation can be served instead of a jail sentence or after a jail sentence. In either situation, an individual is in the community under the supervision of a probation officer with the possibility of serving jail time if the conditions of probation are violated or a new crime is committed. Since probation practices and probation violations are under the jurisdiction of Allegheny County, we explore how these practices might promote diversion for individuals with BH problems.

We will not address the issues related to parole. Parole occurs after an individual has been released from a Pennsylvania Department of Corrections facility, with some additional time on a sentence served in the community under the supervision of a parole officer. Although Allegheny County Adult Probation supervises some parole cases, these cases are not the primary focus of this report.

### **Intercept 5: Allegheny County Processes and Initiatives**

#### **Adult Probation**

The Allegheny County Adult Probation Office (Adult Probation), in conjunction with the Department of Pretrial Services (described earlier in the coverage of Intercept #2), is responsible for providing supervision of offenders in the community for the Fifth Judicial District of Pennsylvania. The office employs 130 probation officers. The primary goal of Adult Probation is to protect the safety of the community while offering assistance to probationers to assist them in becoming productive citizens (e.g. working, reunited with the family, obtaining education). While certainly important, recidivism is not the only outcome of interest, as more immediate measures of successful adjustment are also of central concern.

In 2017, 15,970 *new cases* were filed with Criminal Court in Allegheny County, and 6,316 ended up as probation cases. Seventy-five percent of the cases *sentenced* to county probation in 2017 (n=6,316) committed a misdemeanor offense (75%; 4,717/6,316) while 17 percent were sentenced to county probation for a felony offense and nine percent for a summary offense.

Within the cases with a misdemeanor offense, the most common charge category was a drug offense (42%; 1,979/4,717) followed by a property crime (23%; 1,076/4,717), person crime (14%, 665/4,717) and public order/public peace (12%; 569/4,717). The remaining seven percent of misdemeanor cases were for impaired driving, weapons and other crimes.

These new cases added to the existing caseload of probation cases. At the end of 2017, the total number of individuals under the active supervision of Adult Probation was 24,840. A small proportion of these cases (<1%) are in MHC or Drug Court.

The intensity of supervision provided for a case is determined by an individual's assessed risk to re-offend. Using the Level of Service Inventory-Revised (LSI-R), probation officers formulate a supervision plan to target the criminogenic risk and need factors of an individual probationer. Adult Probation does not complete any screen for BH conditions. In the formulation of a probation plan, the probation officer would only know that an individual has a behavioral condition if: 1) the individual is participating in MHC or drug court; 2) the individual is involved with JRS; 3) the individual was initially identified as having a BH problem in jail; or 4) the individual self-reports a BH condition. When an identified case is encountered, the probation officers typically request a release of information from the client to obtain treatment information. Probation officers report working closely with CTT services in such cases, but often have limited knowledge of available BH resources or the intricacies of insurance coverage for BH services.

Probation officers receive some exposure and training regarding BH problems. Nearly all probation officers are trained in MH First Aid (MHFA) and a limited number (approximately 10) have more intensive training (e.g., the "Hearing Distressing Voices" training). This training is seen as essential by leadership because obtaining a BH evaluation and/or BH treatment involvement are often given as conditions of probation by the court.

Probation officers working with specialty courts have the most intensive involvement with issues surrounding BH problems. Five probation officers and one coordinator are assigned to work specifically with clients who are under the jurisdiction of MHC. There is one high-risk specialized MH probation officer. The average caseload for these officers (as of 6/21/18) is 41. There are two probation officers and one coordinator assigned to work with individuals involved in drug court.

### ***Coordination with Justice-Related Services (JRS)***

Probation officers use JRS for assistance with scheduling MH evaluations and linkages to BH services as needed. In 2017, probation officers made 137 direct referrals to JRS; 77 (56%) were accepted to JRS and assigned to a staff member and 60 (44%) were either denied and referred to specialty courts for consideration or withdrawn because they did not meet program criteria. During 2017, 1,780 clients working with JRS were under some form of probation supervision (County Support, Drug Court, DUI Court, Veteran's Court or MHC). Those individuals involved in MHC remain an open case for JRS for the entire time of their involvement in MHC; other JRS

cases are usually closed after 90 days. From that point forward, JRS will only be involved with a case if there is a new pending criminal court case and/or pending probation violation. This means that a considerable number of cases with BH problems remain under probation supervision beyond their active involvement with JRS.

### ***Managing Violations of Probation***

In Allegheny County, three court liaison officers from the probation office present all cases involving violations of probation conditions to the judge who sentenced the case to probation. This arrangement was made to keep probation officers from having their time tied up in court for a single case. An Assistant District Attorney presents new charges in court at a separate hearing, if there are such charges.

