

Interbranch Advisory Committee on Mental Health Initiatives

Improving Responses to Individuals with Mental Illness in New Jersey

Submitted to the New Jersey Supreme Court:
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I. EXECUTIVE SUMMARY

The Interbranch Advisory Committee on Mental Health Initiatives was appointed to address important concerns regarding the many individuals with serious mental health needs who intersect with the criminal justice system. The goal of the Committee is to improve the Judiciary's responses to individuals with mental illness who have become entangled in the justice system. The Committee is committed to the belief that greater communication, cooperation and education will result in substantial improvements. The Committee framed its recommendations to entities outside the Judiciary in the form of suggestions to avoid any appearance of attempting to mandate initiatives to other branches of government. The following is a summary of the Committee's recommendations.

- RECOMMENDATION 1** It is recommended that the New Jersey Supreme Court establish an Interbranch Mental Health Initiatives Implementation Committee.
- RECOMMENDATION 2** It is recommended that the Judiciary develop and adopt a comprehensive plan of intervention strategies pertaining to individuals with mental illness, including initiatives at various stages along the criminal justice spectrum.
- RECOMMENDATION 3** It is recommended that a local Core Team be established in each county which does not already have one. The team will be the 'go to' local group for assuring that the over-arching structure of collaborative initiatives becomes institutionalized in the county.
- RECOMMENDATION 4** It is recommended that cross-systems mapping strategic planning sessions be initiated by the Core Teams in counties which do not currently have such strategic plans.
- RECOMMENDATION 5** It is recommended that a mental health liaison be established in municipal courts throughout the State.
- RECOMMENDATION 6** It is recommended that Prosecutors Offices which are interested in the diversion process be encouraged and supported in the implementation of these programs.

- RECOMMENDATION 7** It is recommended that the New Jersey Probation Specialized Mental Health Caseload be expanded and further funding applications for it be made.
- RECOMMENDATION 8** It is recommended that the Implementation Committee supervise the development of educational programs for New Jersey judges (Superior and Municipal Court), so they are all fully educated on relevant aspects of mental illness.
- RECOMMENDATION 9** It is recommended that the Implementation Committee supervise the development of educational programs for employees of the New Jersey Judiciary who are not judges (including ombudsmen and drug court staff), so they are all fully educated on relevant aspects of mental illness.
- RECOMMENDATION 10** It is recommended that the Implementation Committee offer suggested assistance to law enforcement and first responders in creating and further expanding educational programs to improve responses to people with mental illness (e.g., expansion of Crisis Intervention Team training).
- RECOMMENDATION 11** It is recommended that the Implementation Committee provide suggestions to the State and municipal public defenders' offices on developing educational programs to improve responses to people with mental illness, encompassing the same issues covered in prosecutorial/attorneys general training, with additional information on dealing with mentally ill clients.
- RECOMMENDATION 12** It is recommended that the Implementation Committee provide training to the Division of Mental Health Services staff and mental health service providers on how the courts work (Superior and Municipal).
- RECOMMENDATION 13** It is recommended that the Implementation Committee structure a comprehensive public information program.
- RECOMMENDATION 14** It is recommended that information sharing procedures be explored and developed to enable

mentally ill individuals to receive services in a timely and effective fashion.

RECOMMENDATION 15 It is recommended that mental health service providers be educated on the benefits of requesting access to judicial computer systems (e.g., the Automated Complaint System and Automated Traffic System), when appropriate, in order for providers to view defendants' outstanding charges and best advocate for them within the court system.

RECOMMENDATION 16: It is recommended that the Superior and Municipal Court computer systems be enhanced to include an indicator for defendants who have manifested mental illness, either through participation in a mental health diversion program, participation in DMHAS programs or some other means.

RECOMMENDATION 17 It is recommended that comprehensive and creative funding strategies be fully explored.

II. INTRODUCTION AND CHARGE

Chief Justice Stuart Rabner convened the Interbranch Advisory Committee on Mental Health Initiatives (“the Committee”) in October of 2010. The Committee is composed of 21 diverse New Jersey stakeholders, including representatives from the Judiciary, the Attorney General’s Office, the Public Defender’s Office, several County Prosecutors’ offices, the Division of Mental Health and Addiction Services, and private mental health service providers.

The Committee was charged with reviewing existing services and programs and developing advice on how to coordinate better among different service providers and defendants and how to improve the Judiciary’s response to mental health needs.

The focus of this report is on individuals with serious mental illness, defined in the psychiatric field as major Axis I diagnoses, including schizophrenia spectrum disorders, bipolar spectrum disorders, and major depressive disorders.¹

¹ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-IV-TR. (4th ed., text rev. 2000). Any references to ‘mental illness’ in this report will refer to this more serious subspecialty of mental illness.

III. COMPOSITION OF THE COMMITTEE

Hon. Wendel E. Daniels, Pr.J.C., Chair

Hon. Louis J. Belasco, Jr., Pr.J.M.C.

Hon. Michael R. Connor, J.S.C. (ret.)

Hon. Ramona A. Santiago, J.S.C.

Joseph J. Barraco, Esq. Assistant Director, Criminal Practice Division
Administrative Office of the Courts

Kevin M. Brown, Assistant Director Probation Services,
Administrative Office of the Courts

Adriana Calderon, Esq., Municipal Division Manager
Somerset/Hunterdon/Warren Counties

Elizabeth Domingo, Trial Court Administrator Union County

Marie Faber, Trial Court Administrator Passaic County

Joseph Fanaroff, Esq., Deputy Attorney General
Office of the Attorney General

Steven M. Fishbein, Coordinator for Mental Health Evidence-Based and
Promising Practices, Division of Mental Health and Addiction
Services

Raquel Jeffers, Deputy Director, Division of Mental Health and Addiction
Services, Department of Human Services

Debra A. Jenkins, Assistant Director, Municipal Court Services Division,
Administrative Office of the Courts

Anthony P. Kearns, III, Esq., Prosecutor Hunterdon County

James J. Kelly, Vicinage Chief Probation Officer Ocean County

Joseph E. Krakora, Esq., Public Defender, Office of the Public Defender

Marcia Matthews, Division of Addiction Services, Department of Human
Services

Laura Rodgers, LCSW, Jewish Family Service of Atlantic and Cape May
Counties

Theodore J. Romankow, Esq., Prosecutor Union County

Carol Venditto, Chief, Drug Court Unit, Criminal Practice Division
Administrative Office of the Courts

Elaine Wladyga, Esq., First Assistant Deputy Public Defender,
Office of the Public Defender

Committee Staff

Julie Sealander Higgs, Esq., Municipal Court Services Division
Administrative Office of the Courts

IV. DEVELOPMENT OF REPORT AND RECOMMENDATIONS

This report provides an overview of issues surrounding the interaction of mentally ill individuals with the judicial system, sets forth the Committee's process and issues addressed by each of the three subcommittees and delineates the Committee's final recommendations.

The recommendations entail various suggestions for developing more effective responses to people with mental illness. They include the suggested expansion of various existing programs/procedures as well as entirely new initiatives. Because of the complex and multi-faceted nature of the issues which the Chief Justice charged the Committee to consider, the recommendations in this report are ambitious and broad in scope. The Committee is cognizant that any recommendation pertaining to entities outside the judicial branch (such as the executive branch) is in the form of a suggestion.

In this report, the interaction of individuals with the criminal justice system has been considered at various points along the continuum of the system. The Committee determined that focusing on initiatives at the earlier chronological end of the spectrum would likely produce the greatest return in terms of effectiveness and financial investment.

A. Mission Statement

The mission of the Chief Justice's Interbranch Advisory Committee on Mental Health Initiatives is to develop models of research-based, cost-effective intervention processes that can be implemented to improve responses of the criminal justice system to persons with mental illnesses.

B. Committee Activity

The full Committee held meetings on February 23, March 23, April 27, August 17, September 14, October 26, December 7, 2011, September 27 and November 28, 2012. At the first seven meetings the Committee heard presentations from the following speakers: Debra Jenkins (Overview of Mental Health Issues and the New Jersey Judiciary); Steven Fishbein, Division of Mental Health Services (Overview of Justice Involved Services by DMHS and Cross-System Mapping); Dr. Nancy Wolff, Ph.D. (Specialized Mental Health Probation Caseload); Dr. Kenneth Gill, Ph.D. (Union County Jail Diversion Program); Stacey Dix-Kielbiowski, mental health evaluator (Jersey City – Court Liaison Program); Judge Nesle Rodriguez, Chief Municipal Court Judge, Jersey City (Jersey City – Court Liaison Program); Laura Rodgers, LCSW (Jewish Family Service of Atlantic and Cape May Counties, NJ); Judge Belasco (Jewish Family Service of Atlantic and Cape May Counties, NJ).

Judge Daniels created three subcommittees: New Jersey Mental Health Services, chaired by Steven Fishbein; Collaboration of Services, chaired by Debra Jenkins; and Education and Training, chaired by Judge Louis Belasco. The subcommittee members and staff reviewed data, shared information from their various perspectives and evaluated models for improvement in the response to individuals with mental illness who intersect with the criminal justice system.

On September 27 November 28, 2012 the Committee met to discuss the final report.

V. OVERVIEW AND BACKGROUND

The overrepresentation of persons with mental illness in the criminal justice system is a matter of profound and long-standing concern. Individuals with mental illness often cycle in and out of jails and prison, frequently engaging in behaviors which lead to re-arrest and multiple terms of incarceration, while the illnesses which give rise to these behaviors remain untreated or inadequately addressed. This issue significantly impacts public safety, public health, the allocation of government resources and the effective implementation of justice.

A. Statistics

There is no precise way to determine the number of mentally ill individuals who interact with the criminal justice system in New Jersey at all points of interception, from pre-arrest law enforcement interactions through post-incarceration/supervisory release. The number of individuals receiving public mental health services was identified by the Division of Mental Health and Addictions Services (DMHAS) by type of program and by county (see Appendix B). There is no method of determining the number of individuals who receive mental health or co-occurring mental health and addiction treatment through the private sector, either reimbursement by insurance or out of pocket.

The courts do not keep track of whether a defendant has been identified with a mental illness. While jails and probation services conduct screenings/assessments for mental health disorders, it is not known how many individuals may have been missed in such evaluations. Some information has been provided by the New Jersey Department of Corrections on one segment of the incarcerated population: according to the medication roster on March 1, 2011, 3,203 inmates, or 13.78% of New Jersey State prisoners, had an Axis 1 diagnosed mental illness and/or were receiving psychotropic medication.²

Statistical reports on the volume number of unduplicated defendants charged in Municipal and Superior courts are not available. Therefore, even applying a percentage based upon the rate of mental illness in the general population or from other states' studies of the mentally ill in the justice system would not produce accurate data for our State regarding the full criminal justice spectrum. The lack of state-specific data inhibits a determination regarding which are the most significant gaps in services to the justice-involved mentally ill in New Jersey. Anecdotally, it is known that many people who interact with the justice system need mental health outpatient and case management services but do receive them.³

² Report of the New Jersey Public Defender to the New Jersey State Advisory Committee to the United States Commission on Civil Rights (2011), *available at* <http://www.state.nj.us/defender/news/DisabilityPanelUSCivilRights.pdf>

³ Information provided on September 24, 2012 by Steve Fishbein, Coordinator for Mental Health Evidence Based & Promising Practices, DMHAS, Department of Human Services.

Outside New Jersey, numerous studies have been conducted on the justice-involved mentally ill which may provide some insight. It has been indicated that individuals with mental illness intersect the criminal justice systems at greater rates than those without mental illness.⁴ One study found that 31 percent of arraigned defendants met criteria for a psychiatric diagnosis at some point in their lives and 18.5 percent had a current diagnosis of serious mental illness.⁵ It has been estimated that in the United States, as many as 2 million bookings of people with serious mental illnesses may occur each year.⁶

According to a 2006 report by the U.S. Bureau of Justice Statistics, more than half of all prison and jail inmates in the United States had a mental health problem.⁷ Mental illness is a likely factor in terms of repetition of incarceration: research has shown that nearly a quarter of both State prisoners and jail inmates who reported they had a mental health problem had served three or more sentences prior to incarceration.⁸ The rate of coexisting disorders is also extremely high: about 74% of state prisoners and 76% of local jail inmates who have mental health problems also have substance abuse issues.⁹ Mental illness is also a factor in length of incarceration: a 2006 study concluded that mentally ill individuals in prisons spend an average of 15 months longer in prison than other inmates.¹⁰

⁴ Mark R. Munetz, Jennifer L. S. Teller, *The Challenges of Cross-Disciplinary Collaborations: Bridging the Mental Health and Criminal Justice Systems*, 32 CAP. U. L. REV. 925, 938-39 (2003-2004).

