

CONSENSUS WORKGROUP POLICY RECOMMENDATIONS TO THE

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**116TH CONGRESS & TRUMP ADMINISTRATION
ON BEHAVIORAL HEALTH ISSUES IN THE
CRIMINAL JUSTICE SYSTEM: NEXT STEPS**



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BACKGROUND

The Consensus Workgroup on Behavioral Health Issues in the Criminal Justice System includes national organizations representing individuals with behavioral health needs and their families, providers, correctional systems and administrators, criminal justice reformers, state and local governments, state and local program directors, and researchers. Participating organizations recognize that the intersection of behavioral health issues and criminal justice necessitates coordinated, collaborative, and sustained efforts. **Together, we call on the Administration and the 116th Congress to comprehensively address issues at the intersection of behavioral health and criminal justice.**

THE ISSUES¹

Increasingly, criminal justice systems are being called upon to manage individuals with mental illness and substance use disorders (SUD). Although many interactions between police and people with behavioral health disorders are not criminal in nature or are for low-level violations, alternatives to enforcement are lacking and many of these individuals end up in prisons and jails. Attempts to address the problem have resulted in a patchwork of federal, state, and local responses.

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

- » 44.8, 56.2, and 64.2 percent of federal prison inmates, state prison inmates, and local jail inmates, respectively, reported impairment over the previous year due to a mental health problem.¹
- » 45.5, 53.4, and 68 percent of federal prison inmates, state prison inmates, and local jail inmates, respectively, met the criteria for drug dependence, abuse, or both.²

A recent federal report on restrictive housing that used a measure of psychological distress found that 18.2 percent of prisoners and 22.2 percent of jail inmates met the criteria for an anxiety or mood disorder;

and 14.6 percent of prisoners and 26.2 percent of jail inmates met the criteria for serious psychological distress.³

Juvenile justice systems also bear the burden of an overwhelmed behavioral health system and have become the de facto treatment setting for many individuals under 18 who lack access to care. Nearly half of children and adolescents in the child welfare system have a mental health disorder, and 70 percent of youths detained in the juvenile justice system have diagnosable symptoms of a mental health disorder—3.5 times the rate among all individuals under the age of 18.⁴ In one recent study, 61.2 percent of justice-involved youths screened positive for an SUD; the study identified comorbid mental health and substance abuse disorders in 48.6 percent of these youths.⁵

Within these populations are groups that require specialized attention or support for their unique needs, including individuals with disabilities, sexual and gender minorities, women, and older adults.

WHAT IS BEING DONE

Congress has recognized these problems and has called upon the federal government to take the first steps toward a response. Recent investments in programs and practices strive to better meet justice-involved individuals' behavioral health needs, make better use of public resources, protect public safety, and reduce the rate of reoffending and re-arrest. Pre- and post-bookings diversion, such as Crisis Intervention Team models and problem-solving courts, help keep those who pose little risk to public safety out of formal criminal justice processes. Significant efforts also are underway to ensure that criminal justice and health agency partnerships, jails, and prisons work together to effectively meet the behavioral health needs of individuals who come into contact with the justice system.

We strongly support existing federal efforts in this area, such as Substance Abuse and Mental Health Services Administration (SAMHSA) grant programs (for example, Jail Diversion, Drug Court and Offender Reentry programs) and the Bureau of Justice Assistance (BJA) grant programs (for

example, National Training and Technical Assistance Center to Improve Police-Based Responses to Mental Health Disorders and Intellectual/Developmental Disabilities, Justice and Mental Health Collaboration Program, the Second Chance Act, and the Byrne Justice Assistance Grant programs) that provide funding to state and local agencies to support community-based services. However, meeting the level of need seen across the nation, spurring, and supporting systematic reforms requires additional support, training, and funding. To that end, we recommend federal support for state and local efforts that are tailored to the needs of specific professions, locales, and decision-making points in the criminal justice system.