There are currently no readily usable figures for estimating the relative rate of probation violations or revocations for individuals with BH problems compared to individuals without such problems. If Allegheny County is similar to other jurisdictions where this has been examined, however, we would expect the violation and revocation rate to be significantly higher (Messina et al, 2004) –possibly as much as two times higher – for individuals with BH problems as compared to those without BH issues (Eno Louden & Skeem, 2011). Adult Probation has policies in place to address violations for offenders detained in the jail on the same date as the disposition of their pending charge (EPVR). Although this policy has been in effect for many years, limited coordination with the DA’s Office and the court has kept this system from being implemented effectively. Thus, from a practical perspective, the County operates with a one person-one judge model, but the separation of the hearings for new charges and probation violations creates a situation where individuals with a probation violation and a new charge spend a considerable time in the ACJ waiting for a hearing in front of their sentencing judge for consideration of the probation detainer (even though their new charge may have been settled). Given extant research and the operational realities in Allegheny County, we speculate that individuals with BH problems are more likely to have a probation violation, and are therefore also more likely to spend more cumulative time in jail during their probation sentence. This speculative statement can be verified or refuted with some of the data analyses suggested throughout the report.

### ***Day Reporting Centers/Community Resource Centers***

Adult Probation operates three Day Reporting Centers (DRCs, also referred to as Community Resource Centers - CRCs). These centers support supervision practices by providing a one-stop shop for a wide variety of social services. DHS partners with Adult Probation to provide and monitor the following services at the centers:

- Drug & Alcohol Evaluations
- Drug and Alcohol Testing
- G.E.D / Adult Education Services
- Case Management
- Cognitive Behavioral Therapy

- Community Service
- Job Readiness / Job Search Programming
- Batterers Intervention Programs

Adult Probation and the DRCs/CRCs also maintain collaborative relationships with numerous community agencies to assist offenders. These include Habitat for Humanity, Veteran's House, Family Links, Mercy Behavioral Health, Pyramid Healthcare Services, Pittsburgh Action Against Rape (PAAR), the Center for Victims of Violent Crime (CVVC), Adopt a Highway, and the H.O.P.E Mentoring Program.

DRCs/CRCs provide a home base for the increasingly mobile probation officers who supervise offenders in the communities where they live. At the same time, they provide an accessible, central hub of social services for offenders. Individuals are referred to social services based on risk and need assessments conducted by probation officers, and many of the available services can be contacted at these centers. Offenders are mandated to attend and complete these programs as a condition of their probation, and the increased accessibility of services at the DRCs hopefully increases the chances of a probationer complying with these conditions.

There is some evidence for a positive impact of the DRCs/CRCs. With guidance from the Vera Institute of Justice, DHS worked with Adult Probation to conduct a cost-benefit analysis of the DRCs/CRCs (Zhou et. al, 2014). The analysis examined three groups of offenders (low-risk, medium-risk and high-risk) participating in employment services at the DRCs/CRCs from March 2011 through January 2013 and compared them to matched groups of offenders supervised through a traditional field office. This analysis found that:

- DRC/CRC participants had lower rates of recidivism but more technical violations
- DRC/CRC participants who recidivated had fewer days in jail compared to the control group (102 vs. 165 days), with an overall cost saving to the county

Beyond Allegheny County, the evidence is mixed but generally positive.

It should be noted, however, that the DRCs/CRCs evaluated are not homogenous in regard to population served or services provided and the evaluations themselves are not equal in scientific rigor. Outcomes should be interpreted with this in mind. For example,

- Carr, Baker & Cassidy, 2016 compared a sample of DRC/CRC probationers with mental illness to a matched comparison group (propensity score matching) on standard probation for the prevalence of and time to a reconviction. They found that participants in the DRC/CRC completers were 40 percent less likely to be reconvicted compared to a matched comparison group.
- McGregor et al, 2016 compared DRC/CRC probationers with a substance use disorder to those with a co-occurring mental illness to determine differences in program completion and measures of well-being. They found that the substance use group was more likely to complete the program but had no differences in well-being.
- In a small, exploratory study, Craddock & Graham (2001) examined re-arrest among clients in two DRCs/CRCs that serve high-risk/high-need probationers with substance abuse problems. Their analysis indicated that the completion of the DRC/CRC program was

associated with a lower chance of re-arrest; however, re-arrest was primarily a function of personal characteristics rather than DRC/CRC participation per se.

- In contrast, a randomized control trial (Boyle et al, 2013) of parolees assigned to a DRC/CRC versus those on regular parole found that DRC/CRC participants were more likely to be arrested and convicted for a new offense in the short term (6 months); there were no differences between the groups in long-term outcomes.

These initial results are somewhat promising, but far from definitive. They seem to support continued examination of the potential of DRCs/CRCs to provide integrated services and to increase engagement of probationers, particularly those with BH problems.