⁵ Nahama Broner, Stacy Lamon, Damon Mayrl, and Martin Karopkin, *Arrested Adults Awaiting Arraignment: Mental Health, Substance Abuse, and Criminal Justice Characteristics and Needs*, 30 FORDHAM URBAN LAW REVIEW 663-721 (2002-2003).

⁶ Henry J. Steadman, Fred C. Osher, Pamela C. Robbins, Brian Case, & Steven Samuels, *Prevalence of Serious Mental Illness Among Jail Inmates*, 60 *Psychiatric Services* 761-65 (2009), available at consensusproject.org/publications/prevalence-of-serious-mental-illness-among-jail-inmates/PsySJailMHStudy.pdf

⁷ William J. Sabol, Todd D. Minton, *Jail Inmates at Midyear 2007*, DEPARTMENT OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS, 2008. This is the most recent information from the Bureau of Justice Statistics; in March, 2012, representatives reported that workers are currently in the field collecting additional data on incarcerated mentally ill individuals, as part of a larger study on sexual violence in prison.

⁸ Doris James and Lauren Glaze, *Mental Health Problems of Prison and Jail Inmates*, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT, (September 2006, revised December 14, 2006.).

⁹ *Ibid.*

¹⁰ *Ibid.* See also, *Mentally Ill Offender Treatment and Crime Reduction Act of 2003: Hearings on S. 1194 Before the S. Judiciary Comm.*, 108th Cong. (2003) (testimony of Dr. Reginald Wilkinson, director, Ohio Department of Rehabilitation and Correction), available at <http://www.judiciary.senate.gov/resources/transcripts/108transcripts.cfm>

B. Cost

From a financial perspective, studies have demonstrated that the monetary cost of incarceration and detention is higher than community-based alternatives. For fiscal year 2012, the per capita cost of incarcerating a person in New Jersey State prison is \$42,329 per year.¹¹ Generally, community-based counseling and treatment can be provided at lower cost than institutionalization.¹²

Additionally, incarcerated individuals with mental illness are at a greater risk of violence in prison and jails.¹³ When individuals are released from incarceration back into the community with more aggravated and complicated mental disorders, this produces an even greater burden on the community-based mental health delivery system.¹⁴

C. Recent History: Responses to Mental Illness

It has been asserted that the large number of individuals with mental illness in the United States criminal justice system developed in great degree because of the “deinstitutionalization” effort that began in the 1960s.¹⁵ Deinstitutionalization was prompted by various factors, including the increasing cost of warehousing the mentally ill in large institutions, the advent of new antipsychotic drugs which held the promise of dramatic improvements in clinical symptoms, as well as the developing civil rights movement with its emphasis on individual rights of marginalized populations.¹⁶

Reform efforts intended to protect the liberties of people with mental illnesses resulted in the release of many severely ill people from mental institutions.¹⁷ This was aided by major cost-shifting by the states to the federal government following the advent of Medicare and Medicaid and an emphasis on

¹¹ This figure provided by a representative of the New Jersey Department of Corrections, Allison delVecchio. This number does not include fringe benefits

¹² Ibid. See also, Bernstein, R., *Criminal Justice Reform: Lessons from the Deinstitutionalization Movement*, White Paper, Bazelon Center for Mental Health Law (2007), available at <http://www.bazelon.org/LinkClick.aspx?fileticket=AremSqYTGyM%3d&tabid=319>

¹³ Nancy Wolff, Cynthia L. Blitz, Jing Shi, *Rates of Sexual Victimization in Prison for Inmates with and without Mental Disorders*, 58 PSYCHIATRIC SERVICES, 1087–1094 (2007). See, BUREAU OF JUSTICE STATISTICS, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2008–09* (August 2010).

¹⁴ Ibid.

¹⁵ Chris Koyanagi, *Learning From History: Deinstitutionalization of People with Mental Illness As Precursor to Long- Term Care Reform*, KAISER COMMISSION, MEDICAID AND THE UNINSURED (2007).

¹⁶ Robert Bernstein, *Criminal Justice Reform: Lessons from the Deinstitutionalization Movement*, White Paper, Bazelon Center for Mental Health Law (2007), available at <http://www.bazelon.org/LinkClick.aspx?fileticket=AremSqYTGyM%3d&tabid=319>

¹⁷ Ibid.

community mental health treatment. However, the community treatment for mentally ill individuals was not properly funded nor provided.¹⁸

The large number of mentally ill inmates has prompted the description of prisons and jails as “surrogate psychiatric hospitals” and the wide-spread belief that individuals with severe psychiatric illnesses are being criminalized.¹⁹ According to a 2010 study, there are now three times more seriously mentally ill people in jails and prisons than in hospitals.²⁰

D. Recent Policy Developments

The multi-faceted problem of individuals with mental illness interacting with the criminal justice system has become more of a focus of policy and practice in recent years. Growing corrections populations, larger court dockets, and the rising number of former prisoners returning to communities have prompted localities to utilize criminal justice resources more effectively.²¹ There is growing recognition in the United States that for many offenses, public goals of safety and crime reduction would be equally - if not better - served by alternatives to incarceration, including drug and mental health treatment programs.²² In recent years, numerous innovative programs and collaborative problem-solving approaches have been developed.²³

In 2002, the Council of State Governments Justice Center developed the Consensus Project, a national effort to help local, state, and federal policymakers and criminal justice and mental health professionals improve the response to people with mental illnesses who come into contact with the criminal justice system.²⁴ In 2006, the sequential intercept model was developed.²⁵ This is a now widely-used strategy tool to evaluate points of interception in the criminal justice

¹⁸ *Ibid.*

¹⁹ New York Human Rights Watch, *Ill-Equipped: US Prisons and Offenders with Mental Illness* (2001), available at www.hrw.org/reports/2003/usa1003

²⁰ E. Fuller Torry, Aaron Kennard, Don Eslinger, Richard Lamb, James Pavle, *More Mentally Ill Persons Are in Jails and Prisons than Hospitals: A Survey of the States*, National Sheriff's Association and Treatment Advocacy Center (May 2010).

²¹ *The Criminal Justice System and Mentally Ill Offenders* before the Senate Committee on the Judiciary, 107 Congress (2002), available at <http://www.gpo.gov/fdsys/pkg/CHRG-07shrg86518/html/CHRG-107shrg86518.htm>

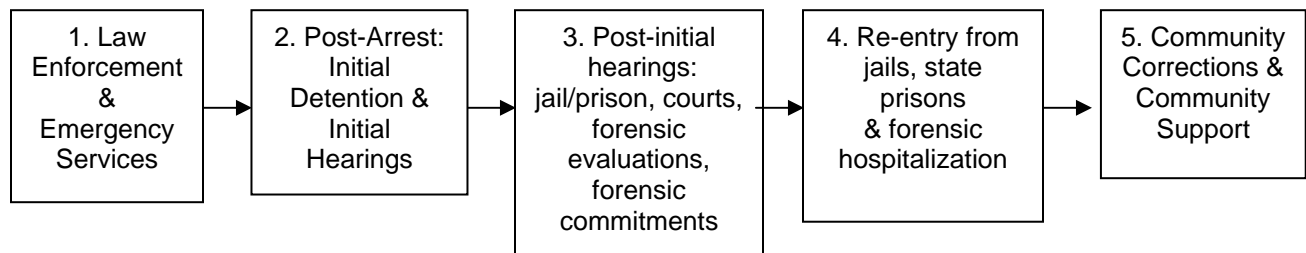
²² *Ibid.*

²³ National Association of Pretrial Services Agencies, *Promising Practices in Pretrial Diversion*, BUREAU OF JUSTICE ASSISTANCE, available at <http://www.pretrial.org/Docs/Documents/PromisingPracticeFinal.pdf>

²⁴ Justice Center, The Council of State Governments, *Active Projects* (YEAR) available at: <http://consensusproject.org/>

²⁵ Mark Munetz and Patricia Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness*, 57 PSYCHIATRIC SERVICES 544-549 (2006). See, Appendix A, *infra*. Also available at <http://ps.psychiatryonline.org/article.aspx?Volume=57&page=544&journalID=18>

process. It is used to determine additional intervention strategies to prevent individuals with mental illness from penetrating further into the criminal justice system.²⁶ In New Jersey, representatives of the DMHAS have been fully trained in how to conduct analyses of court and mental health process/flow according to the sequential intercept model. These analyses are developed through the ‘cross systems mapping’ process and this process has been conducted by the DMHAS in 11 of New Jersey’s 21 counties (see Recommendation 4, *infra*).



E. The Committee’s Vision

In effectuating the Chief Justice’s charge, the Committee seeks to substantively contribute to positive developments in policy and practice regarding individuals with mental illness who interact with the criminal justice system in New Jersey. The Committee members seek to provide for the Supreme Court’s consideration a vision for a collaborative, effective, and creatively funded response to individuals with mental illness in our State and practical steps to achieve this. In this vision, diverse entities are united in full understanding of the nature of mental illness, the operation of the justice system (and how the system can appropriately accommodate those with mental illness), treatment options, new programs for improvement of the system and the myriad of individual, systemic and society-wide benefits which result from a more effective justice-system response to those who are ill.

F. Overview of New Jersey Mental Health Services

All recommendations to improve or reduce interactions between the criminal justice system and those with mental illness must be considered in light of existing New Jersey mental health services. The following are the primary mental health services in the State.^{27 28}

²⁶ *Ibid.*

²⁷ Information provided on September 23, 2012 by Steven Fishbein, Coordinator for Mental Health Evidence Based and Promising Practices, DMHAS, Department of Human Services.

²⁸ Public Defender Joseph E. Krakora has also created a summary of mental health services provided in New Jersey Jails. See, Appendix D.

State Psychiatric Hospitals: The DMHAS operates four psychiatric hospitals which serve people with persistent and severe mental illnesses who are in need of intensive, inpatient care and treatment. They are accredited health care facilities. They are: Greystone Park, Trenton, Anne Klein Forensic, and Ancora Psychiatric Hospitals.

County Psychiatric Hospitals: The DMHAS funds approximately 90 percent of the cost of indigent inpatient care at six county psychiatric units or hospitals through its State Aid Program. These hospitals include: Bergen Regional Medical Center in Paramus, Bergen County; Buttonwood Hospital, Burlington County in Pemberton Township, Burlington County; Camden County Health Services Center in Blackwood, Camden County; Essex County Hospital Center in Cedar Grove, Essex County; Meadowview Hospital in Secaucus, Hudson County and Runnells Hospital in Berkeley Heights, Union County.

Short Term Care Facility: Short term care facilities are locked units to which individuals are involuntarily committed. Individuals have their civil liberties temporarily suspended due to being an imminent danger to themselves or others because of their mental illness. These short term care facility beds are operated by 24 different agencies and serve all 21 New Jersey counties.

Designated Screening Service Programs: The screening and screening outreach program is designed to provide screening, assessment, crisis intervention, referral, linkage, and crisis stabilization services 24 hours per day, 365 days per year, in every geographic area in the State. It is designed to address those citizens who are in an acute psychiatric crisis and need inpatient care; it is where an initial determination of psychiatric commitment is typically made. It is not designed to be the entry to the mental health system.

Early Intervention Support Service: Early intervention support service programs are intended to provide rapid access to short term, nonhospital based crisis intervention and stabilization services for persons with a mental illness. There are seven counties with such programs now and three more are in the development process; it is expected that over time they will be in every county. Community based programs are aimed at offering individuals mental health service options that can divert undue use of emergency room and inpatient programs. Access to this intensive diversionary program is intended to provide a direct alternative to hospital emergency department based crisis services.

Intensive Outpatient Treatment Support Service: Intensive outpatient treatment support service programs operate in 19 counties in order to alleviate strain on the acute mental health system. These new programs are designed to create dedicated access for consumers referred from emergency rooms and other acute settings.