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

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

1. FEDERAL SUPPORT, TRAINING, AND TECHNICAL ASSISTANCE TO STATE AND LOCAL AGENCIES.

A. Cross-cutting

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

information about best practices for utilizing peers, families, and caregivers in supporting recovery for people with mental health and SUD involved with the justice system. This could include implementing the work group on reentry within the 2018 opioid package. The Consensus Workgroup encourages the Center for Medicaid Services (CMS) to deliver an update on the status of the workgroup.

- » **Help state and local systems expand efforts to universally screen and assess at arrest**, sentencing, and all points across the criminal justice continuum for:
 - › **Mental health and SUD** to inform connections to appropriate treatment and services; and
 - › **Criminogenic risk and need**, to further inform recidivism reduction programming and release decisions.
- » Connect justice-involved and at-risk individuals to **health care coverage and services**:
 - › **Allow Medicaid to cover services for individuals who are incarcerated but who have not been adjudicated or convicted for crimes**. Changes in Medicaid coverage should be done with the purpose of promoting continuity of care for incarcerated individuals. Jails and prisons should never be the primary location for people with mental illness and substance use disorders to receive needed treatment, and communities should continue increase the availability of and access to community-based services for mental health as part of larger decarceration efforts. Adequate and timely data should be collected and reported to identify the impact of this policy change.
 - › **Support states in suspending, rather than terminating, Medicaid coverage** during incarceration. When a person is incarcerated, even for a short time pending trial in county jail, it is common for their Medicaid benefits to be terminated. This can be a function of state policy or limitations in information systems. Reinstating Medicaid benefits can take up to several months, meaning a substantial lag in accessing treatment in the community. Research has shown that this delay in starting treatment after incarceration drastically increases recidivism.
 - › **Communicate the availability of services to Medicaid recipients**, ensuring compliance with Mental Health and Substance Use Disorder Parity provisions, which require equal coverage for

medical/surgical and behavioral health services. The application of mental health and addiction parity across health insurance providers enhances the opportunity for individuals to access needed supports in local communities.

- › **Connect individuals to health coverage and services** during the reentry process. Those preparing for release should apply for/reactivate Medicaid or gain coverage on the health insurance marketplace during a 60-day special enrollment window. Minimizing delays in accessing health care services is critical for those with chronic medical conditions and behavioral health needs.
- › **Build capacity of comprehensive, community-based mental health and addiction treatment services to meet the needs of justice-involved populations and those at risk of becoming justice-involved.** The Certified Community Behavioral Health Clinic (CCBHC) model has shown the ability to help behavioral health providers dramatically expand treatment capacity, including by providing same-day treatment access. CCBHCs are required to provide evidence-based, trauma-informed care and collaborate with partners in law enforcement and jails to reduce recidivism and improve health outcomes. **Congress and the Administration should support efforts to expand the scope and length of the CCBHC Medicaid demonstration.**
- » **Support the specific needs of justice-involved individuals in rural communities** through telemedicine and other means of delivering services over longer distances. Some rural communities face barriers to the provision of services because of their proximity to hospitals, qualified professionals, and community behavioral health agencies. In addition, community-based behavioral health treatment organizations should be provided a pathway to register with the Drug Enforcement Administration to be a location in which patients can be prescribed controlled substances, such as those used in medication-assisted treatment and certain psychiatric medications, via telemedicine.
- » **Address behavioral health disparities and the specific needs of special populations** involved in the justice system, including racial and ethnic minorities, women, individuals with disabilities, older adults, people experiencing homelessness, and sexual and gender minorities.

- » **Support the integrated treatment of co-occurring disorders.** Many people suffer from both mental health and SUD, for example. Historically, those with co-occurring disorders have received mental health treatment services separately from substance use treatment services, funded, in part, through separate federal block grant programs. However, current research shows that individuals with co-occurring disorders are best served through integrated care. Many integrated care programs and methods exist, all of which should assess and match the patient to their appropriate level of care based on the severity of their illness. This approach often lowers costs and creates better outcomes.
- » **Support the expansion of trauma-informed systems and care.** Traumatic stress and posttraumatic stress disorder are widespread among the justice-involved population. Trauma can underlie emotional, cognitive, and behavioral patterns that seem to indicate other behavioral disorders and can be made worse through certain treatment modalities for other disorders. Effective trauma-informed systems incorporate psychoeducation for justice-involved individuals, systemwide training for professionals, and evidence-based and promising group and individual interventions.