### **Intercept 5: Gaps**

- **There is no systematic identification process to inform probation officers about the presence or type of BH problems among individuals on their caseload.** Probation officers working with general caseloads currently have information about BH problems in their assigned probationers only if this issue is documented in earlier court or jail records, reported by the individual, or if he/she is involved with JRS. As noted in the analyses of earlier intercepts, however, there is limited systematic sharing of even limited BH indicators between agencies (e.g., DHS and the Court) and across points of criminal justice processing. Unless an individual is involved with MHC, Drug Court, Veterans' Court or JRS, probation staff may not know the BH challenges faced by the probationer. Given the limited and selective reach of the specialty courts, the lack of a systemic method to identify individuals with BH needs means that the attention paid to these issues by probation staff falls necessarily short of what would be desirable.
- **Training for probation staff on BH issues is meager.** Stakeholders consistently report that probation officers have limited knowledge of the interplay between BH problems and involvement in criminal behavior. Specialized training on BH issues seems to be very limited for the majority of probation officers. Furthermore, there is generally a lack of such trainings available with either the detail or depth needed and it is generally expensive, especially for entire units of probation officers.
- **There are no specialized caseloads for individuals with BH problems.** Adult Probation began classifying cases by risk over a decade ago using a locally validated Proxy score. Thus, risk for reoffending is the overarching criterion used currently to assess an individual's level and type of expected supervision by the assigned probation officers. This is certainly a reasonable consideration for assigning overtaxed resources. This approach, however, ignores the possibility that individuals with BH problems may present unique risk factors or needs related to their offending or violating court-ordered conditions. There are specially-trained probation officers assigned to work with probationers who are involved with MHC and one probation officer who supervises high risk offenders with a forensic service plan who are not involved with MHC. However, given the overall prevalence of BH problems

among individuals involved in the CJ system as well as the restricted reach of MHC, this method for linking probationers with BH problems to trained probation officers falls short of the need.

- **Communication and coordination between probation staff and JRS is inconsistent, sometimes creating obstacles for probation officers.** Data from analyses of ACJ releaseses indicate that JRS clients spend a considerable amount of time in jail before release, compared to other inmates. Delays in formulating and executing a community plan for an inmate with BH problems are sometimes attributable to difficulties coordinating between JRS and probation staff. Furthermore, given the extensive time on probation supervision in Allegheny County, the JRS policy to close a case after a service linkage is made or after 90 days often means that probation officers have to make repeated referrals to JRS and/or wait for a significant period of time for an MH evaluation to be completed. In addition, the JRS policy requiring a new charge or probation violation excludes JRS as an option to link individuals to services as a method to prevent such failures. Both of these situations leave probation officers without appropriate guidance for their supervision plans and probationers without the support they may need to stay out of jail.

#### Intercept 5: Opportunities

- **Adult Probation leadership is committed to an efficient use of resources and matching intensity of intervention to a probationer's risk and need profile.** Recent activities in the probation department have been directed toward adjusting the level and type of supervision provided to the likely risk of a probationer violating conditions or committing a new offense. Analyses of the risk level of probationers and their assigned level of supervision are done regularly. Efforts are being made to limit the chances of a technical violation alone resulting in ACJ placement. In addition, procedures are being put into place to approach the court about terminating long probation supervision sentences after a probationer has demonstrated a reasonable period of successful community adjustment.
- **Adult Probation is operating three DRCs/CRCs that can act as convenient sites for access to a range of supporting services.** These centers are a one-stop shop for social services that are designed to address the risks and needs related to the criminogenic factors of medium- and high-risk people under supervision. DHS partners with Adult Probation to provide and monitor a range of services. The DRCs were highlighted as a resource in our analysis of Sequential Intercept #2 where it is suggested that they could serve as accessible sites for people to fulfill their mandated service involvement after diversion at the preliminary arraignment and preliminary hearing.

#### Intercept 5: Recommendations

**5.1 Continue current activities using alternative supervision methods with low-risk cases to free up resources for more specialized services to probationers with BH needs, while examining recent innovative strategies.** Any efforts to focus resources on probationers with

BH needs will require reallocation of already sparse staff time. One method to shift this resource allocation would be to provide more alternative methods for low- and some medium-risk probationers to report in regularly. Currently, probationers classified as low risk based on the Proxy score are assigned to dedicated low risk caseloads; offenders who are compliant with probation requirements and those for whom restitution is the only condition of probation are also assigned to these dedicated low risk caseloads. These current practices likely free up resources that can be put toward the extra supports that probationers with BH problems may need. These activities may be further enhanced by considering the use of innovative supervision strategies (e.g., mobile applications) which have gained popularity in recent years. The evidence-base for these strategies is growing and encouraging.

Kiosk systems, for example, present an option with some clear benefits such as reducing the drain on probation officer time. These systems typically follow the same reporting procedures set in a face-to-face meeting. A client goes to the kiosk location, verifies his or her identity with a fingerprint scan at the kiosk, and answers a series of questions displayed on the touch screen.