Involuntary Outpatient Commitment to Treatment Law: The DMHAS implemented the Involuntary Outpatient Commitment program in May, 2012. The intent is to provide supervision in the community for a class of mental health consumers that had not been well-served. This population comprises those who are not willing to receive treatment voluntarily and will become, in the foreseeable future, dangerous enough because of a mental illness to require supervision, but who are not so imminently dangerous that they need to be physically confined in an inpatient program. Community agencies providing the services for Involuntary Outpatient Commitment are required to provide a comprehensive outpatient service, coordination and referral system. The counties using this program are being phased in over time.

Programs in Assertive Community Treatment (PACT): PACT is a model of service delivery in which a multidisciplinary mobile treatment team provides a comprehensive array of mental health and rehabilitative services to a targeted group of individuals with serious mental illness. The program is designed to meet the needs of those who are at high risk for hospitalizations, are high service users and who have not benefited from traditional mental health programs. PACT teams conduct the majority of their contacts in natural community settings and are available for psychiatric crises 24 hours a day.

Outpatient Services: Outpatient services are mental health services provided in a community setting to individuals with a psychiatric diagnosis, including clients who are seriously and persistently mentally ill but excluding substance abuse and developmental disability, unless accompanied by treatable symptoms of mental illness. Periodic therapy, counseling, and supportive services are generally provided for relatively brief sessions; between 30 minutes and two hours. Services may be provided individually, in group, or in family sessions. Medication monitoring consists of medication services provided under the supervision of a licensed physician, certified nurse practitioner or clinical nurse specialist. Psychotropic medications are prescribed, administered, and/or monitored. Outpatient services are the most frequently used services by the criminal justice system although the demand for these services is much higher than the capacity of DMHAS to meet.

Integrated Treatment for Co-occurring Disorders: The goal of the integrated treatment for co-occurring disorders program is to provide combined mental health and substance abuse disorder treatment for adults in order to reduce hospitalization, homelessness, increase independent living, and employment. The program is not mandated throughout the State, although community providers have historically expressed interest in its implementation. It is incorporated in existing services including Integrated Case Management Services Partial Care, and Supported Housing rather than as a stand-alone service.

Supported Employment: Supported employment assists mental health consumers in forming an attachment to the workforce through employment and educational opportunities and is critical to their full inclusion in their community and

economic independence. Supported employment provides employment assessment, individual job matching and placement and ongoing support on and off the job.

Supported Education: Supported education programs target individuals with severe mental illness and/or co-occurring disorders who either want to or who currently participate in post-secondary education. DMHAS utilizes Supported Education mobile outreach services aimed to assist people to reach their postsecondary academic goals. Services include: accommodation education, managing disclosure issues, exploring/securing funding options.

Justice Involved Services: Justice involved services are essentially case management services intended to assist individuals in diversion from incarceration. These programs target individuals whose legal involvement may be a result of untreated mental illness or co-occurring disorder. They are designed to help them successfully link to mental health or co-occurring and other services and to avoid or reduce the incidence and length of incarceration.

These services are offered through interventions during pre-arrest, post booking and reentry from county jail. Pre-booking diversion typically involves a police based intervention to avoid arrest for non-criminal, non-violent offenses. Police are trained to identify and de-escalate situations involving the mentally ill and to divert to mental health crisis or pre-crisis services when appropriate. Post booking involves individuals who have been arrested but whom the court may release on their own recognizance or release from jail on bail with the defendants' guarantee that they will obtain mental health assistance.

Defendants with mental illness who are serving jail/prison sentences or long detention are targeted for re-entry services utilizing the best-practice guideline called the "APIC model" (assess, plan, identify and coordinate). Re-entry services include identification/case finding, pre-release planning and linkage to critical mental health, social service, employment and housing upon release. These same services may be arranged for individuals who are picked up by police but who are not arrested.

There are presently 16 counties which have one or more of these diversionary/re-entry services for justice involved individuals with mental illness. Their scope depends upon funding and the availability of mental health and other social services in the county.

Illness Management Recovery: Illness Management Recovery is a psychiatric rehabilitation practice operated with the objective of empowering consumers with severe mental illness to manage their illness and develop their own goals for recovery. Components include psychoeducation, behavioral tailoring for medication, relapse prevention training, and coping skills training.

Veterans' Services: The DMHAS provides mental health and related support services to members of the armed forces and veterans as part of its regular behavioral health service delivery system. When possible, the service member is transferred to the VA healthcare system, if eligible.

Projects for Assistance in Transition from Homelessness: There are projects for assistance in transition from homelessness programs (PATH) operating in all 21 counties. These programs conduct outreach to locations known to be frequented by homeless individuals in an attempt to continuously assess and identify individuals with serious mental illness who may benefit from linkage to mental health and housing programs.

Supportive Housing: The DMHAS contracts with approximately 52 supportive housing providers and supervised residential providers in all 21 counties. These services range from completely consumer-driven in the consumer's leased-based housing to supervised settings with 24/7 staffing. In addition, the State funds 11 residential intensive support teams in 13 of the 21 counties – a supportive housing model with a higher staff-consumer ratio and DMHAS funded rental subsidies serving consumers discharged directly from the State hospital system and those at risk of hospitalization. The focus is on the development of skills and supports which promote community inclusion, housing stability, wellness, recovery, and resiliency. These skills include illness management, socialization, work readiness and peer support, all of which foster self-direction and personal responsibility.

Intensive Family Support Programs: An intensive family support services (IFSS) program is funded in each of New Jersey's 21 counties. These programs provide families with greater knowledge about mental illness, treatment options, the mental health system, and skills useful in managing and reducing symptomatic behaviors of the member with a serious mental illness. Services include psycho-education groups, family support groups, single family consultation, respite activities and referral/linkage.

Consumer Operated Services: At the state level, the DMHAS involves individuals with mental illness in upper level management decision-making, program development, proposal reviews, community site reviews, state hospital monitoring, and participation in key committees and workgroups. DMHAS provides funding and support for peer providers working in the system. There are also peers working in designated screening centers/psychiatric emergency rooms, and plans are underway to develop peer-operated alternatives to crisis and screening. The DMHAS currently funds and supports 33 consumer operated self-help centers statewide, including a self-help center on the grounds of three State hospitals.

Managed Behavioral Health Organization: The DMHAS is moving in the direction of placing its entire behavioral healthcare services under a managed care umbrella. This will impact how services are accessed and who is eligible for what

services. Currently, the eligibility, service array, financing and other details are under development.

VI. THE COMMITTEE'S DETAILED RECOMMENDATIONS

As a result of the Committee members' experience, the research and evaluation of existing programs in New Jersey and in other states and in-depth discussion/debate, the Committee makes the following recommendations.

The cost of each recommendation was considered and any increase in cost as the result of implementation of the recommendation is noted in the section following each recommendation. Some Committee members representing the executive branch have advised the Committee that the State cannot commit new funding to the recommendations but is interested in working collaboratively with the Judiciary and other partners to explore the identification of other resources. The concepts of ***communication, cooperation and education*** are themes which weave through the recommendations. These are the principles which will allow current resources to be maximized to achieve an improvement in the response to individuals with mental illness who are involved in the criminal justice system.

A. Implementation

RECOMMENDATION 1. It is recommended that the New Jersey Supreme Court establish an Interbranch Mental Health Initiatives Implementation Committee ("Implementation Committee").

The Implementation Committee will effectuate the recommendations of the original Interbranch Advisory Committee on Mental Health Initiatives ("Mental Health Committee"), once those recommendations are reviewed/approved by the Court. It is suggested that representatives from the entities which participated in the original Mental Health Committee be included in the Implementation Committee.

B. Comprehensive plan

RECOMMENDATION 2. It is recommended that the Judiciary develop and adopt a comprehensive plan of intervention strategies pertaining to individuals with mental illness, including initiatives at various stages along the criminal justice spectrum.

The plan should include Judiciary initiatives as well as suggestions to entities outside the Judiciary. The plan should include programs for diversion before arrest as well as diversion after entry into the judicial system and before adjudication. These various initiatives include suggested training of law enforcement personnel to deal more effectively with mentally ill individuals before arrest and the filing of formal charges, (e.g., Crisis Intervention Team training). These programs also include those in which family members, court staff and others identify certain defendants who may have mental illness, and these defendants are then brought to the attention of trained prosecutors who can arrange for evaluations, craft

alternatives to bail and potential deferred dispositions which are contingent on defendants completing mental health treatment (see Recommendation 6, *infra*). Multiple sources of funding for these various initiatives would be aggressively pursued.

C. Development of Core Teams and Problem Solving Committees

Recommendation 3: It is recommended that a local Core Team be established in each county which does not presently have one. The team will be the ‘go to’ local group for assuring that the over-arching structure of collaborative initiatives becomes institutionalized in the county.

Members will serve as point people to help professionals and mental health consumers build solid working relationships and also will report development and results back to the Implementation Committee and the New Jersey Supreme Court. These Core Teams will be critical to implementing the recommendations of the Mental Health Committee and will provide the important, networking component where key relationships are formed and sustained. There are forms of Core Teams operating in approximately 11 counties presently; they are also known as jail diversion task forces or re-entry task forces. Core Teams should be established in counties which do not already have one in operation.

The Core Team would consist of a Municipal and/or Superior Court judge, representatives from the vicinage municipal and/or criminal division staff, probation, the prosecutor’s office, the public defender’s office and the county mental health administrator. Also included would be the municipal court liaison, DMHAS program analyst for the county, the coordinator for intensive case management services, the program of assertive community treatment team leader, a screening director, the justice involved services coordinator or other representatives of the mental health system. A mental health consumer and a family member of an individual with mental illness would also be participants and representatives of other systems may also be invited as needed.

An important function of each county Core Team will be to establish a subgroup – a county ‘Problem Solving Committee.’ The Problem Solving Committee will meet monthly (or more frequently, if needed) to address court related issues in both Municipal and Superior Court which may result from a defendant’s mental illness and or co-occurring mental health and substance use disorder.

The Core Team is the initial group which will facilitate the foundational relationships between key players and, when necessary, and initiate a systems analysis to establish the collaborative structure for each county. In contrast, the Problem Solving Committee is an outgrowth of the Core Team and will handle ongoing meetings regarding case-specific issues. Every effort will be made to ensure that members of the Core Team and the Problem Solving Committee be comprised of existing staff. The groups will be forums for productive

communication and collaborative resolution which should not themselves engender additional costs beyond staff time. However, the associated expenses for mental health and related services may add substantial cost to the effort and presently many services are operating at capacity.

The goal of the monthly Problem Solving Committee meetings would be to avoid or shorten incarceration in favor of community treatment and to explore dismissal or reduction in charges if possible and appropriate. This would be accomplished by reviewing specific cases at the monthly meetings. The committee members would identify options agreeable to all parties which may be recommended to the court and may result in dismissal with stipulations for mental health or co-occurring disorder treatment or some other disposition which maintains the defendant with mental illness in the community.

In some situations, a previous referral to mental health services may have already occurred and was not adequate enough to address the circumstances or there may be new circumstances such as repeat appearances before the court on additional charges related to their illness. The objective of the Problem Solving Committee meetings would be to fully analyze the cases and – when appropriate – enable the defendant to obtain access to personally tailored mental health and recovery support. The goal would be to reduce the impact of their mental illness on offending behavior and reduce the likelihood of repeated criminal justice involvement.

The piloting of a Core Team/Problem Solving Committee would be recommended for counties that currently have a criminal justice or jail diversion task force or where there is presently a regular meeting between criminal justice and mental health or where such meetings have been recently held. These counties include Cumberland, Camden, Burlington, Gloucester, Monmouth, Middlesex, Ocean, Union, Essex, Hunterdon, Warrant, Sussex and Bergen. It might also be initiated in vicinages where there is an established relationship between court staff and mental health providers.

D. Cross-systems mapping

RECOMMENDATION 4: It is recommended that cross-systems mapping strategic planning sessions be initiated by the Core Teams in counties which do not currently have such strategic plans.

A key responsibility of each Core Team is to work with designated facilitators from DMHAS to organize a systems mapping/sequential interception information session which would involve both Municipal and Superior Courts. Currently, 11 of New Jersey's 21 counties have gone through the cross-systems mapping process and have developed county plans from which they operate. The process should be initiated in counties which have not undertaken it.