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

- » **Encourage further dissemination and implementation of evidence-informed and promising diversion (pre-arrest, pre-trial, post-adjudication, and short-term crisis facility) responses,** such as law enforcement, court-based, and jail-based responses. The Consensus Workgroup recognizes existing federal efforts in this area and strongly supports the Office of Justice Programs (OJP) in their expansion to train and provide technical assistance through state grant-making agencies to service providers.
- » **Improve and expand promising law enforcement responses** to individuals with behavioral health needs. Effective assessment is essential at the earliest point of contact so that an appropriate diversion path can be determined. This requires additional training for law enforcement. Great demand also exists for training to help law enforcement respond safely to emergency situations involving

individuals experiencing a mental health or addiction crisis. We support expansion of the National Training Center to meet this demand; training to help officers triage potential mental health crises and intensive training for a smaller group of officers to respond in conjunction with a behavioral health team in a more comprehensive way to mental health and addiction crises; and training of nonsworn personnel.

- » **Help state and local jurisdictions develop policies to support the participation of individuals in treatment plans, supervision conditions, incentives, and reimbursement for community commitment**, including incentives and graduated sanctions that are the least restrictive necessary, reasonably calculated to address addiction and mental health issues to prevent further criminal justice involvement, and do not inadvertently or deliberately disadvantage people with these disorders. Officers also need to be able to adjust the restrictiveness and intensity of supervision conditions based on individual circumstances. SUD are defined by their chronic and relapsing nature, and federal agencies should extend support to jurisdictions that wish to implement accountability measures other than secure detention for failed drug screens.

C. Effective practices during incarceration

- » **Facilitate and support the universal adoption of evidence-based screening, assessment, and treatment** in jails and prisons, including access to both psychosocial and psychopharmacological treatments, as indicated. The U.S. Department of Justice (DOJ) can take model policies and practices from state and local corrections and the Bureau of Prisons (BOP) and help other facilities improve the care they provide.
- » **Improve correctional officer responses** to mental illness and mental health crises. Build on the work of the National Institute of Corrections to provide correctional officers with training on de-escalation and other means of safely resolving situations involving inmates in mental health crisis.
- » **Continue reforms and innovative programming to further reduce the use and harmful effects of restrictive housing, leading to reduction of trauma and mental health issues.** Give jails and prisons guidance, standards, and other tools to **reduce the use of restrictive housing.**

Correctional systems are placing a premium on reducing their restrictive housing populations, especially those with behavioral health needs, who may be at increased risk for worsening symptoms in these settings. DOJ should build on its restrictive housing report and BOP reforms, provide support to state prisons and local jails, and disseminate lessons learned from these efforts. DOJ should also adopt and implement policy ensuring that the use of restrictive housing is limited to emergency circumstances and that inmates are placed in such housing for only as long as necessary to alleviate emergency circumstances.

- » **BOP has requested additional funding dedicated to removing mentally ill offenders from restrictive housing** through expansion of the Secure Mental Health Step-Down Program and to placing a mental health professional in each of the agency's Secure Housing Units. Local departments of correction have also implemented reforms and innovative programming, such as limiting the maximum number of days that any individual can be placed in restrictive housing, including limitations for juveniles. We strongly support these goals. In addition, BOP can further improve their efforts by adopting successful strategies from local and state corrections, including eliminating the use of solitary confinement and other forms of long-term segregation for individuals with severe mental illness.
- » **Help local and county jails** address the unique challenges they face related to behavioral health. Jails house a higher proportion of individuals diagnosed with severe and chronic mental illness than prisons; operate with unpredictable inmate release dates, which hampers the development of reentry plans; and have limited ability to coordinate with local behavioral health authorities, link inmates to core services in the community, and provide for continuity of care during reentry. Jails also need support specific to suicide prevention, including universal, validated suicide risk assessments and policies and services for those deemed to be at risk. In 2013, the suicide rate among jail inmates was 46 per 100,000, while the suicide rate in the general population was 12.6 per 100,000.⁶

