Forensic – Mental Health Services
In New York State

Clarifying the Parameters:
A Survey of Programs in New York State for Mentally Ill Defendants and Offenders

Patricia O'Connor, Ph.D.
Evaluation Consultant
March 2004

Executive Summary

The focus in this report, part of a larger, Rensselaer County based 'Closing the Gap' effort, is on the existing programs in New York State to improve outcomes for persons in the criminal justice system with serious mental illness. The overall goal was to provide the Division of Probation and Correctional Alternatives (DPCA) with a 'blueprint', i.e., to identify factors in existing forensic-mental health services initiatives related to the appropriate diversion of detainees or offenders from incarceration to mental health services, specifically describing relevant programmatic characteristics, identifying elements of model programs, and providing recommendations to DPCA regarding dissemination.

Data were available from several sources: interviews with seven county programs funded by DPCA, with 12 other initiatives identified through a previous survey conducted through the New York State Office of Mental Health (OMH), and with 32 nationally identified jail diversion programs; and site visits to six counties. Results are described in detail.

Based on these data, three generic **elements of model programs** were identified:

- A program 'champion', a single individual committed to the concept of diversion of detainees for mental health interventions,
- Systemic structures, including regularly scheduled system-focused meetings, ongoing collaboration with key stakeholders, clear cross-system linkages, the integration of services with some form of case manager (boundary spanner) who can facilitate within and across system linkages.
- Clear definitions of case identification and of success and failure. For criminal justice, cases may be identified at several points on the arrest to incarceration continuum. For mental health, cases may be identified by the nature of the illness and by different assessment methods. Defining success and failure raises complex issues: whether the responsibility for success or failure lies with the program or with the individual, and whether success can be defined at a single point or must be defined by the service received (e.g., employment services = found employment).

Two core issues for the development of forensic-mental health services emerged: the difficulties associated with case definition and definitions of success and failure, and with the complexity of integrating services.

From the data collected here, **lessons learned** seem to emerge in three domains.

- Recognizing the importance of systems issues, e.g., including all relevant stakeholders to ensure collaboration, communication, and trust among stakeholders
- Understanding the need for flexibility in programming, particularly to enable criminal justice detainees' or offenders' participation.
- Providing both appropriately trained staff and adequate access to supportive programs.

There are two levels of **recommendations to DPCA**: local and statewide.
At the local level, I recommend that DPCA:

1. Build on existing relationships;
2. Promote the identification of a local ‘champion’;
3. Provide seed money for program credibility in the face of competing priorities;
4. Encourage program managers to leverage their seed money;
5. Provide training and support for service integration, in context of local culture;
6. Allow time for the ‘building’ of relationships.

Statewide, I recommend that DPCA:

1. Pursue avenues with the Office of Court Administration to encourage judicial awareness and involvement;
2. Facilitate and pursue avenues for training of district attorneys and public defenders as well as other attorneys when possible;
3. Engage jail administrators to support linkages with mental health services;
4. Maintain links with the New York State Office of Mental Health to facilitate strategies to increase the inclusion of forensic clients in mental health programs.
5. Maintain links with the New York State Office of Alcoholism and Substance Abuse Services to continue the development of linkages with forensic systems.

Table of Contents

Introduction

The project reported here is part of a larger effort in Rensselaer County, named 'Closing the Gap', to enhance the provision of appropriate services to persons in the criminal justice system who have mental illness. The value of such efforts for people committing minor offenses has been documented elsewhere, with reports of reductions in length of incarceration for those with mental illness (Desai, 2003; Hoff, Baranosky, Buchanan, Zonana, & Rosenheck, 1999) and with co-occurring disorders (Hoff, Rosenheck, Baranosky, Buchanan, & Zonana et al., 1999). Solnit (1999) reported that, in a post-booking, pre-conviction program in Connecticut, detainees diverted from jail to appropriate mental health services were incarcerated, on average, 15.5 fewer days than non-diverted detainees, although those findings are not widely replicated (Steadman, Cocozza, and Veysey 1999).

The focus in this report is on the existing county-based efforts in New York State to improve outcomes for detainees with serious mental illness. Seven of these efforts have received five-year funding grants from Division of Probation and Correctional Alternatives (DPCA) and three of those have local and/or external grant funding in addition to the DPCA grants. Other programs rely solely on local county and/or other grant funding, or operate without specific funding streams. The information here is based primarily on 19 telephone interviews with program managers and six site visits, all in New York State.

Additionally, information is available from a set of 32 interviews conducted with jail diversion programs nationwide by Marisa Beeble, M.A., as part of her thesis project. Where appropriate, data from those interviews are included in this report to provide additional perspectives on these results from efforts within NYS. An important distinction, however, between the NYS and the national-level programs is that the latter were identified strictly because they were considered jail diversion programs, with the goal typically defined as either preventing or reducing jail time (Desai, 2003; Borum, 1999). These detainees are commonly identified post-booking. The NYS programs are more typically intersections or linkages between the mental health and criminal justice systems, which comprise formal structured programming efforts or less formal connections with limited contacts or linkages, but are not necessarily jail diversion programs, according to the recognized definition (Desai, 2003; Borum, 1999). These NYS detainees are more commonly identified post-conviction or pre-release. Further, jail diversion programs true to the model described by Morris and Steadman (1994) include three core activities: Routine screening and evaluation of detainees, negotiation for appropriate mental health (MH) disposition, linking of detainees with appropriate MH services. The combination of these should result in reduced time in jail, according to Morris and Steadman.