The cross-systems mapping process highlights different points at which people may be identified and diverted out of the criminal justice system (points of interception) and it maps the local criminal justice resources and the court flow. It addresses the entire spectrum of criminal justice involvement and includes developing a strategic plan of cross-system collaboration as the basis for a subsequent action plan. Critical to the success of cross-systems mapping is the connection and communication among members of the Judiciary, substance abuse and mental health service providers, other social service groups. Ideally cross-system mapping can help transform fragmented systems, identify local resources/gaps and help identify where to begin interventions.

Funding would need to be fully explored, although since cross-systems mapping involves increasing communication between existing staff, significant costs would likely not be generated.

(see appendix for model of sequential intercept model, upon which cross-systems mapping plans are based)

E. Municipal Court liaison program

Recommendation 5: It is recommended that a mental health liaison be established in municipal courts throughout the State.

This strategy involves a qualified mental health specialist employed by DMHAS who is stationed at a municipal court(s). There are several programs of this type operating in the State; the ideal model is a post-booking, pre-adjudication assessment and case management intervention upon which this recommendation is based. In this model, the specialist acts as a consultant and liaison between the court and the mental health system regarding defendants who appear to have severe mental illness. The goal is to identify mentally ill defendants involved in the justice system and reduce the length of time spent in jail by offering the courts alternatives to incarceration, typically involving treatment options. It is different from the Problem Solving Committee method discussed in Recommendation 4. It is recognized that establishment of such programs would be contingent upon a new allocation of federal, state or county mental health resources to the DMHAS.

Defendants in the Municipal Court with non-indictable charges that may result in a sentence of incarceration are eligible for referral. Acceptance for services requires that the defendant be an adult diagnosed with a severe and persistent mental illness (i.e. schizophrenia, bipolar disorder, major depressive disorder). Defendants with co-occurring substance abuse disorders also qualify for services. Participation in the project is voluntary and a defendant must be willing to agree to services and treatment.

Referrals are accepted from the courts, community mental health providers, family members, and law enforcement based on an individual's psychiatric history or current symptoms, direct observations of behaviors indicating mental illness, the nature of the charge or arrest incident and/or involvement with current mental health treatment.

Once a defendant has been identified as exhibiting symptoms of a possible mental illness, the mental health specialist is contacted by the court administrator, and responds to the courtroom to conduct a clinical interview of the defendant, if the individual is agreeable to participate. A mental health assessment is completed based on the clinical interview and collateral information obtained, and the findings are verbally presented to the court with the consent of the defendant.

If a defendant is determined to suffer from a qualifying psychiatric illness or co-occurring disorder, and meets all other criteria for service acceptance, a treatment plan is developed with the mental health specialist, which would include a referral to a treatment provider, if not currently receiving treatment.

Possible avenues for diversion are explored with attorneys and the judge, with an initial focus on release of a defendant from incarceration, if currently detained, to allow for linkage to appropriate community based treatment after release. Diversionary alternatives may include reduction of bail amounts (including release on own recognizance), deferred prosecution, reduction of imposed sentences, and dismissal and amendment of charges.

If a defendant's release from custody is not deemed suitable, then a referral to the county jail's mental health services is made and the mental health specialist will coordinate the care. A community based treatment referral would be provided at the time of the defendant's release into the community. Additionally, general case management services are coordinated, tailored to an individual's needs, which may include service referrals to medical providers, housing resources/shelters, entitlement/benefit agencies, and education or employment programs.

Once a defendant is in the community, the municipal court will typically continue to schedule monthly or bi-monthly status hearings to allow for periodic treatment updates. Other diversionary alternatives such as deferred prosecution/adjournments, reduction of imposed sentences (i.e. suspended sentences, probation with a condition of mental health treatment), and dismissal and amendment/downgrade of charges are reviewed for suitability as the case continues. The mental health specialist attends all scheduled court hearings to provide information to assist the court with case adjudication, and to offer possible options. The specialist continues to actively monitor and assist a defendant throughout the duration of the court case, and generally over the course of six months to one year.

A defendant's active treatment involvement provides the court with an indication of rehabilitative and preventative steps being taken to address potential future behaviors that may be a symptom of a mental illness and lead to criminal behavior. The success of the clients in the program relies on the collaboration established among the criminal justice system, including law enforcement, judges, and attorneys. The project serves as a liaison between these legal entities and mental health services.

The total yearly cost of a municipal court liaison program would vary depending on the nature and extent of the services required by defendants. One case manager can serve upwards of 25 individuals a year and consult with the court on an additional number. Very often, individuals with severe and persistent mental illness require multiple services which increase the overall expense, although the total expense is unique to each individual. For example, one defendant may need a medication evaluation and monitoring and 20 outpatient treatment visits which may cost \$2,000 while another defendant might need partial care at an annual cost of \$20,000 or specialized supported housing at over \$27,000.

It is recommended that the piloting of municipal court liaison programs occur in vicinages which have expressed interest and in municipalities where a larger number of individuals with mental illness tend to reside. It is recognized that establishment of such pilots would be contingent upon a new allocation of federal, state and/or county mental health resources to the DMHAS.

F. Superior Court prosecutor diversion process

Recommendation 6: It is recommended that Prosecutors Offices which are interested in the diversion process be encouraged and supported in the implementation of these processes.

The model for this recommendation is a collaborative effort between mental health provider agencies and the Prosecutors Office.²⁹ The purpose is to provide evaluation and intensive case management services to non-violent offenders facing probationary, county jail and state prison terms who are suspected of having a severe and persistent mental illness. Diversion from county jail and state prison custodial sentences as the result of successful completion of acquired treatment services may be recommended to the Court. When appropriate, successful completion of treatment conditions may result in the dismissal of or a reduction in charges. This model is suggested for consideration by Prosecutors Offices interested in offering diversion alternatives within their counties; any implementation of the program would necessitate an additional allocation of federal, state and/or county funding for mental health resources to the DMHAS and may also require funding and/or training of Prosecutors Office staff.

²⁹ This model is based on the Union County Jail Diversion Program. Appendix C provides a detailed analysis of the Union program, by Kenneth Gill, Ph.D. and Ann Murphy, M.A.

The overall objective of this diversion program is to prevent recidivism which results in re-incarceration and re-hospitalization of this population.

The comprehensive judicial education program described in Recommendation 8 below would enable the Superior Court Judges involved in a Prosecutor Diversion process to fully understand and assess the proposals presented to them.

To be eligible for this process, a defendant must have a serious mental illness and be someone whom the prosecutor, defense counsel and designated mental health evaluator/provider agree is expected to comply with regular participation in ongoing mental health services and who will maintain a stable mental status for at least three months. Referrals may come from local police departments, either pre- or post-booking, Municipal and Superior courts, Public Defender's Offices, the defense bar, mental health treatment providers and case management agencies, inpatient hospitals, county and local jails, psychiatric emergency rooms and probation.

The program services include comprehensive clinical and psycho-social evaluations at the time of referrals to establish the presence of severe mental illness. If accepted, treatment plans are individually tailored to include therapy, family counseling, medication management, substance abuse counseling, and career planning, housing and related advocacy services. The enrollee should also be eligible for case management services, depending upon the nature of the case and the needs of the participant. The determination of who would provide these services would be made at the local level.

These services could function as initial conditions of bail pre-dispositionally with the ultimate resolution to include continued program participation as a condition of dismissal or probation as part of a plea bargain agreed to by the prosecutor, defense counsel and defendant and accepted by the court.

Several County Prosecutors have expressed a strong interest in establishing programs of this type. It would require that an Assistant Prosecutor spend time establishing eligible charges and conditions, the public defender and private bar be informed and the local mental health system and providers be engaged.

This recommendation does not provide for extensive Judiciary involvement. Although participants may report back to the judge who directed the diversion, all judges will be fully educated regarding the various aspects of mental illness, treatment and diversion so that they are prepared to appropriately evaluate diversion the proposals fashioned by the prosecutors/defense counsel/mental health service providers (see Recommendation 8). The time and resources allotted may vary from vicinage to vicinage. The vicinages will make appropriate determinations as to the implementation of the process.

The total yearly cost of a Prosecutor Diversion process would vary depending on the nature and extent of the services required by defendants. Mental health services can range from median, annual costs per client of \$3,300 for the necessary case management services plus single or multiple mental health services from \$2,600 for outpatient services, up to \$16,500 for partial care services, upwards of \$22,000 or more for specialized supported housing services and \$16,000 for Programs of Assertive Community Treatment (PACT) without housing subsidies. Very often, individuals with severe and persistent mental illness require multiple services which increase the overall expense. The profile of services needed by any specific defendant is unique, hence the need for new, additional mental health resources.

G. Specialized probation caseloads

RECOMMENDATION 7: It is recommended that the New Jersey Probation Specialized Mental Health Caseload be expanded and further funding applications for it be made.

This successful program links probationers, through the Judiciary's Probation Service Division, with mental health services. In 2009 the Division was awarded \$5.4 million in federal stimulus funding to hire 30 probation officers to establish adult mental health caseloads statewide, establish collaborative partnerships between Probation and community agencies in the State and reduce the average caseload size of other agency adult caseloads. These probation officers, many with an educational background in mental illness, receive specialized mental health training prior to going into the field.

H. Educational programs

RECOMMENDATION 8: It is recommended that the Implementation Committee supervise the development of educational programs for New Jersey judges (Superior and Municipal Court), so they are all fully educated on relevant aspects of mental illness.

This education will include:

- a. The general background of mental illness
- b. Methods of best dealing with individuals in crisis in the courtroom (including de-escalation)
- c. Referral options (including all available NJ resources, state and county-wide). This may include distribution of an information referral package (similar in format to the "Intoxicated Driver Resource" packet).
- d. Legal issues, including civil commitment
- e. Connections between other entities

These educational programs will be offered for both experienced and new judges at annual conferences/retreats and various new judge trainings. Continuing legal education credit may be offered for each training. A booklet explaining commonly-used terms relating to mental health will be distributed to every judge in the State (“Judges’ Guide to Mental Health Jargon: A Quick Reference for Justice System Practitioners”).

RECOMMENDATION 9: It is recommended that the Implementation Committee supervise the development of educational programs for employees of the New Jersey Judiciary who are not judges (including ombudsmen and drug court staff), so they are all fully educated on relevant aspects of mental illness.

This education will include:

- a. The general background of mental illness
- b. Resources for the mentally ill and their families: national, state and county-wide
- b. The best immediate methods of dealing with individuals in crisis in all relevant environments (including the use of de-escalation techniques)
- c. The best responses to individuals with mental illness, beyond immediate crisis-management (e.g., referrals, interactions with the court)
- d. Connections between other entities

These educational programs will be offered at new employee orientations and continuing education trainings. Continuing education credit will be offered for each training when appropriate (e.g., for mandatory training required of municipal court administrators). A document explaining commonly-used mental health jargon will be distributed to all these court employees.

RECOMMENDATION 10: It is recommended that the Implementation Committee offer suggested assistance to law enforcement and first responders in creating and further expanding educational programs to improve responses to people with mental illness (e.g., expansion of Crisis Intervention Team training).

These programs should be provided (and appropriately tailored) to:

- a. Prosecutors
- b. Deputy attorneys general
- c. Local police officers (and police management)
- d. Police and EMT dispatchers
- e. State police officers (and State police management)
- f. First responders such as emergency medical technicians

RECOMMENDATION 11: It is recommended that the Implementation Committee provide suggestions to the State and municipal public defenders’ offices on developing educational programs to improve responses to people with mental illness, encompassing the same issues covered in

prosecutorial/attorneys general training, with additional information on dealing with mentally ill clients.

RECOMMENDATION 12: It is recommended that the Implementation Committee provide training to the Division of Mental Health Services staff and mental health service providers on how the courts work (Superior and Municipal).

This training would enable mental health professionals to better advise their clients about options/processes and would include an overview of the criminal justice process, information on landlord/tenant, family and other non-criminal matters in which mentally ill individuals would tend to become involved, opportunities for diversion, and advice on negotiating with the prosecutor. The Committee should also provide vicinage-specific information on the judicial process for local, mental health service providers. This training will be provided in the form of:

- a. An annual "Mental Health Symposium" to which mental health professionals would be invited, with various presentations on relevant aspects of the justice system. Invitations would be extended to families of the mentally ill and patient support groups. County mental health boards in each county have the most connections to the community and would be effective at publicizing this training. These symposiums should be held in a central location and could then serve as models for separate, regional program which could provide more specific, local information.
- b. Standard PowerPoint presentations on the operation of the justice system, distributed to mental health professionals
- c. Directions on how to access existing information on the Internet and InfoNet (e.g. "Criminal 101" on the Criminal Division website, educational resources on the Municipal InfoNet page)

RECOMMENDATION 13: It is recommended that the Implementation Committee structure a comprehensive public information program.