New York City and over 30 other jurisdictions using kiosks were included in a recent study conducted by Westat (Crosse, et al, 2016). The study compared public safety outcomes for low-risk clients assigned to kiosk supervision to low-risk clients assigned to traditional officer supervision. The investigators found the kiosk system as effective as officer supervision on important outcomes, including probation violations, rearrests and successful probation completion for low-risk offenders. Importantly, preliminary cost data from the study indicate substantial savings from kiosk reporting.

Mobile applications (typically involving smartphones) offer another alternative. These have been used in locales as diverse as San Diego, CA and Monroe County, Indiana. In San Diego, a smartphone application, Probation Utility Mobile Application (PUMA), allows probation officers to use their smartphones to search for offenders and to enter information into the department's case-management system (see [https://assets1.dxc.technology/consulting/downloads/MD\\_7157a-18\\_San\\_Diego\\_Success\\_Story\\_v1.pdf](https://assets1.dxc.technology/consulting/downloads/MD_7157a-18_San_Diego_Success_Story_v1.pdf)). The app can be used in offline mode if there is no connectivity, with synchronization of information occurring once a mobile connection is established. Probation officers also use the application and other smartphone technologies to review their case files, conduct follow-up office visits, map their daily routes, take evidence photos, and access their email, calendar and contacts. In Monroe County, a smart phone application called Telenav can track the location of the officer carrying the device and provides a date, time and location record for management to review against staff client contact logs (<http://www.co.monroe.in.us/tsd/Justice/Probation/tabid/99/ctl/Detail/mid/702/itemid/208/Default.aspx>). The system is also used to monitor home detention and drug treatment cases. Offenders' addresses are entered into the system as landmarks for GPS to recognize when officers are there. These technological strategies offer the potential to free up probation officer time. The study of kiosks and the creative use of technology are both worthy of consideration for their potential to bolster the current efforts in the County to use probation resources effectively. This increased efficiency could translate into resources that can be used for

situations where face-to-face interactions are most useful. Shifting more resources to cases with BH problems would be possible if innovative, cheaper strategies for monitoring lower-risk probationers were put into place or if requirements for monitoring of low risk cases could be cut back.

**5.2 Establish a system for sharing information with probation staff regarding the BH status of each client coming onto supervision.** Currently, probation staff do not have adequate information about a particular client's BH issues when he/she is assigned to a general probation caseload. There may be some information available if the individual has a supervision history or is coming on probation after release from ACJ. Having consistent information about whether the individual has a history of MH or substance use treatment would be useful to a probation officer at an initial meeting with a probationer. We made a recommendation earlier in this report for the development of a flag indicating previous use of BH services (see the recommendations at intercept 2). Sharing this information with the probation officer could allow for more informed interviews with the probationer, more appropriate case planning, or the assignment of these clients to specially-trained probation officers. Any new system for sharing information with probation staff will need to comply with rules governing the sharing of this type of information under HIPAA and the statute governing the sharing of pretrial information. There are several national experts on these issues (e.g., John Pettila) who could provide consultation on these issues.

**5.3 Continue efforts to reduce the length of probation terms for all probationers.** We mentioned above that there is an effort underway to have the district attorney and judges collaborate to reduce the length of the period of probation supervision of individuals with long probation sentences who have demonstrated positive community adjustment for an extended period (possibly half or more of their original lengthy sentence). We are encouraging continued effort on this initiative because any positive effect from such a change in practice should disproportionately positively affect individuals with BH issues. There are sound reasons for this presumption.

First, there is a clear association between length of time on probation and probation revocation (see, for example, Phelps, 2013); shorter periods of supervision allow minor incidents to go unnoticed rather than becoming grounds for probation violation and an extended jail stay. Second, probationers with mental illnesses, most of whom have co-occurring substance use disorders, are twice as likely as people without mental illnesses to have their community supervision revoked (Skeem, Manchak & Peterson, 2011). When these findings are put together with the fact that the terms of probation for Allegheny County are considerably higher than the national average (Institute of Politics, 2016), it is apparent what reform in this area could achieve. Shorter probation terms overall should keep more individuals with BH issues from serving jail time for probation violations that would not need to be detected in the first place.

**5.4 Expand the services provided at DRCs/CRCs to provide BH evaluation and treatment services to probationers.** In our earlier section on Intercept #2 (Recommendation 2.6), we

recommended the use of the probation DRCs/CRCs as platforms for providing a range of services for individuals diverted at the preliminary arraignment or preliminary hearing. If our recommendation to provide information to probation officers about the BH needs of probationers is accepted, these centers can also serve as sites for the provision of these services to probationers as well (provided PA Department of Drug and Alcohol Program regulations are addressed). Individuals often do not seek out BH services because of the hassles of enrollment and access. The co-location of services in the DRCs/CRCs would reduce these barriers. As indicated above, it would be important to document the outcomes for these cases, given the sparse evidence available on these service models.