This report begins with the articulation of project goals and methods of information collection. Elements of model programs and core issues are next, followed by the detailed

interview results, which include lessons learned as reported by the program managers or noted on the site visits. Finally the report ends with recommendations proposed to DPCA, which could facilitate their efforts to encourage the implementation of appropriate county-based mental health jail diversion efforts across New York State.

Project Goals

The overall goal of this project was to provide DPCA with a 'blueprint', i.e., to identify program or system-based factors in existing forensic-mental health services programs and initiatives that either facilitate or inhibit the appropriate diversion of criminal justice detainees from incarceration to mental health services. Three specific objectives more narrowly defined the scope of this project:

1. To describe the relevant programmatic characteristics of seven DPCA-funded forensic-mental health services programs and NY-Based programs. These characteristics would enable or preclude the development and maintenance of systemic diversion for mental health services efforts.
2. To identify elements of model programs associated with the successful establishment of diversion efforts, based on the information collected from the efforts in New York State and on those reported in the extant literature.
3. To provide recommendations to DPCA which would facilitate the dissemination of strategies to encourage the development of locally based diversion programs.

Project Methods

Project Design. This project comprised two strategies in collecting information, both of which are more fully described below. First, two sets of interviews were conducted, with DPCA-funded programs with an interview protocol described below, and with programs based in New York which were identified through New York State Office of Mental Health regional forensic coordinators, with the DPCA interview protocol appropriately modified to fit the program. A third set of interviews, reported here in a secondary fashion only, was conducted with the nationally identified programs. Second, I conducted six site visits with three DPCA and three NY-Based programs to elaborate the information gathered in the interview. Several of the visits included my observation of a regularly scheduled meeting, typically focused on system issues. At each of these, participants completed a brief questionnaire, described below.

Interview design. The interview protocol for the seven DPCA-funded programs, which was approximately the same for the 32 national programs, comprised five sections: start-up, current program and practices, accountability, political factors, and critical lessons. In the start-up section, I solicited information about previous efforts in the county, particularly focusing on factors that made the initial implementation of the DPCA-funded program easier or harder to accomplish. In the current programs and practices section, interviewees described the basic goals and implementation strategies of their program, including

- The nature and extent of meetings, e.g., formal or informal, minutes taking, agenda, content (case review, systems reviews)

- The degree of collaboration with key stakeholders and across systems
- Nature and timing of case identification
- The use of a boundary spanner
- The nature of program leadership
- The use of integrated services, and
- The nature of case management.

In the third section, accountability, program managers provided their programmatic definitions of success and failure, and described their funding mechanisms, specifying the extent of their reliance on the DPCA funding. Additionally, they detailed the nature and extent of other, non-monetary resources allocated to the program, and whether there were any 'cost-free' aspects to program implementation or maintenance. The next section comprised questions about the political strengths and weaknesses of the program, including those factors that enhance or weaken program implementation. Finally, interviewees were asked whether there were specific 'lessons learned' that would be helpful to DPCA or other programs, what worked particularly well and what needed 'fixing' to make it better.

Site visit questionnaire. This information collection comprised four open-ended questions, soliciting meeting participants' perceptions about specific factors:

- That are important to making their program effective
- That make the work of the collaboration (meeting) easier
- That make the work of the collaboration more difficult
- That would be useful to others trying to start such collaborations.

Project Participants. DPCA provided contact information for the seven funded programs, all of whom completed interviews during October and November 2003. McCormick and Chakedis (2003), in a 2001 survey, identified 18 programs throughout New York State. I was able to contact 17 of those and complete interviews with 12. Additionally the national survey comprised interviews with 32 program managers. These participants are hereafter distinguished as DPCA-funded, NY-Based and National.

Elements of Model Programs

Three clusters of elements for model programs emerged from these interviews, all of which are supported by existing research, as noted below. First is the importance of a program 'champion', a single individual committed to the concept of diversion of detainees for mental health interventions, which others have named strong leadership (Desai, 2003; Morris & Steadman, 1994; Steadman, Deane, Morrissey, Westcott, Salasin & Shapiro, 1999). It is essential that this person either has or can make the appropriate connections to provide both the political and fiscal support for the program. Also, this person must exhibit the requisite persistence and tenacity to enable program start-up and continuation. Further this champion calls together meetings as necessary and desirable, pursues participation from key stakeholders, and otherwise makes every effort to ensure program stability. Among the 19 program managers interviewed for this project, three

specifically (and spontaneously) identified the critical role that a single 'champion' played in the initiation and maintenance of their programs.

The second cluster of elements centers on system structures in program implementation, including maintaining regularly scheduled system-focused *meetings* (Desai, 2003; Morris & Steadman, 1994; Steadman, Deane et al., 1999). Five DPCA-funded, seven NY-Based, and 31 National programs reported meeting schedules, ranging from monthly to quarterly. Additionally, those five DPCA-funded, five NY-Based, and 14 National programs include systems-based issues in their meeting content. The remainder of the meetings focus on clinical case reviews or other non-system issues.