This program will encompass:

- a. The courthouse public (including brochures offered in every NJ courthouse, which generally explain the legal process and provide information on local, State and national organizations and government entities which can help the mentally ill)
- b. The general public. General public information will be conveyed via:
 - i. Internet site with concrete information and links to resources
 - ii. Internet public service videos on YouTube -- these would explain important components of the justice process (including videos of the informational presentations provided to DMHS staff and mental health service providers, above) as well as explanations of important mental health service complex processes and resources (including videos of informational presentations made to Judiciary staff). These videos will be

effectively tagged so that they will turn up in common searches conducted by the public.

iii. Inviting the public to attend the annual Mental Health Symposium (described above), with particular emphasis on outreach to families of mentally ill individuals.

I. Information sharing

RECOMMENDATION 14: It is recommended that information sharing procedures be explored and developed to enable mentally ill individuals to receive services in a timely and effective fashion.

It should be suggested to jails that information regarding daily admit lists be conveyed to local mental health service providers and advocacy groups so that individuals who have been receiving local services might be flagged by service providers, who will then be better able to assist them early in the criminal justice process or upon release from incarceration. This procedure is currently in place at several correctional facilities throughout the State. This type of initiative would not appear to involve added costs. Cross-systems mapping programs (as described in Recommendation 2, above) would also facilitate information sharing.

RECOMMENDATION 15: It is recommended that mental health service providers be educated on the benefits of requesting access to judicial computer systems (e.g., the Automated Complaint System and Automated Traffic System), when appropriate, in order for providers to view defendants' outstanding charges and best advocate for them within the court system.

Mental health service providers in certain counties have requested and obtained such access, enabling them to examine an individual's offense history, coordinate payment of fines and communicate with the public defender and prosecutor about arranging for treatment as part of disposition.

RECOMMENDATION 16: It is recommended that the Superior and Municipal Court computer systems be enhanced to include an indicator for defendants who have may have manifested mental illness, either through participation in a mental health diversion program, participation in DMHAS programs or some other means. Prior to implementation, the confidentiality aspect of this recommendation will be fully explored to ensure that privacy concerns and any other legal considerations pertaining to defendants are completely addressed. This will include an analysis of the process by which such an identifier would be attached to a defendant and the security of data. This indicator will enable the Judiciary to gather data regarding the number of mentally ill individuals involved in the criminal justice system and facilitate the development of programs to assist the justice-involved population.

J. Funding

RECOMMENDATION 17: It is recommended that comprehensive and creative funding strategies should be fully explored.

This exploration should include:

- a. an aggressive investigation and review of grants and other funding sources, including full assessment of monies available for co-occurring disorder initiatives and options available from the Criminal Justice/Mental Health Consensus Project coordinated by the Council of State Governments Justice Center
- b. a request that the Judiciary's legislative liaisons collaborate with the Implementation Committee on any legislative initiatives which could produce funding for mental health/diversion programs
- c. an investigation of whether new court assessments could be a source of funding
- e. an exploration of expanding the use of mental health service user fees (for those who have the income and/or insurance to fund their own treatment)
- f. an offer of guidance to mental health entities to work more effectively at obtaining funding for which individuals may be qualified for, on a case-by-case basis (e.g., assisting with the application for SSI or veteran's benefits)
- g. obtaining quantifiable data regarding the beneficial outcome of various mental health initiatives which will assist with the successful implementation of these funding strategies.

APPENDIX A

**“Use of the Sequential Intercept Model as an
Approach to Decriminalization of People with
Serious Mental Illness,” by Mark R. Munetz, M.D.
and Patricia A. Griffin, Ph.D.**

Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness

Mark R. Munetz, M.D.

Patricia A. Griffin, Ph.D.

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment. (*Psychiatric Services* 57:544–549, 2006)

Over the past several years, Summit County (greater Akron), Ohio has been working to address the problem of overrepresentation, or “criminalization,” of people with mental illness in the local criminal justice system (1,2). As part of that effort, the Summit County Alcohol, Drug Addiction, and Mental Health Services Board obtained technical assistance consultation from the National GAINS Center for People with Co-occurring Disorders in the Justice System. From that collaboration, a conceptual model based on

public health principles has emerged to address the interface between the criminal justice and mental health systems. We believe that this model—Sequential Intercept Model—can help other localities systematically develop initiatives to reduce the criminalization of people with mental illness in their community.

The Sequential Intercept Model: ideals and description

We start with the ideal that people with mental disorders should not “penetrate” the criminal justice sys-

tem at a greater frequency than people in the same community without mental disorders (personal communication, Steadman H, Feb 23, 2001). Although the nature of mental illness makes it likely that people with symptomatic illness will have contact with law enforcement and the courts, the presence of mental illness should not result in unnecessary arrest or incarceration. People with mental illness who commit crimes with criminal intent that are unrelated to symptomatic mental illness should be held accountable for their actions, as anyone else would be. However, people with mental illness should not be arrested or incarcerated simply because of their mental disorder or lack of access to appropriate treatment—nor should such people be detained in jails or prisons longer than others simply because of their illness.

With both this ideal and current realities in mind, we envision a series of “points of interception” or opportunities for an intervention to prevent individuals with mental illness from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points. Each point of interception can be considered a filter (Figure 1). In communities with poorly developed mental health systems and no active collaboration between the mental health and criminal justice systems, the filters will be porous. Few will be intercepted early, and more people with mental illness will move through all levels of the criminal justice system. As systems and collaboration develop, the filter will become more

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finely meshed, and fewer individuals will move past each intercept point.

The Sequential Intercept Model complements the work of Landsberg and colleagues (3) who developed an action blueprint for addressing system change for people with mental illness who are involved in the New York City criminal justice system. The Sequential Intercept Model expands that work by addressing Steadman's (4) observation that people with mental illness often cycle repeatedly between the criminal justice system and community services. The model addresses his key question of how we can prevent such recycling by showing the ways in which people typically move through the criminal justice system and prompting considerations about how to intercept those with mental illness, who often have co-occurring substance use disorders.

Interception has several objectives (4,5): preventing initial involvement in the criminal justice system, decreasing admissions to jail, engaging individuals in treatment as soon as possible, minimizing time spent moving through the criminal justice system, linking individuals to community treatment upon release from incarceration, and decreasing the rate of return to the criminal justice system.

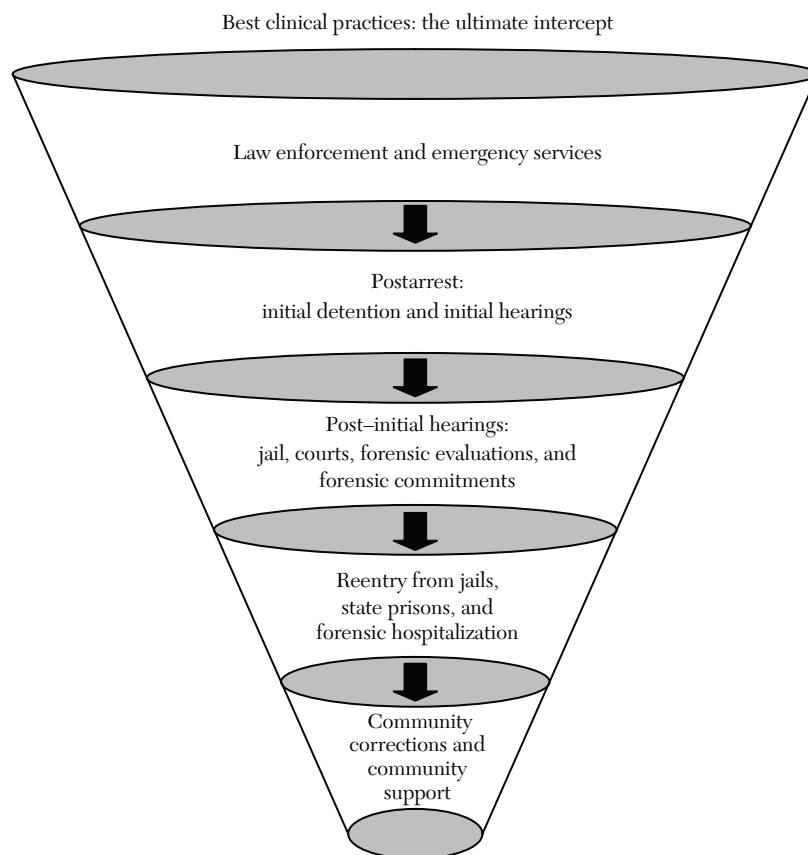
In contrast to the six critical intervention points identified in Landsberg's conceptual roadmap (3), we have specified the following five intercept points to more closely reflect the flow of individuals through the criminal justice system and the interactive nature of mental health and criminal justice systems (Figure 2):

- ◆ Law enforcement and emergency services
- ◆ Initial detention and initial hearings
- ◆ Jail, courts, forensic evaluations, and forensic commitments
- ◆ Reentry from jails, state prisons, and forensic hospitalization
- ◆ Community corrections and community support services

In the next sections we describe the points of interception and illustrate them with examples of relevant interventions from the research and practice literature.

Figure 1

The Sequential Intercept Model viewed as a series of filters



An accessible mental health system: the ultimate intercept

An accessible, comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders is undoubtedly the most effective means of preventing the criminalization of people with mental illness. The system should have an effective base of services that includes competent, supportive clinicians; community support services, such as case management; medications; vocational and other role supports; safe and affordable housing; and crisis services. These services must be available and easily accessible to people in need. Unfortunately, few communities in the United States have this level of services (6).

In addition to accessible and comprehensive services, it is increasingly clear that clinicians and treatment systems need to use treatment interventions for which there is evidence of efficacy and effectiveness (7,8). In many systems, evidence-based treat-

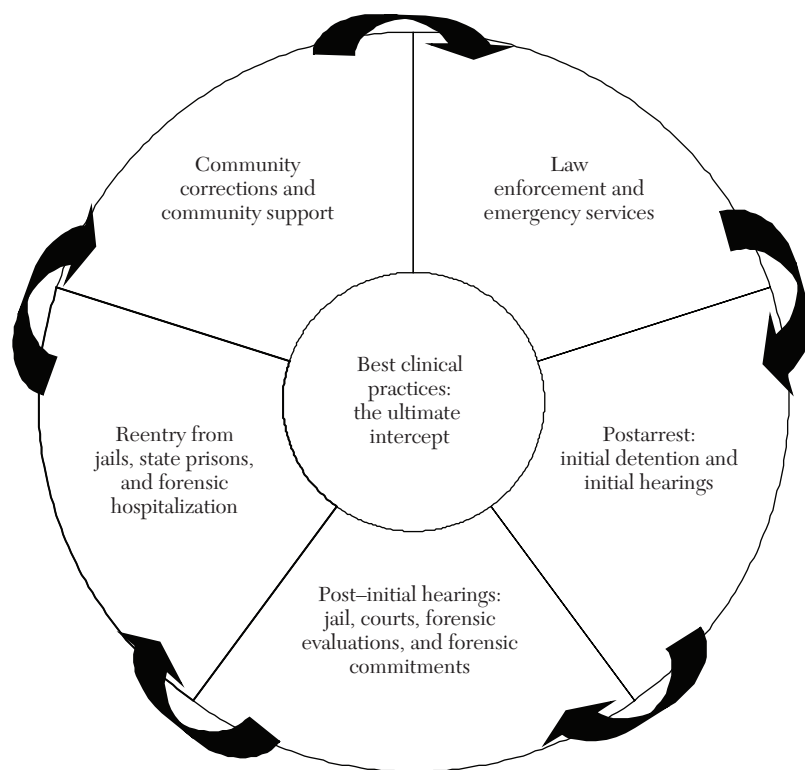
ments are not delivered consistently (9). Examples of such interventions include access to and use of second-generation antipsychotic medications, including clozapine (10); family psychoeducation programs (11); assertive community treatment teams (12); and integrated substance abuse and mental health treatment (13). Integrated treatment is especially critical, given the fact that approximately three-quarters of incarcerated persons with serious mental illness have a comorbid substance use disorder (14,15).