### **5.5 Create specialized BH caseloads assigned to probation officers with extensive training.**

**These probation officers will be expected to work closely with BH case managers in a collaborative team to provide services using a Forensic Assertive Community Treatment (FACT) team model.** While almost all probation officers in Allegheny County are trained in MHFA and a limited number have more intensive training, there is not a specialized unit that handles probationers with BH problems (except for the officers that work with MHC, which we noted earlier are just a small proportion of probationers with a BH problem). There are, however, multiple studies regarding the comparative effectiveness of traditional probation versus specialized MH caseloads (Skeem, Manchak & Montoya, 2017; Manchak, Skeem, Kennealy & Eno Loudon, 2014). These studies show: 1) more individualized, treatment-oriented supervision plans; 2) improved relationship between the probation officer and probationer; 3) better treatment access; 4) better rule compliance and; 5) a lower re-arrest rate. The use of specialized probation caseloads is regarded as a promising practice for improving probation outcomes.

There are certain features that are core to the specialized MH caseload model (Prins & Draper, 2009). These are:

- Specialized caseloads smaller than traditional caseloads (averaging 45 people per probation officer), composed exclusively of people with BH problems.
- Specialized probation officers who receive significant and sustained training on MH issues (averaging 20 to 40 hours per year).
- Specialized probation officers collaborating extensively with community-based service providers, integrating internal and external resources. This feature implies a hands-on approach for the probation officers whereby they are actively coordinating with treatment and other needs-based resource providers (e.g., housing) as well as actively participating in planning meetings about these individuals.

Implementing this unit would require resources and attention devoted to incorporating these features. Furthermore, since Allegheny County already has some strategies in place for the management of low-risk offenders, the specialized MH caseloads referenced here may be most reasonably reserved for probationers at medium or high risk for reoffending.

These specialized probation officers need specially-trained case managers on the BH services side. Unfortunately, criminal justice involvement is not currently a portal through which an individual is likely to be linked to a case management service. Case management teams

(including CTTs) serve justice-involved individuals only if they have previously been assigned to a team due to an MH condition.

The establishment of Forensic Assertive Community Treatment (FACT) teams, done in collaboration and with the active involvement of the probation department, would be an advance for the County (there may be one unverified team in existence now). FACT teams implement the key components of regular ACT but they also include elements of forensic rehabilitation into their approach. Overall, there is mixed evidence regarding the effectiveness of FACT for forensic outcome measures (Marquant, et. al, 2016; Morrissey & Louison, 2014), but there is some promising solid evidence from a randomized control trail (Cusack, et al, 2010) that FACT has a positive effect on both criminal justice outcomes (fewer jail bookings) and MH outcomes (greater outpatient contact and fewer hospital days).

We must emphasize, however, that the positive outcomes seen across FACT/ACT studies are only achieved when the model is implemented with fidelity; the greater the fidelity the better the outcomes (California Board of Corrections, 2005 cited in Heilbrun et al, 2012). Given the tight connection between fidelity to the model and positive outcomes, it is imperative that the County monitor teams for their implementation of the FACT/ACT model. This point is particularly important because our interviews with County stakeholders revealed consistent concern about wide variability in the quality of the work across current CTTs to their justice-involved clients. There are established elements associated with ACT that can be used to guide the development of benchmarks for performance.

## Summary

### Cross-Cutting Observations and Initiatives

This report has attempted to provide a comprehensive portrait of how the criminal justice system in Allegheny County currently responds to individuals with BH problems and to present some possible alternative strategies to address this challenge. This report is one in a line of reports on how the County can improve its efforts in human services and criminal justice. Over the years, the County has not shied away from inviting outside groups (e.g., Urban Institute, RAND, University of Pittsburgh) to take an unbiased look at programs and operations with an eye toward identifying potentially useful changes. In that spirit, this report has identified several opportunities for improvement.

It is important to recognize at the outset, though, that Allegheny County already has made tremendous efforts in this regard, and is operating a rather sophisticated and mature system for integrating services into the criminal justice system. There are already numerous building blocks for a coordinated system for these individuals, i.e., developed data systems, specified guidelines, training curricula, evidence-based practices, and dedicated personnel at several points in the criminal justice and service provision processes. At the same time, there are some resources that are not used to their full potential. Given this context, the recommendations presented here are not for rudimentary steps to build an integrated system or a litany of new programs to adopt; they are instead ideas for capitalizing on what is in place.

Some of the recommended activities from this report are specific to the intercept discussed, e.g., adding questions about homelessness status to the ACJ screening interview. Other recommendations, however, are related to more broadly-based initiatives that span several intercepts. In this final section, we want to highlight five broader, cross-cutting activities identified in the report that could have far reaching positive effects for several of the sequential intercepts examined. Coordinating efforts on these issues would seem wise to maximize resources and to ensure successful adoption at each sequential intercept where they are recommended.