Another system structures element is ongoing *collaboration with key stakeholders* (Desai, 2003; Morris & Steadman, 1994; Steadman, Deane et al., 1999), represented by most programs in meeting participation and specifically endorsed by six of the DPCA-funded, two of the NY-Based and all of the National programs. These collaborations represent connections that are both within system, e.g., among mental health service agencies, and across systems, e.g., between mental health and probation. Related to this collaboration is the development of *clear cross-system linkages*, e.g., shared office space, official appointment to committees, etc., so that communication and system problem definitions and resolutions are supported by identifiable, permanent connections between systems. Solutions to problems are then institutionalized into practice, rather than resulting from informal connections between individuals.

Finally, a core system structures element is the *integration of services* (Borum, 1999; Desai, 2003; Morris & Steadman, 1994; Steadman, Deane et al., 1999), including mental health treatments, substance abuse services, supported employment programs, and housing. The integration for an individual is typically accomplished with some form of boundary spanner function, usually named as a case manager or forensic case manager. Critical to providing appropriate services for any detainee will be the adaptability of those service possibilities to the specific needs of the individual. More integrated services offer easier, and probably more effective, transitioning from one service to another. The case manager/boundary spanner is essential to facilitate linkages but the process will be seriously hampered if the linkages are not consistent through some level of service integration. Four of the DPCA-funded, five of the NY-Based, and 26 of the National programs have case managers who function as boundary spanners.

The third cluster of elements for model programs centers on the need for clarity in definitions, first of cases, and second, of success and failure. The question of *defining a case* requires attention to two perspectives:

- From the criminal justice side: first, what kinds of crimes make detainees potentially eligible for diversion: misdemeanors, or felonies, or both? Second, when, in the arrest to incarceration process, should diversion to mental health and associated services occur: pre- or post-booking, pre- or post-conviction, pre- or post-incarceration, pre-release?
- From the mental illness side: what is the definition of a mental illness, and then, what is the nature of the illness, and, separately, who will decide that there is a

mental illness (initial clinical screen, psychological or psychiatric assessment, etc.)?

Although most jail diversion programs attempt to avoid any incarceration, reduction of time spent in jail is also an acceptable outcome for such programs, as noted above. The usual best practice for jail diversion programs is early case identification, ideally within the first 24 to 48 hours of arrest (Borum, 1999; Morris & Steadman, 1994; Peters & Bartoi, 1997; Steadman, Morris & Dennis, 1995). The expectation is that earlier identification will lead to more timely interventions and more successful diversions. Among these NYS initiatives, however, few engage in early identification procedures. Four DPCA-funded programs identify cases post-conviction; two others can be identified at any point in the arrest to incarceration process. Most programs focus on misdemeanors; one explicitly assesses and diverts only individuals who have committed felonies. Screening for mental illness occurs in a variety of ways. At one end, case managers in small counties review arrest records daily to identify people familiar to the mental health system. At the other, the judge, prosecutor (district attorney), or the attorney for the defendant may request an assessment for mental illness.

The issues associated with *defining program success and failure* are very complex. First is whether the locus of responsibility for success or failure is with the individual or with the program. Success could be the result of the appropriate constellation of services and supports for an individual, i.e., appropriate integration of relevant services, or the result of the individual's willingness to participate in what providers deem the appropriate services. Conversely, however failure may be defined, whether by domain or by a single outcome (e.g., return to jail), that failure could be construed either as the implementation of inappropriate systems interventions or as the unwillingness of the individual to participate.

Second is the systemic location of the success or failure: in the mental health service system, where recovery or stabilization might be the goal; or in the criminal justice system, where avoidance of jail or dropped charges might be the goal; or in some other part of an integrated system, e.g., in the substance abuse system, where abstinence might be the goal. Only one DPCA-funded program defines success with this systemic complexity, as the relative attainment of the appropriate goal in each domain relevant to that individual.

The majority of DPCA-funded (4) and four NY-Based programs have loose definitions of success, considering it program involvement or engagement, a definition that may be appropriate when the program is a unified set of activities and participation is simple to monitor. Several include combinations, e.g., mental health program completion and charges dropped, or retention in mental health program and stable housing.

Core Issues

Although several questions are raised in this discussion of the elements of model programs, two core issues emerge, both of which will need attention when there are

efforts to develop effective forensic – mental health services programs. The first is the need to clarify the meaning of success and failure so that programs can effectively develop strategies purposely targeted to attain the program-specific definition of success and to avoid the concomitant definition of failure. Second is the issue of detailing the meaning and methods of systems integration, which will include determining the scope of services, identifying the necessity and nature of system linkages, and developing appropriate structures to cope with barriers and challenges which will arise.

Results

Presented here are the detailed results of the completed interviews with the seven DPCA-funded programs. Woven in are the responses from the 12 NY-Based programs, most of which were not structured so as to fit easily into all parts of the DPCA-funded protocol. For example, there was not a clear 'start-up' point for NY-Based programs whereas the DPCA-funded programs began with the funding opportunity. Additionally, questions about funding were not relevant as NY-Based programs did not have specific funding streams. Further, without the impetus of funding only a few of the NY-Based programs had built specific structures, i.e., committees or consortia, to address the integration of forensic and mental health services. Also included are the relevant responses from the 32 National programs.