Intercept 1: law enforcement and emergency services

Prearrest diversion programs are the first point of interception. Even in the best of mental health systems, some people with serious mental disorders will come to the attention of the police. Lamb and associates' (16) review of the police and mental health systems noted that since deinstitutionalization "law enforcement agencies have played an increasingly important

Figure 2

The Sequential Intercept Model from a revolving-door perspective with best practices at the core



role in the management of persons who are experiencing psychiatric crises.” The police are often the first called to deal with persons with mental health emergencies. Law enforcement experts estimate that as many as 7 to 10 percent of patrol officer encounters involve persons with mental disorders (17,18). Accordingly, law enforcement is a crucial point of interception to divert people with mental illness from the criminal justice system.

Historically, mental health systems and law enforcement agencies have not worked closely together. There has been little joint planning, cross training, or planned collaboration in the field. Police officers have considerable discretion in resolving interactions with people who have mental disorders (19). Arrest is often the option of last resort, but when officers lack knowledge of alternatives and cannot gain access to them, they may see arrest as the only available disposition for people who clearly cannot be left on the street.

Lamb and colleagues (16) de-

scribed several strategies used by police departments, with or without the participation of local mental health systems, to more effectively deal with persons with mental illness who are in crisis in the community: mobile crisis teams of mental health professionals, mental health workers employed by the police to provide on-site and telephone consultation to officers in the field, teaming of specially trained police officers with mental health workers from the public mental health system to address crises in the field, and creation of a team of police officers who have received specialized mental health training and who then respond to calls thought to involve people with mental disorders. The prototype of the specialized police officer approach is the Memphis Crisis Intervention Team (CIT) (20,21), which is based on collaboration between law enforcement, the local community mental health system, and other key stakeholders. A comparison of three police-based diversion models (22) found the Memphis CIT program to

have the lowest arrest rate, high utilization by patrol officers, rapid response time, and frequent referrals to treatment.

Intercept 2: initial hearings and initial detention

Postarrest diversion programs are the next point of interception. Even when optimal mental health service systems and effective prearrest diversion programs are in place, some individuals with serious mental disorders will nevertheless be arrested. On the basis of the nature of the crime, such individuals may be appropriate for diversion to treatment, either as an alternative to prosecution or as an alternative to incarceration. In communities with poorly developed treatment systems that lack prearrest diversion programs, the prototypical candidate for postarrest diversion may have committed a nonviolent, low-level misdemeanor as a result of symptomatic mental illness.

If there is no prearrest or police-level diversion, people who commit less serious crimes will be candidates for postarrest diversion at intercept 2. In communities with strong intercept 1 programs, postarrest diversion candidates are likely to be charged with more serious acts. In such cases, although diversion at the initial hearing stage is an option and treatment in lieu of adjudication may be a viable alternative, some courts and prosecutors may look only at postconviction (intercept 3) interventions.

Postarrest diversion procedures may include having the court employ mental health workers to assess individuals after arrest in the jail or the courthouse and advise the court about the possible presence of mental illness and options for assessment and treatment, which could include diversion alternatives or treatment as a condition of probation. Alternatively, courts may develop collaborative relationships with the public mental health system, which would provide staff to conduct assessments and facilitate links to community services.

Examples of programs that intercept at the initial detention or initial

hearing stage include the statewide diversion program found in Connecticut (23) and the local diversion programs found in Phoenix (24) and Miami (25). Although Connecticut detains initially at the local courthouse for initial hearings and the Phoenix and Miami systems detain initially at local jails, all three programs target diversion intervention at the point of the initial court hearing. A survey of pretrial release and deferred prosecution programs throughout the country identified only 12 jurisdictions out of 203 that attempt to offer the same opportunities for pretrial release and deferred prosecution for defendants with mental illness as any other defendant (26).

Intercept 3: jails and courts

Ideally, a majority of offenders with mental illness who meet criteria for diversion will have been filtered out of the criminal justice system in intercepts 1 and 2 and will avoid incarceration. In reality, however, it is clear that both local jails and state prisons house substantial numbers of individuals with mental illnesses. In addition, studies in local jurisdictions have found that jail inmates with severe mental illness are likely to spend significantly more time in jail than other inmates who have the same charges but who do not have severe mental illness (27,28). As a result, prompt access to high-quality treatment in local correctional settings is critical to stabilization and successful eventual transition to the community.

An intercept 3 intervention that is currently receiving considerable attention is the establishment of a separate docket or court program specifically to address the needs of individuals with mental illness who come before the criminal court, so-called mental health courts (29–32). These special-jurisdiction courts limit punishment and instead focus on problem-solving strategies and linkage to community treatment to avoid further involvement in the criminal justice system of the defendants who come before them. The National GAINS Center estimates that there are now 114 mental health courts for adults in the United States (33).

Intercept 4: reentry from jails, prisons, and hospitals

There is little continuity of care between corrections and community mental health systems for individuals with mental illness who leave correctional settings (34). Typically, communication between the two systems is limited, and the public mental health system may be unaware when clients are incarcerated. Mental health systems rarely systematically follow their clients once they have been incarcerated. In a recent survey of jails in New Jersey, only three jails reported providing release plans for a majority of their inmates with mental illness, and only two reported routinely providing transitional psychotropic medications upon release to the community (35).

Nationally, the issue of facilitating continuity of care and reentry from correctional settings is receiving increasing attention. In part these efforts are fueled by class action litigation against local corrections and mental health systems for failing to provide aftercare linkages, such as the successful *Brad H* case against the New York City jail system (36). In addition, pressure is increasing on corrections and mental health systems to stop the cycle of recidivism frequently associated with people with severe mental illness who become involved in the criminal justice system (37–39). The APIC model for transitional planning from local jails that has been proposed by Osher and colleagues (40) breaks new ground with its focus on assessing, planning, identifying, and coordinating transitional care. Massachusetts has implemented a forensic transitional program for offenders with mental illness who are reentering the community from correctional settings (41). The program provides “in-reach” into correctional settings three months before release and follows individuals for three months after release to provide assistance in making a successful transition back to the community.

Intercept 5: community corrections and community support services

Individuals under continuing supervision in the community by the criminal justice system—probation or pa-

role—are another important large group to consider. At the end of 2003, an estimated 4.8 million adults were under federal, state, or local probation or parole jurisdiction (42). Compliance with mental health treatment is a frequent condition of probation or parole. Failure to attend treatment appointments often results in revocation of probation and return to incarceration. Promising recent research by Skeem and colleagues (43) has begun to closely examine how probation officers implement requirements to participate in mandated psychiatric treatment and what approaches appear to be most effective.

Other research by Solomon and associates (44) has examined probationers’ involvement in various types of mental health services and their relationship to technical violations of probation and incarceration. Similar to mental health courts, a variety of jurisdictions use designated probation or parole officers who have specialized caseloads of probationers with mental illness. The probation and parole committee of the Ohio Supreme Court advisory committee on mentally ill in the courts (45,46) has developed a mental health training curriculum for parole and probation officers.

Discussion

Some people may argue that the basic building blocks of an effective mental health system are lacking in many communities, and therefore efforts to reduce the overrepresentation of people with mental illness in the criminal justice system are futile. This argument is not persuasive. Even the most underfunded mental health systems can work to improve services to individuals with the greatest need, including the group of people with serious and persistent mental disorders who have frequent interaction with the criminal justice system. Such efforts require close collaboration between the mental health and criminal justice systems.

The Sequential Intercept Model provides a framework for communities to consider as they address concerns about criminalization of people with mental illness in their jurisdiction. It can help communities un-

derstand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time. Different communities can choose to begin at different intercept levels, although the model suggests more “bang for the buck” with interventions that are earlier in the sequence.

Five southeastern counties in Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia) used the Sequential Intercept Model as a tool to organize their work in a forensic task force charged with planning coordinated regional initiatives (47). As a result of that year-long effort, Bucks County staff organized a countywide effort to improve the local continuum of interactions and services of the mental health and criminal justice systems (48), and Philadelphia County started a forensic task force that uses the model as an organizing and planning framework. The model is also being used in a cross-training curriculum for community change to improve services for people with co-occurring disorders in the justice system (49).

Conclusions

Although many communities are interested in addressing the overrepresentation of people with mental illness in local courts and jails, the task can seem daunting and the various program options confusing. The Sequential Intercept Model provides a workable framework for collaboration between criminal justice and treatment systems to systematically address and reduce the criminalization of people with mental illness in their community.

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APPENDIX B

Data on New Jersey Mental Health Services

Counts of Total Individuals Served by DMHAS in SFY 2011 (Quarterly Contract Monitoring Report - QCMR Data)

County	Bilingual / BiCultural	Community Advocates	ICMS	Acute IFSS *****	IFSS	IOTSS	JIS	Legal	Outpatient	Partial Care	PACT*	PATH	Residential Services	Supported Employment	Supportive Housing	Grand Total	
Statewide								86								86	0.00%
Monmouth	127		390	618	202		32	115	19,371	1,437	138	119	163	150	340	23,202	0.65%
Cumberland	172		210		138	235	73		4,697	138	71	97	43	42	91	6,007	0.70%
Hudson	372	89	907	532	178	172	88	126	8,421	479	80	607	188	99	147	12,485	0.79%
Union		59	634	154	178	218	204	258	10,736	1,179	221	148	118	118	177	14,402	0.82%
Bergen	133		884	135	259	331	54	1,209	8,399	697	66	177	294	116	367	13,121	0.88%
Atlantic	209	71	553	40	197	343	156	125	7,963	479	136	125	102	102	319	10,920	0.93%
Ocean	66	70	686		115	314	85	86	8,294	1,057	160	84	85	111	324	11,537	0.96%
Passaic***	300	73	458	907	102		55	77	4,862	650	142	170	430	103	355	8,684	1.19%
Essex	252		1,379	168	360	164	190	236	5,898	896	308	242	160	134	433	10,820	1.24%
Cape May	128		174	51	139	91			2,882	118	66	33	30	49	48	3,809	1.29%
Middlesex	117		729	22	185	194	94	248	4,308	498	210	129	264	97	311	7,406	1.31%
Camden	313		1,242	1,326	108	455	151	222	3,695	1,027	77	302	205	128	215	9,466	1.35%
Burlington	50		548	2,196	108	307	53	173	1,910	1,308	69	79	325	103	339	7,568	1.36%
Morris	58	82	491		357	385	40	182	6,004	286	69	153	237	120	334	8,798	1.36%
Somerset**	156		298		98	87			5,293	339	68	76	61	120	130	6,726	1.78%
Hunterdon**			210	198	632			56	3,789	42	27	66	74	94	74	5,262	1.79%
Mercer	458		468			199	223	289	4,722	856	215	123	183	174	333	8,243	2.11%
Gloucester	104		281		142	86	56		1,442	200	64	54	22	64	37	2,552	2.51%
Salem	127		162		52	52			1,831	131	24	39	14	65	94	2,591	2.51%
Warren			334		109	98		75	816	210	41	41	53	63	44	1,884	3.34%
Sussex***			126		202				2,132	421	23	18	24	107	44	3,097	3.45%
Grand Total	3,142	444	11,164	6,347	3,861	3,731	1,554	3,563	117,465	12,448	2,275	2,882	3,075	2,159	4,556	178,666	

* - Three PACT teams serve multiple counties (Cumberland/Salem, Morris/Sussex & Warren/Hunterdon) the exact counts of consumers served by county are based on estimates of relative proportions.

** - Hunterdon and Somerset Counties are served with IOTSS by single agency. Values for county of client origin are not available.

*** - County does not have its own IOTSS agency, it is assumed that county residents are served by IOTSS facilities in nearby counties.

**** - Passaic received IOTSS services from St. Mary, which did not go online until April 2011. No SFY11 data available

***** - Not all counties have their own Acute IFSS agencies, it is assumed that residents of those counties by facilities in nearby counties. County of origin values are therefore approximate.