First, there is a clear potential for ***more integration and analyses of existing data sets*** to guide program design, implementation and focused improvements. Allegheny County is known for its Data Warehouse and access to data from multiple systems affecting peoples' lives. The current challenge at the intersection of the criminal justice and the BH service systems is to use this information thoughtfully in program planning. At this juncture of systems, there seems to be a good deal of data *available* across systems; much more than the amount that is *used* effectively. Integrating data systems and increasing data analytic skills (ability to address question-focused inquiries rather than counts of cases meeting certain conditions) at several points in the criminal justice system (most notably, the ACJ) could set the stage for more data-driven decision making (the ultimate goal of the Stepping Up Initiative endorsed by the County).

Second, there is a need to engage the ***positive involvement of the District Attorney's office***. Allegheny County has many committed leaders who are invested in the dual goal of balancing public safety with the humane treatment of justice-involved individuals with BH issues. The active involvement of some officials, however, is more important than that of others. Other locales that have adopted innovative approaches to diversion of individuals with BH problems have noted that their efforts hinged on the willingness and enthusiasm of their District Attorney's office for such efforts. The District Attorney's office ultimately sets the latitude that the criminal justice system will tolerate in pursuit of targeted treatment, e.g., what charges are filed, recommendations for conditional bonds, and the criteria for specialty court involvement and release. Without the cooperation and positive involvement of the District Attorney's office, the idea of diversion can rapidly be seen as a push to undermine rightful prosecution.

This is not to say that personnel in the Allegheny County District Attorney's office do not share the commitment of other stakeholders; indeed, there are several District Attorney-initiated strategies in the County (e.g., charging review). However, if the County is going to fully capitalize on a shared vision for system-wide reform, policies and practices need to be informed by the concerns of stakeholders across all points in criminal justice processing. This means that the District Attorney's office has to be at the table during the planning of diversion activities from the outset as well as the oversight of any changes in criminal justice processing procedures.

Third, there appears to be a clear need to ***expand the provider pool*** for justice-involved individuals. This theme emerged consistently in discussions with professionals across the range of diversion points in criminal justice. Police officers, District Magisterial Justices, probation officers and jail personnel all report a limited number of services to recommend to individuals, especially for the high proportion of individuals whom they encounter with complicated, co-occurring disorders. This lack of familiarity with services among criminal justice personnel might be somewhat attributable to limited exposure and knowledge about providers, but service providers also indicate a shortage of appropriate services and a reluctance among providers to work with justice-involved individuals.

The suggested methods for building the pool of engaged service providers seemed to involve two basic strategies. One is to have DHS build in a contractual obligation affecting reimbursement for service providers to give priority to justice-involved individuals, and to assess compliance with this requirement. Another is to take a more positive approach, establishing networks of providers who would take part in learning communities about the needs and innovative approaches to treatment for this group. It was mentioned by several individuals that these approaches had been implemented with some success in DHS services for children and adolescents in their care, and that these experiences should be transferrable to criminal justice services.

Fourth, capitalizing on widely-used technologies to enhance the reach of MH services to these individuals makes sense; specifically, considering ***the use of tele-MH*** seems warranted. There are simply not enough MH providers for the multiple settings where they could be useful in the

criminal justice system. This is especially true regarding psychiatrists. In addition, the need for such services at most points in criminal justice processing is generally sporadic. Individuals who need to be assessed for the relevance of their BH problems to their court actions under consideration (e.g., decision to arrest or take to a treatment center, appropriate bond conditions at a hearing) do not come in all at once on schedule. As a result, physically locating MH resources at the numerous locations where they might be useful is unrealistic; even if the locations were limited, such a strategy would be too expensive.

The use of tele-MH is a possible solution. MH personnel can be in any distant location, available to accept questions or provide assessments or consultation to a variety of criminal justice personnel. As noted in the recommendations for this strategy, there is a substantial body of evidence regarding the attractiveness and effectiveness of these approaches in several settings (e.g., rural clinics, jails). Nonetheless, there is considerable skepticism among criminal justice personnel, and some MH providers, about the feasibility of these approaches. Adoption of tele-MH would have large potential pay-off, but only if it were implemented systematically and in consultation with line staff in criminal justice settings.

Finally, innovative approaches are required to address the ***need for housing***. Stable housing as a necessary resource for justice-involved individuals with BH problems was raised by numerous County stakeholders, and its robust connection to efforts to reduce justice involvement has been repeatedly noted in the broader literature. This issue is not simply the well-known shortage of community treatment beds and the difficulty of obtaining placement for justice-involved individuals in these slots. It is instead a broader problem of general housing unavailability and residence instability for this group. Simply getting a place to live is often a severe challenge for these individuals; public housing won't take them and private landlords don't want them. This issue is frequently associated with repeated police contacts and difficulties at the point of re-entry, not to mention the huge obstacle it presents to those trying to put together a community treatment plan. There is a clear need for continued collaborative work between social service administrators and providers, housing authority officials, criminal justice personnel and entrepreneurial housing developers to take on this challenge. This issue goes beyond the reach of a new program or set of guidelines; it seems to require new structures and ways of operating.