Initial Program Implementation

In three of the seven counties that were afforded this DPCA funding opportunity, one person was the specific impetus for program initiation, usually a mental health director. This person, in a position to advocate effectively for program start-up, brought the relevant key stakeholders together and engaged them in the process. In two other counties, the funding opportunity enabled action on an issue, the forensic – mental health services intersections, which had been generally recognized as a problem in the county. The final two DPCA-funded programs used the availability of funds to focus their existing programs more specifically on jail diversion efforts, beyond the provision of mental health services to detainees or inmates. The grant was particularly useful to these two because it enabled them to set a clear direction for their efforts. Among the National programs, the most common impetus for start-up was the influence of advocates, reported by 6 (19%) of interviewees. (For ease of understanding the numbers are also given in Table 1).

Among the DPCA-funded programs several factors seemed to facilitate program implementation. Four reported that the existing relationships were most important because they served as the basis on which to build support. Nine of the National programs also described that building on existing relationships and committee structures made program start-up easier. Also within this context was the degree of support provided by staff and other county officials, noted by two DPCA-funded and three National programs.

Three DPCA-funded programs reported that difficulties associated with having those involved understand the differences between detainees with and without mental illness made initial implementation more difficult. This would include probation officers' lack of familiarity, and consequent discomfort, with people with mental illness and, similarly, mental health workers' lack of familiarity, and consequent discomfort, with people as perpetrators of crime. Two other programs noted that initial, idiosyncratic communication difficulties made start-up harder, one because of a change in staff and the other because of the complications associated with the local funding mechanisms. The remaining two described their personal situations as contributing to initial implementation difficulties. One of those was new to the position and to the county workforce, and the other described a lack of background in criminal justice as decreasing that individual's credibility among the criminal justice staff.

Table 1
Program Start-Up

	DPCA	National
Impetus		
Single person	3	
County recognition w/ funding	2	
Existing program	2	
Advocacy efforts		6
Facilitating factors		
Existing relationships	4	9
County/political support	2	3
Inhibiting factors		
Unfamiliarity across systems	3	
Communication difficulties w/ funder	2	
Need for education about diversion		4
Difficulties in starting collaborations		9
Personal factors	2	

At the National level, the general problems associated with developing collaborations among the requisite stakeholders groups was the most common difficulty, named by nine. Four National interviewees also noted that start-up was made more difficult by the need for education about diversion, both for the community and for participants.

Current Program: Structures and Practices

Two foci for *current practices* have emerged among the DPCA-funded programs with several programs centered on the provision of some degree of integrated services, implemented in virtually all of the National programs. Other DPCA-funded programs are primarily concerned with screening for mental illness among detainees or inmates, with an appropriate referral for treatment, but not in an integrated services model. At the time of the interview, one program, somewhat late in its development, had not yet identified a

specific focus. Among the NY-Based programs, several offer specific treatment programs, e.g., day treatment, substance abuse programs, after screening such that the forensic-mental health services link is between some aspect of the criminal justice system and the specific type of available program. Only one has developed any degree of integrated services. Again, for ease in understanding, numbers are reported in Table 2.

Implementation of programmatic structures, such as regular meetings, formal leadership, ongoing collaborations, varies somewhat among the DPCA-funded programs. These structures occur less frequently among NY-Based efforts where a formal 'program' is less likely to be in place. Only five of the 12 NY-Based programs have regular *meetings*, consortia, or consistent collaborations of any kind, compared to five of the seven DPCA-funded programs, though two of those have recently decreased their frequency of meeting. Nearly all of the National programs have regularly scheduled meetings, the majority of which (22) occur monthly or more frequently. *Leadership* generally comes from the mental health side, either from independent agencies or from county mental health departments, for all of the DPCA-funded programs. Among the five NY-Based programs with more formal collaborations, e.g., through meetings, three have mental health leadership, one is from substance abuse and the fifth uses a rotating leadership. Among the National programs, leadership affiliation was not asked, but 30 report having strong leadership, though the affiliation of the leaders is not known. Six DPCA-funded programs report ongoing *collaborations*, with many fewer noted among NY-Based programs. One of the latter, however, emphasizes that a critical component in their county was close collaboration with the police; two others name collaboration as essential. One describes that "it is all about relationships." Collaboration occurs among 32 of the National diversion programs.

Among four of the DPCA-funded programs *case identification* occurs post-conviction, two others can be identified at any point in the arrest to incarceration process, and the last was still clarifying the point for case identification at the time of the interview. Among the NY-Based programs, two include cases at post-booking, one is described as post-conviction, another is pre-sentencing, and four are pre-release programs.

Four of the DPCA-funded programs have a case manager who fulfills the function of a *boundary spanner*, making service connections for detainees with some level of follow up. Among several of the NY-Based programs the common practice, particularly among those that are pre-release, is that the clinician who conducts a mental health screening makes referrals to specific programs, acting in the role of a boundary spanner. Typically there are not formal mechanisms in place for follow up to determine the appropriateness or success of the referral. Most (26) of the National programs have boundary spanners and the majority of those promote system linkages (14) and provide information to the court (15). Three DPCA-funded, two NY-Based, and all National programs have what they describe as *integrated service* models.