Counts of Total Individuals Served in SFY 2011 (QCMR Data)

County	Bilingual / BiCultural	Community Advocates	ICMS	Acute IFSS *****	IFSS	IOTSS	JIS	Legal	Outpatient	Partial Care	PACT*	PATH	Residential Services	Supported Employment	Supportive Housing	Grand Total
Atlantic	209	71	553	40	197	343	156	125	7,963	479	136	125	102	102	319	10,920
Bergen	133		884	135	259	331	54	1,209	8,399	697	66	177	294	116	367	13,121
Burlington	50		548	2,196	108	307	53	173	1,910	1,308	69	79	325	103	339	7,568
Camden	313		1,242	1,326	108	455	151	222	3,695	1,027	77	302	205	128	215	9,466
Cape May	128		174	51	139	91			2,882	118	66	33	30	49	48	3,809
Cumberland	172		210		138	235	73		4,697	138	71	97	43	42	91	6,007
Essex	252		1,379	168	360	164	190	236	5,898	896	308	242	160	134	433	10,820
Gloucester	104		281		142	86	56		1,442	200	64	54	22	64	37	2,552
Hudson	372	89	907	532	178	172	88	126	8,421	479	80	607	188	99	147	12,485
Hunterdon**			210	198	632			56	3,789	42	27	66	74	94	74	5,262
Mercer	458		468			199	223	289	4,722	856	215	123	183	174	333	8,243
Middlesex	117		729	22	185	194	94	248	4,308	498	210	129	264	97	311	7,406
Monmouth***	127		390	618	202		32	115	19,371	1,437	138	119	163	150	340	23,202
Morris	58	82	491		357	385	40	182	6,004	286	69	153	237	120	334	8,798
Ocean	66	70	686		115	314	85	86	8,294	1,057	160	84	85	111	324	11,537
Passaic****	300	73	458	907	102		55	77	4,862	650	142	170	430	103	355	8,684
Salem	127		162		52	52			1,831	131	24	39	14	65	94	2,591
Somerset**	156		298		98	87			5,293	339	68	76	61	120	130	6,726
Statewide								86								86
Sussex***			126		202				2,132	421	23	18	24	107	44	3,097
Union		59	634	154	178	218	204	258	10,736	1,179	221	148	118	118	177	14,402
Warren			334		109	98		75	816	210	41	41	53	63	44	1,884
Grand Total	3,142	444	11,164	6,347	3,861	3,731	1,554	3,563	117,465	12,448	2,275	2,882	3,075	2,159	4,556	178,666

* - Three PACT teams serve multiple counties (Cumberland/Salem, Morris/Sussex & Warren/Hunterdon) the exact counts of consumers served by county are based on estimates of relative proportions.

** - Hunterdon and Somerset Counties are served with IOTSS by single agency. Values for county of client origin are not available.

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***** - Not all counties have their own Acute IFSS agencies, it is assumed that residents of those counties by facilities in nearby counties. County of origin values are therefore approximate.

Proportions of Total of County Individuals Served By Program in SFY 2011 (QCMR Data, Row Proportions)

County	Bilingual / BiCultural	Community Advocates	ICMS	Acute IFSS	IFSS	IOTSS	JIS	Legal	Outpatient	Partial Care	PACT*	PATH	Residential Services	Supported Employment	Supportive Housing	Grand Total
Atlantic	1.91%	0.65%	5.06%	0.37%	1.80%	3.14%	1.43%	1.14%	72.92%	4.39%	1.25%	1.14%	0.93%	0.93%	2.92%	100.00%
Bergen	1.01%	0.00%	6.74%	1.03%	1.97%	2.52%	0.41%	9.21%	64.01%	5.31%	0.50%	1.35%	2.24%	0.88%	2.80%	100.00%
Burlington	0.66%	0.00%	7.24%	29.02%	1.43%	4.06%	0.70%	2.29%	25.24%	17.28%	0.91%	1.04%	4.29%	1.36%	4.48%	100.00%
Camden	3.31%	0.00%	13.12%	14.01%	1.14%	4.81%	1.60%	2.35%	39.03%	10.85%	0.81%	3.19%	2.17%	1.35%	2.27%	100.00%
Cape May	3.36%	0.00%	4.57%	1.34%	3.65%	2.39%	0.00%	0.00%	75.66%	3.10%	1.73%	0.87%	0.79%	1.29%	1.26%	100.00%
Cumberland	2.86%	0.00%	3.50%	0.00%	2.30%	3.91%	1.22%	0.00%	78.19%	2.30%	1.19%	1.61%	0.72%	0.70%	1.51%	100.00%
Essex	2.33%	0.00%	12.74%	1.55%	3.33%	1.52%	1.76%	2.18%	54.51%	8.28%	2.85%	2.24%	1.48%	1.24%	4.00%	100.00%
Gloucester	4.08%	0.00%	11.01%	0.00%	5.56%	3.37%	2.19%	0.00%	56.50%	7.84%	2.51%	2.12%	0.86%	2.51%	1.45%	100.00%
Hudson	2.98%	0.71%	7.26%	4.26%	1.43%	1.38%	0.70%	1.01%	67.45%	3.84%	0.64%	4.86%	1.51%	0.79%	1.18%	100.00%
Hunterdon	0.00%	0.00%	3.99%	3.76%	12.01%	0.00%	0.00%	1.06%	72.00%	0.80%	0.52%	1.25%	1.41%	1.79%	1.41%	100.00%
Mercer	5.56%	0.00%	5.68%	0.00%	0.00%	2.41%	2.71%	3.51%	57.28%	10.38%	2.61%	1.49%	2.22%	2.11%	4.04%	100.00%
Middlesex	1.58%	0.00%	9.84%	0.30%	2.50%	2.62%	1.27%	3.35%	58.17%	6.72%	2.84%	1.74%	3.56%	1.31%	4.20%	100.00%
Monmouth	0.55%	0.00%	1.68%	2.66%	0.87%	0.00%	0.14%	0.50%	83.49%	6.19%	0.59%	0.51%	0.70%	0.65%	1.47%	100.00%
Morris	0.66%	0.93%	5.58%	0.00%	4.06%	4.38%	0.45%	2.07%	68.24%	3.25%	0.78%	1.74%	2.69%	1.36%	3.80%	100.00%
Ocean	0.57%	0.61%	5.95%	0.00%	1.00%	2.72%	0.74%	0.75%	71.89%	9.16%	1.39%	0.73%	0.74%	0.96%	2.81%	100.00%
Passaic	3.45%	0.84%	5.27%	10.44%	1.17%	0.00%	0.63%	0.89%	55.99%	7.49%	1.64%	1.96%	4.95%	1.19%	4.09%	100.00%
Salem	4.90%	0.00%	6.25%	0.00%	2.01%	2.01%	0.00%	0.00%	70.67%	5.06%	0.92%	1.51%	0.54%	2.51%	3.63%	100.00%
Somerset	2.32%	0.00%	4.43%	0.00%	1.46%	1.29%	0.00%	0.00%	78.69%	5.04%	1.01%	1.13%	0.91%	1.78%	1.93%	100.00%
Statewide	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100.00%
Sussex	0.00%	0.00%	4.07%	0.00%	6.52%	0.00%	0.00%	0.00%	68.84%	13.59%	0.74%	0.58%	0.77%	3.45%	1.42%	100.00%
Union	0.00%	0.41%	4.40%	1.07%	1.24%	1.51%	1.42%	1.79%	74.55%	8.19%	1.53%	1.03%	0.82%	0.82%	1.23%	100.00%
Warren	0.00%	0.00%	17.73%	0.00%	5.79%	5.20%	0.00%	3.98%	43.32%	11.15%	2.17%	2.18%	2.81%	3.34%	2.34%	100.00%

Proportions of Individuals Served By Program in Each County in SFY 2011 (QCMR Data, Column Proportions)

[illegible]

APPENDIX C

Outcome Data Report on Union County Jail Diversion Program

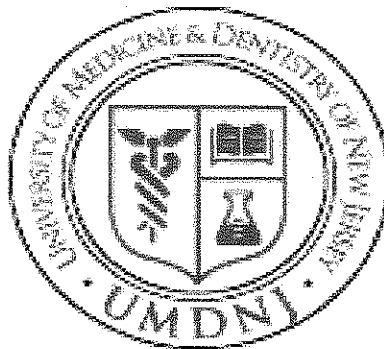
**Report on Union County
Jail Diversion Program 2006-2011 to
The Union County Prosecutor's Office**

May 24, 2011

Prepared by:

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Executive Summary

This report summarizes the outcomes of the Jail Diversion Program of the Union County Prosecutor's Office delivered in collaboration with Bridgeway Rehabilitation Services and Trinitas. From April 2006 through April 2011, 131 individuals with serious mental illnesses participated in this service, with 7 individuals still being served at the end of this time frame. All individuals had a diagnosis of a serious mental illness with 58% of these individuals also having a co-occurring substance abuse disorder. Many had several previous arrests and convictions, and had served jail and/or prison time. In the first year of follow-up, participation in the program significantly reduced time spent in jail or prison, compared to the previous twelve months. Increases in Global Level of Functioning were also found over a six-month period. However, sustained gains over the four subsequent years, in terms of reduction of incarcerations and arrests, were seen only among those who were completers of the Jail Diversion Program (n=52) who on average received 57 weeks of services. Non-completers (n= 72) received significantly less service (an average of 38 weeks) and in general did not experience a reduction in jail days or arrests in years 2 through 5 of the follow-up period. Survival analysis revealed that "completers" were more likely to not be incarcerated throughout the five-year follow-up. There were additional positive gains for "completers", including being arrested far less often and remaining in the community longer before being arrested, if at all. There was some evidence that later in the follow-up period the gains of the "completers" were waning with some increase in their arrest rate. In general though, program completion was associated with positive outcomes. More negative outcomes were associated with a more extensive prior record of arrests, a history of substance abuse, prior convictions and incarceration regardless of program completion.

Introduction

Nationally, attention has focused upon persons with serious mental illnesses becoming recidivists in the criminal justice system, that is, in terms of arrests, court appearances and incarceration in local jails and state prisons (Steadman et al., 2011, Rivas-Vazquez et al., 2009). Often these individuals are homeless with co-occurring substance abuse disorders. Many of the criminal charges these individuals are involved with are disorderly persons' offenses or other minor non-violent offenses. Many stakeholders in the criminal justice and mental health systems, as well as much of the public, believe that the circumstances that lead to these offenses are in part a consequence of their psychiatric disorders. The public may be better served and protected if these individuals were provided with adequate mental health services and supported housing rather than incarceration. Furthermore, this kind of intervention would reduce the likelihood of individuals committing these offenses in the future.

People with mental illness spend longer sentences in jail than the general jail population, are more likely to return to prison than other prisoners in about half the time, and are more expensive to incarcerate than those without mental illness (Lamberg, 2004). A study at Riker's Island, in New York, found that inmates with mental illness spent 215 days on average in jail compared to 42 days for the general jail population. People with mental illness are also more expensive to incarcerate. For example, the Pennsylvania Department of Corrections found that their expenses for incarceration of inmates with mental illness were 82% higher than that of the general prison population (Lamberg, 2004).

Serious mental illness (SMI) also represents a major risk for repeated incarceration, yet recidivism studies often do not specifically focus on persons with SMI as compared to non-SMI offenders. In Utah, a study of over 11,000 state prisoners released from 1998 to 2002 was

conducted (Cloyes et al., 2010). A total of 23% met criteria for serious mental illness ($n = 2,112$) with 9,245 not meeting criteria for mental illness. A very significant difference in return rates to prison and community tenure for offenders with SMI compared to non-SMI offenders was found. The median time for offenders with SMI to return to prison was 385 days compared to 743 days for all offenders. That is, 50% of all offenders with SMI were re-incarcerated less than 13 months after release. For offenders without mental illness, it took more than 24 months before 50% were re-incarcerated (Cloyes et al., 2010). Both statistics are sobering, but the significantly shorter period before reoffending for persons with mental illness, about half that of the general population, is particularly noteworthy.

Another study of 79,211 inmates in Texas who began serving a sentence between 2006 and 2007 was conducted (Baillargeon et al. 2009). Inmates with major psychiatric disorders (major depressive disorder, bipolar disorders, schizophrenia, and non-schizophrenic psychotic disorders) had substantially increased risks of multiple incarcerations over the preceding 6-year study period. The greatest increase in risk was observed among inmates with bipolar disorders, who were 3.3 times more likely to have had four or more previous incarcerations compared with inmates who had no major psychiatric disorder.