D. Effective reentry practices

- » **Support comprehensive transition planning** that begins at the time of admission to jail or prison and continues without disruption into the community. Each transition plan should be based on a risk/needs assessment and should address continuity of care and other social/relational needs (that is, criminogenic risk, housing, health care coverage, access to appropriate health care services and treatment, employment, family/peer relationships, and so on). Proper planning and maintaining health through the reentry process are crucial to individual success in the community, as is the provision of essential supports. Particularly important is the availability of community residential planning, sober/transitional housing with supportive services for ongoing behavioral health treatment, case management, and supported employment.
- » **Expand the availability of services provided to individuals returning to the community and their families.** Programs and services should be tailored to the unique needs of the individual based on risk and need; be developmentally appropriate; be trauma-informed; and be responsive to the gender, age, and cultural background of the participants. Effective reentry practices consider the interactions among multiple factors (a biopsychosocial approach), particularly the connections between behavioral, physical, and relational health.
- » **Support the expanded provision of medication-assisted treatment,** including all medications approved by the U.S. Food and Drug Administration, as this treatment has been found to be successful in treating SUD by combining behavioral therapy and medications.
- » **Federal grant programs focused on reentry** (for example, BJA's Second Chance Act program, SAMHSA's offender reentry program) should further emphasize a comprehensive approach to reentry for returning citizens with behavioral health needs in their solicitations and performance metrics.
- » **Prioritize information sharing between justice systems and community physical and behavioral health providers.** When facility records are not available to community services providers, efforts to ensure seamless care can be hobbled. Federal grant programs focused on reentry (for example, BJA's Second Chance Act program, SAMHSA's offender reentry program) should further emphasize the importance of

record sharing in their solicitations and performance metrics. Also, the federal government should provide clear guidance around the application of the Health Insurance Portability and Accountability Act (HIPAA), which prevents unnecessarily sharing medical information.

2. FEDERAL COURTS AND PRISONS.

- » **Increase resources for behavioral health programming in the federal BOP in male and female institutions.** To meet the goal of adequately addressing the needs of all inmates, BOP needs additional providers, physical space, and financial resources.
- » **Engage in more pilot programs, expand innovative efforts, and disseminate lessons learned and effective practices.** BOP plays an important role in American corrections and, with increased authority and resources, can provide new models for state and local corrections to improve care for offenders with behavioral health needs.
- » **Develop policies to support adherence to treatment plans, supervision conditions, incentives, and reimbursement for community commitment,** including incentives and graduated sanctions that are the least restrictive necessary, reasonably calculated to prevent further criminal justice involvement, and do not inadvertently or deliberately disadvantage people with mental health disorders or SUD. Officers also need to be able to adjust the restrictiveness and intensity of supervision conditions based on individual circumstances, including through measures other than secure detention for failed drug screens.

3. BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT.

- » **Build on current student loan forgiveness and repayment.** Educate medical and behavioral health professionals about Public Service Loan Forgiveness for work in criminal justice settings. Expand National Health Service Corps (NHSC) eligibility to local and county corrections and a wide range of addiction treatment and recovery support professionals, and make permanent the FY 2018 NHSC expansion of eligible participating sites to include addiction treatment facilities. Support behavioral health-specific workforce programs such as the new SUD Loan Repayment program enacted through the 2018 Opioid Package (H.R. 6) and a similar program for mental health professionals as

described in the Mental Health Professionals Workforce Shortage Loan Repayment Act of 2018.