Table 2
Current Programs and Practices

	DPCA	NY-Based	National
Program emphasis			
Integrated services	3	1	31
MH screening	3		
One or more independent program		5	
Regular meetings	5	5	31
Leadership			
Mental health affiliation	7	3	
Other affiliation		2	
Strong, no affiliation indicated			30
Collaborations	6	3	32
Case identification			
Post-booking		2	32
Post-conviction	4	1	(selected
Pre-sentencing		1	for post-
Pre-release		4	booking)
Any point in time	2		
Boundary Spanner	4	5	26
Integrated services	3	2	32

Accountability

Accountability here begins with a definition of success, and concomitantly, of failure, as core concepts in determining whether programs are providing appropriate services and achieving expected outcomes. Then, for DPCA-funded programs, I review the sources of funding, program reliance on DPCA, and other resources available to DPCA-funded programs. Finally is an examination of the more common notions of accountability, i.e., external and/or internal regulators, and factors in program implementation or maintenance that are 'cost-free'. Numbers are also given in Table 3.

Although the notion of success for jail diversion programs is complicated, as described above (p. 9), it comprises program participation or engagement in services for three DPCA-funded programs and either program completion or appropriate program departure for two others and for one NY-Based program. One DPCA-funded and one NY-Based program each define success within service domain, e.g., in employment, if the individual is working; in housing, if the individual has a stable residence; overall success then comprises appropriate achievements in each relevant domain. The seventh DPCA-funded program was still in the start-up phases and had not yet defined success. In one NY-Based there are several, completely autonomous treatment programs, each of which would have its own definition. One program, NY-Based, incorporated the dropping of

charges and another included not re-offending in their characterizations of success. All of the National programs except one define success as either reduced recidivism (28) and/or reduced jail time (15), generally in combination with other outcomes such as increased access to services (8).

The notion of failure, which could be described as the reverse of success, is even less clearly defined among these programs. The majority of DPCA-funded consider failure as the individual either leaving the program or services inappropriately or not being engaged in the programs. The other three programs named returning to jail or 'being violated' as evidence of failure. In light of the questions and concerns regarding the definitions of success and failure noted above, characterizing failure in these terms seems limited, both in principle by holding the individual solely accountable, and in practice by restricting the designation to a single point.

Table 3
Accountability

	DPCA	NY-Based	National
Success			
Program participation/engagement or Access to services	3		8
Program completion/appropriate departure	2	1	
By specific program completion/domain	1	1	
Charges dropped		1	
Reduced recidivism		1	28
Reduced jail time			15
Failure			
Leave program inappropriately/not engaged	4	-	-
In jail or violated	3	-	-
Funding			
DPCA Grant only	4	na	
Multiple sources	3		14
State funding			12
County funding			9
Billable services			9
External accountability			
Funding source (DPCA, SAMHSA)	4		12
CJ (judges, DA, probation)	4		
Politicians/local legislators	2		18
Internal accountability			
Tracking, monitoring, reporting	5		27

By definition, all of the DPCA-funded programs receive grant funds, which is the only source of income for four of them. The other three have leveraged the grant monies into additional funding sources, although two of those were already in existence and therefore had funding, at the time of the initial DPCA awards. NY-Based efforts generally rely on county-based funding. The most common source of funding for National programs is county based with only nine reporting the availability of state funds. Nine rely on billable services to sustain their programs, some of whom also have county funding. Of those who report funding sources (26), 14 have more than one source.

All of the DPCA-funded programs report that they would be affected by any withdrawal of those monies. Two noted the particular seriousness of their situations with one describing that it would be the end of the program and another that it would 'cripple' the program. Funding reductions or limitation would have less of an impact on those with multiple sources of funding.

Six of the seven DPCA-funded programs are able to access other resources to support their programmatic efforts. Those include office space, the only additional resource for one program, and some clerical assistance for the others. Several note the importance of those resources to their programs, not only for their actual value but also for the degree of legitimacy the provision of those resources represents.

Four of the DPCA-funded programs report that they have external accountability demands from the criminal justice system, specifically from judges, district attorneys, and probation departments. These may comprise reports back to the courts on specific cases, summaries of case outcomes, or simple tracking of the number and outcome of mental health screenings. Four also note that there is accountability from DPCA, though they are unclear about content and format at the time of the interviews. Two also report that local politicians and/or legislators seek accountability, particularly if local funding supports the program. Again, the nature of that accountability is not clearly specified. The NY-Based programs were not asked about external accountability. Twelve of the National programs are accountable to federal Substance Abuse and Mental Health Services Administration (SAMHSA), nine to their state governments, and nine to county governments. There is minimal overlap among the three funding sources, with only six having accountability to more than one source.

Five of the DPCA-funded programs have internal accountability requirements, primarily in some form of monitoring, tracking, or some kind of reporting system. This information may be collected and reviewed by the grants specialist within an agency, an executive director, or some other person/position to whom the program is accountable. Most (27) National programs track clients, typically number of days incarcerated and re-arrests.

Finally, related to funding, DPCA requested that we identify any aspects of program implementation or maintenance that could be considered 'cost-free', i.e. strategies or aspects that could be implemented without funding. Four DPCA-funded programs were not able to respond but three others provided interesting perspectives. For one, the extent to which the program, usually in the person of the case manager, provided advocacy and

support for clients in some add-on way, or extra, or beyond what was required or expected was cost-free. For this respondent, there is a base level of advocacy and support that all clients would receive; whatever is beyond that base level is cost-free. A second described that partnerships with other programs which emerge out of the forensic-mental health initiatives are cost-free. Such collaborations can extend beyond their initial purpose and offer additional benefits to local settings, all of which are cost-free. Finally, the third was able to provide onsite training for probation officers that was cost-free to the department.