Continued attention to these general initiatives is critical to success for the approaches outlined in this report. Diverting justice-involved individuals with BH problems requires more than a few new programs. It involves collaborative undertakings by leaders in several areas at the intersection of criminal justice and social services simultaneously, all guided by a common goal and set of principles. As Ray and Goldman (2013) note,

*...the most effective outcomes are not necessarily determined by the types and kinds of services provided, but by the degree and extent to which local community leaders and agency heads share a common vision, regularly exchange relevant information and data, and actively work together to eliminate political and egocentric barriers from planning and decision making. The most effective local MH delivery systems do not operate from*

*protected independent silos but from a protected value system of collaboration, shared knowledge and resources, and mutual respect.” (Ray & Goldman, 2013, page 41)*

Allegheny County has the ability to meet this challenge.

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## Appendix A

### Comparing the content of the Allegheny County Jail Mental Health Screening to the content of other recommended MH screening tools Memorandum provided to the County Jail

#### MEMORANDUM

**TO:** Warden Harper, Dr. M. Barfield, Dr. A. Joseph, Mary Jeanne Serafin and Laura Williams  
Allegheny County Jail Mental Health Personnel

**FROM:** Edward Mulvey and Carol Schubert  
Allegheny County Behavioral Health and Criminal Justice Cross-system Evaluation

**DATE:** May 25, 2018

**RE:** Examining the contents of the Allegheny County Jail Mental Health Screen

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The purpose of this document is to summarize our findings from a content evaluation of the mental health screening completed in the Allegheny County Jail Booking Center. This comparison was done as part of the Allegheny County Behavioral Health and Criminal Justice Cross-system Evaluation.

**Process:**

The mental health screening completed in the jail booking center is intended to identify individuals with current or chronic serious mental health needs, those with an intellectual disability and those in immediate need of further assessment. We compared the content of the Allegheny County Jail Mental Health Screening (locally developed) to various screening tools that have received support in the GAINS Center 2015 report on *Screening and Assessment of Co-occurring Disorders in the Justice System* as well as a 2013 systematic review article of mental health screening tools for correctional settings (Martin, Colman, Simpson, & McKenzie, 2013). Because of the broad scope of the Allegheny County Mental Health Screening, we compared it to measures used to assess several specific domains beyond simply mental health and substance use. In addition to mental health and substance use, we included screening tools for co-occurring disorders, suicide risk, motivation for change, and trauma/PTSD. We limited the comparison tools to those that could be administered by jail staff with minimal mental health training (i.e., extensive clinical experience would not be required to administer any of the tools examined). The specific tools used for comparison are:

- Brief Jail Mental Health Screen
- Correctional Mental Health Screen (male and female versions; CMHS – M and CMHS-F)
- Mental Health Screening Form III (MHSF-III)
- Simple Screening Instrument-Substance Abuse (SSI-SA)
- Texas Christian University Drug Screen (TCU-Drug Screen)
- Addiction Severity Index –Substance Use Section
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- Alcohol Use Disorders Identification Test (AUDIT)
- Gain Short Screener (Gain –SS)
- Texas Christian University Motivation Form (TCU-MotForm)
- University of Rhode Island Change Assessment Scale-M (URICA-M)
- Beck Scale for Suicide Ideation (BSS)
- Adult Suicidal Ideation Questionnaire (ASIQ)
- Trauma History Screen
- Life Stressor Checklist

Our overall strategy involved first identifying the general “constructs” (not specific questions) included in the County screening process. We then examined the comparison tools for those same constructs as well as other constructs not assessed in the Allegheny County jail tool. Admittedly, there could be debate as to the definition of specific constructs and question items included. However, the purpose of this document is to provide a broad picture of the overlaps of the instruments, not to construct a strict scientific test of comparability. Furthermore, we are comparing content only, not the comparative psychometric quality or utility.

### **Summary of findings:**

Through this process, we discovered that the Allegheny County Jail Mental Health Screening process is comprehensive, covering much of the content included across a range of other screening tools. In the attached tables, we have listed the constructs included in the Allegheny County screening tool in the far left hand column of the table and the names of the comparison instruments across the top row. We have inserted a “✓” in the cells indicating when a construct is assessed in the Allegheny County Mental Health Screening process and the corresponding other comparison tools. Items in the far left column that appear in italics/red font are those that were in the comparison tool(s) but not in the County screening process.

In addition to Tables A and B, we provide a list of the constructs which, in our judgement, do not appear to be included in the County jail screening process. It is possible that the County jail personnel have a rationale for not including these items in the screening and/or that these items are captured in another phase of the evaluation process at the jail. We offer this list to simply draw your attention to the fact that these constructs are not covered by the existing screening process. No single tool can or should cover every conceivable dimension of

potential problems. We leave it to your judgment about whether the current review of the mental health screening highlights any constructs that might be valuable to include or exclude from your screening efforts.