- » **Support partnerships between institutions of higher education, local and state correctional agencies, and community providers** to expand opportunities for training and placement in correctional settings for students enrolled in accredited behavioral health professions training programs.
- » **Strengthen funding for programs that expand the behavioral health workforce**, such as the existing Behavioral Health Workforce Education and Training Program and new SUD Loan Repayment program enacted through the 2018 Opioid Package (H.R. 6), and that prepare behavioral health providers to intervene with families and work with at-risk children, adolescents, justice-involved youths, transitional-age youths, and others at high risk for developing mental health disorders and entering the criminal justice system. Strengthen funding for programs that are proven to help behavioral health providers to hire well-trained staff, such as the CCBHC program. Increase training for nonclinical staff so that they can recognize the signs and symptoms of behavioral issues and respond appropriately. Such training should be provided by qualified trainers in techniques with a strong research base.
- » **Provide spaces, such as conferences and remote trainings, for service providers** (for example, licensed professional counselors, psychiatrists, psychologists, social workers, community-based programs), judges, prosecutors, public defenders, and community corrections administrators and officers to maintain ongoing dialogue about standardization of and competencies for forensic behavioral health treatment.
- » **Encourage employment-related reentry programs** that are designed to address the mental health, substance abuse, and developmental needs and challenges of each participant.

4. FEDERAL RESEARCH, EVALUATION, AND COORDINATION.

- » **Fund evaluations, higher-level analyses, and outcome comparisons** of pre- and post-bookings diversion, medication-assisted treatment (inside and outside of secure settings), and other programs and practices.

- » **Fund studies to bridge the gap in research on people with behavioral health disorders** involved in the justice system, such that both recovery and recidivism reduction outcomes are considered or examined. Both the reduction of mental health symptoms and recidivism reduction among this group are imperative goals, and the federal government can take a leadership role in aligning this work.
- » **Create an interagency council or permanent working group** on behavioral health issues in criminal justice modeled on the Federal Interagency Reentry Council and the U.S. Interagency Council on Homelessness. Involve representatives from the U.S. Departments of Justice, Health and Human Services, Housing and Urban Development, Labor, and any other agencies who work with the criminal justice populations. Ensure the group addresses issues related to different funding streams, confusion around jurisdiction on Capitol Hill, and the array of federal legislation and programs that do or could address these issues.
- » **Support coordinated local, state, and federal innovations.** Numerous local and state governments have placed a priority on designing interventions for justice-involved individuals with behavioral health issues, and federal agencies are providing financial support for these localized initiatives through the Byrne Justice Assistance Grant program and several discretionary grant programs. With additional support for local, county, and statewide planning and national coordination, efforts across the country can culminate in more widespread effective and coordinated programs. Exemplary programs, including those encouraged through recent legislative strides, involve multiple service agencies, and as such, DOJ can help to establish best practices for data collection, communication, and sharing among these agencies.

5. JUVENILE JUSTICE.

- » **Ensure robust federal funding for culturally and developmentally appropriate prevention programs** that identify and target services to at-risk juveniles and their families at the first indication of problems, to maximize the chances that juveniles do not engage with the juvenile justice system in the first place.

- » **Emphasize diversion** for justice-involved youths with behavioral health needs, and include aggression management, mental health, and substance use treatment in interventions for this group. Home- and community-based treatment for justice-involved youths can be provided in ways that protect public safety. Allowing more appropriate agencies, such as state and local behavioral health services, to address the needs of these youths would allow juvenile justice facilitators to focus their limited resources on the mission of rehabilitation and delinquency prevention.
- » **Exercise oversight power** to ensure that the Office of Juvenile Justice and Delinquency Prevention is enforcing compliance with the updated core protections of the Juvenile Justice and Delinquency Prevention Act, including the requirement that youths charged as adults must be held in juvenile detention facilities pretrial.
- » **Expand and invest in evidence-based screening, assessment, and treatment** of both criminogenic and behavioral health needs for youths who must be held in secure detention or corrections. We recognize that not all justice-involved youths will receive services in the community. For this group, it is imperative that juvenile justice facilities provide the best possible services from qualified providers and staff to address risk of reoffending and behavioral health problems.

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

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