Political Strengths and Weaknesses

The strong degree of local legislative and political support comprises their primary political strength according to three of the DPCA-funded, two of the NY-based, and six of the National programs. With that support programs can receive local monies, leverage funding to increase the fiscal support for their programs, and/or exercise influence in their efforts to develop collaborations across systems. Others, three DPCA-funded, one NY-Based, and three National programs, report that their political strength emanates from the criminal justice system, specifically the judges, district attorneys, probation and/or police. One judge, interviewed on a site visit, emphasized the role of the district attorney, noting that they are the decision-makers regarding prosecution and plea-bargaining for all cases in New York. On another site visit, participants stressed the important role of probation as the initial connection for identifying detainees with mental illness. Additionally, two National programs note the role of the community as an impetus to creating change.

Having political strengths implies the likelihood that there will also be political weaknesses. Among these programs, three funded by DPCA recognize that natural to any political involvement will be the tensions related to those connections. Acquiring and maintaining political support may require meeting the needs and expectations of those supporters, which may lead to decision dilemmas, or to difficult-to-meet reporting expectations, as noted by one DPCA-funded program. The ability to demonstrate any positive outcomes, however, is a strength, as noted by one National program. A change in political leadership, presumably based on concomitant shifts in priorities, was named as a political weakness by two National programs. A second area of political weakness is the reverse side of the political strength that can come through the criminal justice system, according to two DPCA-funded and four National programs. If local judges, probation, or the police do not support, or are unwilling to recognize, that detainees may have issues related to mental illness, the work of forensic-mental health initiatives will be more difficult.

More generic but related factors include the simple reality that programs need to be involved in political processes, as described by four DPCA-funded programs. However, at the county level priorities may shift so that at one time attention to forensic-mental health services may be considered critical and yet, at another time, slip to become a much lower priority. Then political involvement may become somewhat moot. One program suggested that whenever there is an economic downturn, there will be a decrease in support for people with mental illness, again, minimizing the possible effects of previous or ongoing political involvement. Another aspect to political involvement is the time-

consuming nature of the requisite cultivation of legislative and/or foundation support, noted by one DPCA-funded program. The last DPCA-funded program stressed that with political support comes an increased expectation regarding accountability; if funding is made available, then the program must produce results.

There may be other, more individualized factors which require attention, from a political perspective, as illustrated in two DPCA-funded programs. Individuals who are new to a system, whether as a new hire or as a new position in a different system, will need time to build their credibility in that system, particularly because, as noted above, most of these programs develop out of and build upon existing relationships.

Lessons Learned

From these DPCA-funded and NY-Based programs, lessons learned seem to emerge in three domains. First is the importance of systems issues, recognized by three DPCA-funded, three NY-Based, and three National programs. One critical systemic issue, from a DPCA-funded program, is the *distinction* between the fundamental, underlying perspectives that organize the work of criminal justice, specifically probation, and mental health. The former emphasizes adherence to the rules, here the conditions of probation, and an infraction may result in a violation. Necessarily, the focus is on monitoring. The latter stresses the need for engaging the clients, highlighting the occasional need for incentives to generate or support that engagement in the treatment process.

Other systemic issues include the importance of including all relevant *stakeholders* (five National programs), ensuring *collaboration and communication* between stakeholders (one NY-Based and eight National programs), and recognizing the extensive amount of *time* that is required to work across systems with a concomitant need to establish *trust* across those systems (two DPCA-funded programs). Mental health providers have to trust the probation officers, and the reverse, though the aforementioned differences make such trust more difficult to achieve. One NY-Based program commented on the degree of control that is exercised by parole officers who are centrally involved in their efforts.

To forge forensic-mental health linkages successfully, there is a need for flexibility in programming, particularly enabling criminal justice detainees' or offenders' participation. Traditional mental health providers are unaccustomed to work with forensic clients and have to accommodate their specific needs for support and demands for accountability. Also learned, according to two National programs, is that the locus of responsibility must be identified, whether for memoranda of understanding (MOU) or other matters.

One DPCA-funded program also stressed, as a lesson learned, that programs should build linkages with other systems and/or agencies and follow those linkages with supportive funds. That order increases the likelihood that such linkages will become institutionalized linkages. Four National programs emphasized the need to be proactive about obtaining funding.

Two other areas provide important lessons in ensuring that needed services and supports will be available for program implementation, according to two DPCA-funded programs.

First is the necessity of having appropriately trained staff who understand and can work effectively with forensic clients, also noted by two National programs. Second, there is a serious need for supportive programs, particularly housing programs and programs for people with dual diagnoses (mental illness and substance abuse). On the housing side, in some areas the issue is not that local departments of social services are not providing housing supports but that there is a serious lack of housing units. In others the problem is more the lack of affordable housing. Programs which have been developed to address co-occurring disorders (mental health and substance abuse) are not adequately prepared to provide services for forensic clients; there are an insufficient number of treatment options available.