Constructs not covered in the current tool include:

*Psychiatric Symptoms*

- Frequent mood changes
- Trouble sleeping
- Recent weight loss/gain
- Manic/hyper symptoms
- Jumpy/irritability
- Paranoia
- Impulse to do things over and over or pervasive/intrusive thoughts
- Description of eating disorder

*Suicide Risk*

- Frequency and duration of suicidal ideation
- Deterrents to suicide and/or reasons for an attempt
- Opportunity or capability for an actual suicide attempt

*Substance Use/other addictive behavior*

- Feeling guilty about drug or alcohol use
- Family history of drinking or drug problems
- Drove a vehicle while under the influence
- Voluntary abstinence from substances
- Alcohol D.T.'s
- Other substance use dependency symptoms
- Other substance use social consequences
- Sold, distributed, or helped make illegal drugs
- Gambling problems

*Trauma*

- Troubled by thoughts you've experienced or witnessed
- Experienced strong fears
- Additional life stressors (e.g. divorce, financial problems, sudden death)
- Sexual assault victim
- Experiencing a bad accident/natural disaster

*Other*

- Stealing

- Damage property that doesn't belong to you
- Disagreement that led to physicality
- Lacking sympathy/remorse
- Holding grudges/silent treatment
- Motivation for change
- Self-reported desire for help/treatment

We still hope to complete more of the validation study we described in earlier communications and will do so if we received the necessary data from the electronic health records. In the meantime, we hope that this information is useful as you examine the mental health screening process.

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**References:**

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Martin, M.S., Colman, I, Simpson, A. & McKenzie, K. (2013). Mental health screening tools in correctional settings: A systematic review. *BMC Psychiatry*, 13, 275.  
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<i>Continued</i>	Mental Health				Substance Use					Co-Occurring
<b>Allegheny County Jail MH Screening Components</b>	Brief Jail MH Screen	CMHS - F	CHMS -M	MHSF- III	SSI- SA	TCU- Drug Screen	Addiction Severity Index – Substance use section	ASSIST	AUDIT	GAIN-SS
Has social supports and responsibilities	---	---	---	---	---	---	---	---	---	---
Has suicidal ideation	---	---	---	---	---	---	---	---	---	✓
Has a suicide plan	---	---	---	---	---	---	---	---	---	---
Individual speaking of behaviors of concern for suicide	---	---	---	---	---	---	---	---	---	---
Interviewer feels inmate is suicide risk and/or should be on suicide watch	---	---	---	---	---	---	---	---	---	---
<b>GENERAL MH ASSESSMENT</b>										
Disoriented (observation of rater)	---	---	---	---	---	---	---	---	---	---
Feels capable of dealing with stress	---	---	---	---	---	---	---	---	---	---
Hx of psych treatment &/or prior psych meds	✓	---	---	✓	---	---	---	---	---	---
List of meds, providers and location of tx		---	---		---	---	---	---	---	---
Prior Psych Hospitalization		✓	✓	✓	---	---	---	---	---	---
Hx of self harm (other than suicide)	---	---	---	---	---	---	---	---	---	---
Hallucinations	✓	---	---	✓	---	---	---	---	---	---

<i>Continued</i>	Mental Health				Substance Use					Co-Occurring
<b>Allegheny County Jail MH Screening Components</b>	Brief Jail MH Screen	CMHS - F	CHMS -M	MHSF- III	SSI- SA	TCU- Drug Screen	Addiction Severity Index – Substance use section	ASSIST	AUDIT	GAIN-SS
Delusions	✓	---	---		---	---	---	---	---	---
Anxiety	---	---	---	✓	---	---	---	---	---	---
<i>Frequent mood changes</i>	---	✓	✓	---	---	---	---	---	---	
<i>Anything you want treatment for or help with</i>	---	---	---	---	---	---	---	---	---	✓
<i>Recent weight loss/gain</i>	✓	---	---	✓	---	---	---	---	---	---
<i>Manic/hyper symptoms</i>	✓	---	---	✓	---	---	---	---	---	---
<i>Jumpy/irritability symptoms</i>	---	---	✓	✓	---	---	---	---	---	---
<b>Paranoia</b>	---	---	---	✓	---	---	---	---	---	---
<i>Impulse to do things over &amp; over or pervasive/intrusive thoughts</i>	---	---	---	✓	---	---	---	---	---	---
<b>SUBSTANCE USE</b>										
Illegal drug use or abuse of px drugs	---	---	---	---	✓	✓	✓	✓	✓	✓
Alcohol or sedative abuse	---	---	---	---	✓		✓	✓	✓	✓
Alcohol or drug withdrawal	---	---	---	---	✓	✓	✓	✓	✓	✓
Hx of Outpt or inpatient detox	---	---	---	---	✓	---	✓	---	---	---