Implementation of Core Jail Diversion Activities

Morris and Steadman (1994) proposed three activities as core for jail diversion programs: routine screening and evaluation of detainees, negotiation for appropriate mental health disposition, and the linking of detainees with appropriate mental health services. Virtually all programs engage in regular screening of detainees, typically followed by some kind of referral if mental illness is present. Few programs seem directly involved in negotiations with regard to the criminal justice disposition of the case, although some describe having direct reporting responsibilities to their respective judges. The third core activity, linking detainees with services, is regularly accomplished by most programs, though not within an integrated services model. More common might be the screening of individuals, particularly on pre-release basis, to determine their appropriateness and eligibility for specific programs which are available in their respective counties.

According to Morris and Steadman (1994), engagement in these activities should result in a reduction of jail time, which might also mean the avoidance of jail time. Among the programs, the impact of programmatic efforts and activities on length of incarceration is generally not assessed.

Recommendations to DPCA for Dissemination

On the local level, a variety of factors are critical to the successful implementation of forensic – mental health services linkages. Encouraging the development of those connections should take into account several factors, all of which could be developed into a set of steps for a model forensic – mental health initiatives program. Thus, I recommend that DPCA incorporate the following into any dissemination efforts:

1. Build on existing relationships, particularly in smaller counties where people may have positions which include a variety of functions. This strategy requires working closely with local key stakeholders to identify positive connections that are already in place, and to note where previous efforts may have had less than positive consequences. The determination of the latter will facilitate overcoming their effects.
2. Promote the identification of a local ‘champion’, one individual who is committed to the implementation of forensic – mental health services linkages and will exhibit the determination and persistence necessary to accomplish a specific programmatic goal.
3. Provide seed money, which should be sufficient for program credibility in the

face of competing priorities in any county. Particularly in larger counties with substantial budgets, programs that have minimal funding have a more difficult time establishing legitimacy and marshalling needed supportive resources, e.g., office space and clerical support.

4. Encourage program managers to develop strategies to leverage seed money to obtain other funding. This may require specific sets of recommendations or targeted training efforts to provide relevant information about such strategies.
5. Provide training and support to encourage service integration, in context of local culture. The relationships among mental health services, criminal justice, and social services will vary by county. In some counties, e.g., unified services counties, there is likely to be a culture of collaboration among mental health service providers, frequently extending to collaborations across systems. Alternatively, in other counties, where mental health services may be more competitive, the nature of relationships may be more tenuous. Thus, the methods to achieve some levels of integrated services must build on those local cultures.
6. Allow time for the 'building' of relationships, recognizing that having the relationships firmly established will more likely institutionalize the program practices and lead to their being sustained in a county, regardless of the level of funding. With a habit of collaboration and/or cross-system linkages in place, program implementation will persist, as it becomes systematized into regular practices. The continuation will probably occur, whether the program has standing as an official program or simply evolves into an accepted set of practices.

Thus, it seems possible to have the essential *cross-system linkages*, which could comprise a basis for forensic – mental health services, without the infusion of additional dollars, beyond some initial seed monies. However, such a scenario could occur only if there were an appropriate champion who could build on existing and foster new relationships and who could ensure adequate training to encourage and support involvement from critical stakeholders.

At the State level, participation of critical mental health and criminal justice systems can be encouraged. Without their substantial involvement, or at least acquiescence, forensic – mental health service linkages will be more difficult to establish and maintain. Also important will be the inclusion of substance abuse services. To accomplish these supports, I recommend that DPCA:

1. Pursue avenues with the Office of Court Administration to encourage judicial awareness and involvement, including the provision of training and incentives to encourage participation in such training.
2. Facilitate and pursue avenues for training of district attorneys and public defenders as well as other attorneys when possible through, for example, State and county bar associations. Helping these critical stakeholders understand the consequences of mental illness and the impact of appropriate treatments will facilitate their involvement.
3. Engage jail administrators to support linkages with MH services. Chavez (1999), Dank & Kulishoff, (1983), Veysey, Steadman & Salasin (1995) and Walsh, (1998) have noted the need to provide training for correctional staff on mental

illness. Correctional officers, as key stakeholders, are particularly important because of their direct-contact status with detainees. Their ability to recognize symptoms of mental illness and a potential need for services will substantially enhance the likelihood of appropriate interventions.

4. Maintain links with the New York State Office of Mental Health to facilitate strategies to increase the inclusion of forensic clients in MH programs, recognizing the particular needs of those in the forensic systems. This might include training for frontline staff in, for example, programs for co-occurring disorders, or expanding criteria for program participation to allow those with forensic involvement to be clients.
5. Maintain links with the New York State Office of Alcoholism and Substance Abuse Services to continue the development of linkages with forensic systems. Such connections at the State level will encourage the building of linkages at the local level.

References

Borum, R. (1999). Jail diversion strategies for misdemeanor offenders with mental illness: Preliminary report. (Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Fl).

Chavez, N. (1999). The courage to change: A guide for communities to create integrated services for people with co-occurring disorders in the justice system. (The Open Society Institutes Center on Crime, Communities, and Culture and The National GAINS Center).

Dank, N.R., & Kulishoff, M. (1983). An alternative to the incarceration of the mentally ill. Journal of Prison and Jail Health, 3 (2), 95-100.

Desai, R.A. (2003). Jail diversion services for people with mental illness: What do we really know? Research in Community and Mental Health, 12, 99-122.

Hoff, R.A., Baranosky, M.V., Buchanan, J., Zonana, H., & Rosenheck, R.A. (1999). The effects of a jail diversion program on incarceration: A retrospective cohort study. The Journal of the American Academy of Psychiatry and the Law, 27 (3), 377-386.

Hoff, R.A., Rosenheck, R.A., Baranosky, M.V., Buchanan, J., & Zonana, H. (1999). Diversion from jail of detainees with substance abuse: The interaction with dual diagnosis. The American Journal on Addictions, 8 (3), 201-210.

McCormick, C.T. & Chakedis, V. (2003). Criminal justice diversion programs serving persons with serious and persistent mental illness: A New York State survey. Community Mental Health Report, March/April, pp. 35-36, 46-48.

Morris, S.M., & Steadman, H.J. (1994). Keys to successfully diverting mentally ill jail detainees. American Jails, July/August, 47-49.

Peters, R.H., & Bartoi, M.G. (1997). Screening and assessment of co-occurring disorders in the justice system. (Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Fl).

Solnit, A.J. (2000). The cost and effectiveness of jail diversion, A report to the joint standing committee of the general assembly. (Connecticut's Department of Mental Health and Addiction Services).

Steadman, H.J., Cocozza, J.J., & Veysey, B.M. (1999). Comparing outcomes for diverted and nondiverted jail detainees with mental illness. Law and Human Behavior, 23 (6), 615-627.

Steadman, H.J., Deane, M.W., Morrissey, J.P., Westcott, M.L., Salasin, S., & Shapiro, S. (1999). A SAMHSA research initiative assessing the effectiveness of jail diversion programs for mentally ill persons. Psychiatric Services, 50 (12), 1620-1623.

Steadman, H.J., Morris, S.M., & Dennis, D.L. (1995). The diversion of mentally ill persons from jails to community-based services: A profile of programs. American Journal of Public Health, 85 (12), 1630-1635.

Veysey, B.M., Steadman, H.J., & Salasin, S. (1995). Double jeopardy, Persons with mental illnesses in the criminal justice system. (A report to Congress from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Public Health Service, U.S. Department of Health and Human Services).

Walsh, A. (1998). Jail: The first link in our chain of collaboration. American Jails, March/April, 51-59.

APPENDIX A
Interview for DPCA Programs

1. Introduction: key elements
    - Brief description of this project and interviewer
    - Time required for interview: now or schedule another time?
    - Anonymous to DPCA (I may call back for more info)
    - Goal: to provide DPCA with 'lessons learned' to enable wider dissemination of programs
        - through an examination of the different stages of program development and implementation among the seven DPCA programs, and
        - through the identification of 'what is working' and 'what needs fixing' in existing programs
        - therefore we will be asking:
            - What works?
            - What needs fixing? Or doesn't work?
            - What's changed since the program began? [followed up with: How did or has that affected the program?]
    - Is contact person best source of information? or someone else (even for part of interview)?
    - Structure of interviews:
        - Begin with description of program start-up (Who? How?)
        - Describe current program (with additional questions to clarify)

2. Program start-up
    - What, if anything, existed before this program began?
    - How did the program actually begin? Who was involved?
    - Were there key factors that made start-up easier? Or harder?

3. Current program description: Can you describe your program as it is now?
   [note inclusion of key elements:]

    - Regularity and nature of meetings (including membership, minutes, content, etc.)
    - Nature and degree of collaboration (evenly spread among stakeholders? Some key and some peripheral stakeholders?)
    - Use of boundary spanner (or similar position)
    - Program leadership
    - Use of integrated services
    - Timing of case identification (early? Pre- post- booking?)
    - Nature of case management
    - Definitions of success and of failure: impact of failure on program?
    - Funding issues

- Grant funding only? Blended funding? How would the program function without grant funding?
- What would happen if the grant funding ended? In other words, could the program function without the infusion of funds?
- Are there other, non-monetary resources allocated to the program? (space, time, etc.)

- Political factors:
  - Political strengths and weaknesses of the program
  - Political factors that enhance (weaken?) program implementation
- Accountability of project?
  - External demands for accountability?
  - Internal mechanisms for accountability? Motivation for program involvement?

4. Any particular 'lessons learned' that would be helpful to DPCA or other programs?
   - Any that are 'cost-free' (i.e. no new dollars)?

5. Anything else that we should know about how your program works?

   - What works particularly well?
   - Or what needs fixing to make it work better?

APPENDIX B

NEW YORK STATE PROGRAMS: LOCATION BY COUNTY:

DPCA-FUNDED[1]	NY-BASED[2]
Albany	Allegany
Bronx (2)	Broome
Cattaraugus	Cattaraugus
Erie	Chautauqua
Lewis	Chemung
Madison	Cortland
	Erie
	Fulton
	Jefferson
	Niagara
	Oneida
	Rensselaer
	Rockland
	Schenectady
	Sullivan
	Wayne
	Westchester

[1] All completed interviews, three were site-visited.
[2] Twelve completed interviews, three were site-visited.

ACKNOWLEDGEMENTS

The willingness, cooperation and openness of all participants who were interviewed and/or visited for this report are gratefully acknowledged. Equally important was the contribution of Marisa Beeble who conducted all of the national interviews and the review of the literature.

Funding was provided by the New York State Commission on Quality of Care for the Mentally Disabled through the New York State Division of Probation and Correctional Alternatives under a grant to Rensselaer County with the assistance of the Mental Hygiene Institute, Albany, N.Y.