A number of jurisdictions are developing programs to divert jail and prison admissions for persons with serious mental illnesses. One of the more prominent programs is in Kings County, New York (Brooklyn) which provides a wide range of interventions (O'Keefe, 2006). This mental health court is primarily for felony offenders. It is an effort to balance a fair court process with effective, and usually lengthy, treatment mandates. During the first 12 months of Brooklyn Mental Health Court operation, a total of six participants of their initial sample of 72,

only (16%), committed a new offense. Clearly this is a very low rate compared to the statistics normally reported, as above, for persons with serious mental illness.

In a multi-site study of over 500 individuals with mental illness (Case et al., 2009), it was found that 52% had an arrest in the 12 months following enrollment in a jail diversion program. However, their number of arrests compared to the previous year dropped from 2.3 to 1.1, as did their jail days which decreased from 51.6 days to 34.5 on average. Also, individuals under the jurisdiction of mental health courts are less likely to be arrested for any new charge compared to their peers with mental illness overseen by the usual court of jurisdiction (McNeil & Bender, 2007) For example, at one year after enrollment in a mental health court, 46% of those who were not assigned to the mental health court had new charges filed. Among those assigned to the mental health court, this percentage was only 32%. At two years, the cumulative proportion of any new charge had grown to 60% for those who did not receive mental health court services vs. only 37% for those who did (McNeil & Binder, 2007).

In New Jersey, the Union County Prosecutor's Office has been a leader in Jail Diversion for persons with serious mental illness. It began with the establishment of the Special Offenders Unit in 2004 and was followed by the collaborative partnership with Bridgeway Rehabilitation Services and Trinitas established in 2006 with partial funding from the New Jersey Division of Mental Health Services. At the time, it was one of only three programs in the state and the only to include the prosecutor's office. In 2009, the Superior Court Jail Diversion Program was established.

This report looks at the characteristics of people served in the Union County Jail Diversion Program and their outcomes. These outcomes included whether or not the individual is incarcerated in county jail or state prison in a follow-up period of up to 5 years after

enrollment. If one is incarcerated, during what time frame did this take place? How much time was spent incarcerated and how does this compare to before their participation in the jail diversion services. Follow-up data for this study also includes changes in the global level of community functioning and management of symptoms. Also assessed is the arrest history of individuals served in the diversion program. How long before someone is arrested? What is the number of total arrests post-enrollment?

Characteristics of Persons Served

The program participants (n=131) are in the diagnostic categories considered among the most serious of the mental illnesses (see Table 1). Over 90% have diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder or major depression. Their mean age is 40, ranging from 20 through 67 at the start of the Jail Diversion Program. The sample was 72.5% male and 27.5% female. Participants had a fair level of impairment in functioning, as measured by Global Level of Functioning (GLOF) of 4.76 (S.D. 1.03). In short, this average level of GLOF is indicative of some persistent symptomatology and lack of full integration in terms of housing, employment, and social life. A large proportion of the study participants, 57%, in addition to their psychiatric diagnosis also have substance abuse or addiction disorders.

Table 1- Description of Characteristics of Participants

	<u>N</u>	<u>%</u>
Diagnosis		
Schizophrenia/Schizoaffective	44	33.6
Bipolar	52	39.7
Depression	22	16.8
Anxiety	6	4.6
Other	5	3.8
Unknown	2	1.5
Drug/Alcohol Diagnosis		
Yes	74	56.5
No	56	42.7
Unknown	1	0.8

These individuals have significant histories of involvement with the criminal justice system with an average of 3.18 jail/prison admissions, 5.33 arrests and 177 lifetime days of incarceration on average prior to entry into the Jail Diversion Program. There is significant variability in the figures with individuals who have as many as 25 instances of incarceration, 33 arrests and over 3000 lifetime days incarcerated. However, the great majority were found at the lower end of these figures with median number of jail admissions being 1, median number of arrests of 3, and median days incarcerated at 11. See table 2.

Table 2: Jail Admissions and Days

	Mean	S.D.
Total Jail Admits Prior (lifetime)	3.18	4.61
Total Jail Days Prior (lifetime)	170.68	420.32
Jail Admits in 12 months prior	0.78	0.87
Jail Days in 12 months prior	28.88	68.71

In the 12 months prior to enrollment in the jail diversion services, 60% of the participants had been incarcerated. On average, they spent 28.88 days of that year incarcerated in jail or prison.

Jail diversion was implemented for individuals at different points in their process and within different systems, with more than half diverted from the county jail (53.4%), and a quarter from the prison (26.7%). About 15% were diverted before prosecution with only 1.5% being diverted from arrest. A variety of forms of diversions were utilized including: downgraded charges to disorderly persons' charges (20%), other downgrades to less serious charges (39%), suspended or modified sentencing (14.5%), dismissal of charges (13.7%), and pre-trial

interventions and other approaches (12.9%). All were referred to community mental health programming. See table 3.

Table 3- Diversion Types

Diversion Type	N	%
Downgraded charge, downgrade to disorderly persons	25	19.2
Reduced Charge	50	38.5
Dismissal	17	13.1
Sentence	20	15.4
Other, Pre-trial intervention, unknown	18	13.8
Diversion From		
County Jail	70	53.4
Prison	35	26.7
Prosecution	19	14.5
Other/Not provided	5	3.9
Arrest	2	1.5

Measures

Data was compiled by staff of the Union County Prosecutor's Office and Bridgeway Rehabilitation Services. Basic demographic data was collected from both sources. Bridgeway provided diagnostic information, both psychiatric diagnosis and addictions, and global level of functioning (GLOF) scores which were collected at baseline entry and six months post program entry. Essential dates of referrals, court decisions, program participation, discharge and reason for discharge were collected from both sources.

The Union County Prosecutor's Office compiled information regarding the types of arrests (disorderly persons and indictable arrests), convictions, jail/prison days, dates of jail admission and release, total jail days both lifetime before participation in the jail diversion program and through April 15, 2011, allowing for up to 60 months of follow-up. To complete this task, Union County Prosecutor staff accessed county, state, and federal databases. Thus, measures of prior history were available as predictors and covariates. Measures of outcomes post-enrollment, in terms of whether someone is arrested or not, how many arrests, and the community tenure before any arrest were computed regardless of jurisdiction. In addition, the number of days spent incarcerated in any jail or prison and at what point in the follow-up time period could also be computed.

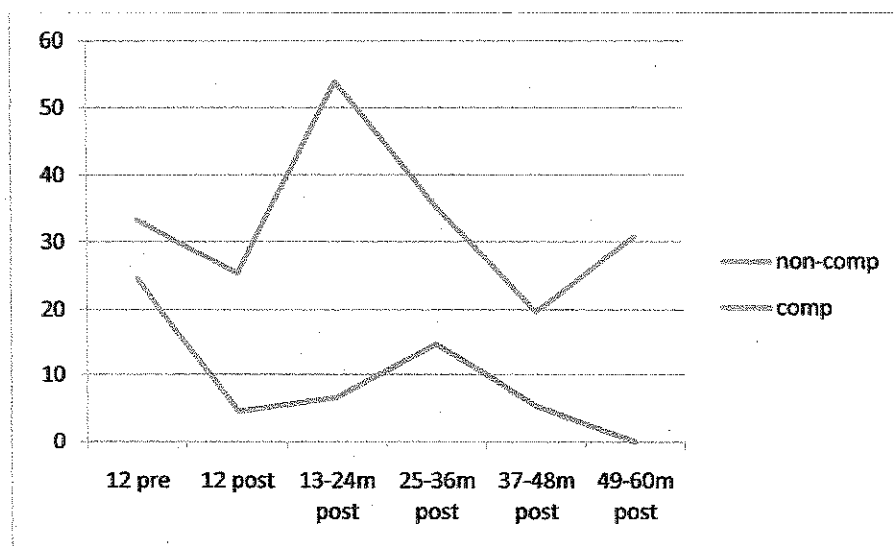
Survival analysis was employed to enable the inclusion of all cases regardless of the follow-up period. Survival analysis allows for inclusion of cases with varying amounts of follow-up data. In this case, survival was defined as the amount of time before an arrest or an incarceration following intake into the jail diversion program. With survival analysis, the outcomes measured take into account that varying numbers of persons are available for the follow-up periods of Year 1 (1-12 months), Year 2 (13-24 months), Year 3 (25-36 months), Year 4 (37-48 months), and Year 5 (49-60 months) post program intake due to their varying intake dates, but a uniform closing date of April 15, 2011.

Results

A total of 131 persons were enrolled in the program. In the year prior to their enrollment in the jail diversion program, they spent an average of 28.88 days incarcerated with significant variability ($SD=70$ days). In the 12 months of follow-up after enrollment, the average number of days incarcerated was reduced significantly by 13 days to a mean of 15.82 days ($t(129) = 1.97, p$

= .05). In the subsequent time period of 13-24 months post enrollment, the mean numbers of jail days rose back to a mean of 34 days per participant. In the third year follow-up, jail days dropped to 27 days per person. In the fourth year, it fell again to an average of about 15 days, only to rise again in the fifth year to 26 days.

This pattern is, in part, explained by the differential outcomes of persons who completed the program, "*Completers*" (n=52), versus those who did not, "*Non-Completers*" (n=72), (7 were still enrolled). Many of the analyses that follow compare *completers* to *non-completers* with the rationale that completers are likely to have received more of the potential benefits of the jail diversion services compared to non-completers. It was found that those who completed the program had significantly better outcomes than non-completers. Figure 1 presents the number of days incarcerated in prison or jail of the completers vs. non-completers. Note that non-completers compared to completers had more days incarcerated in the year prior to enrollment in jail diversion (33.13 days vs. 24.5 days, respectively). In the years post-enrollment, the differences become even more pronounced (see Figure 1). In the 12 months prior to enrollment compared to the 12 months post enrollment, those who completed the program spent an average of 20 fewer days incarcerated, dropping from about 25 days in the prior year, to only 4 days in the first year following enrollment. Those who did not complete the program reduced their time incarcerated only eight days, from 33 days to 25 days, which does not represent a statistically significant decrease. Those who completed the program tended to maintain their gains in the second year of follow-up with only 6.6 days incarcerated on average that year.

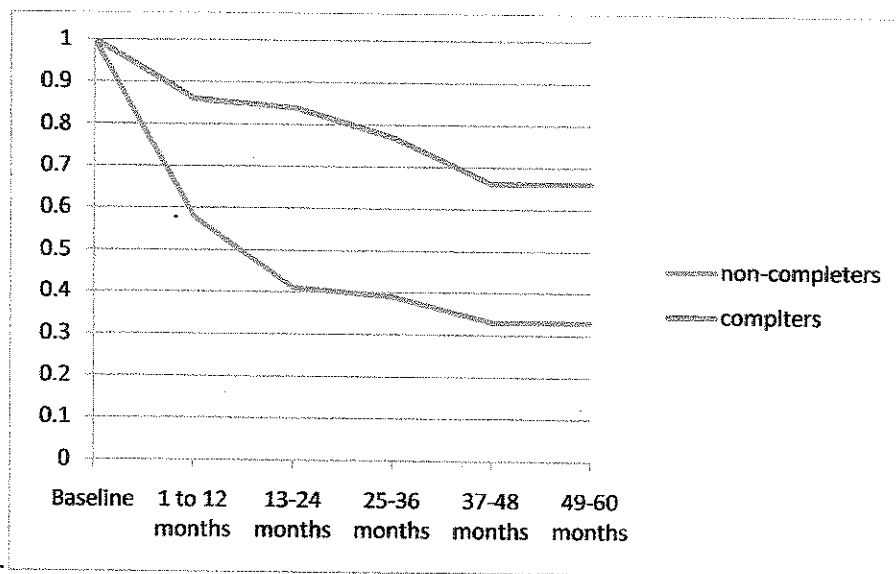
Figure 1 – Days Incarcerated each Year for Completers vs. Non-Completers

As the graph illustrates, those who completed the program have consistently lower numbers of days incarcerated each year in prison and jail than non-completers over the 60 month follow-up period. Compared to the year prior to enrollment, completers reduced their number of days incarcerated in the five subsequent years. Non-completers only did this in 2 years and, in fact, had more days incarcerated in year 2 (13-24 months) than in the year before enrollment. In terms of the numbers of days actually spent in jail, this is always higher for the non-completers, but particularly in year 2, reflecting the increase in jail admissions toward the end of year 1. In the follow up years, non-completers spent between 19 and 54 days per year incarcerated on average. Over the same time period, completers spent between 0 and 15 days incarcerated.

A survival analysis examined length of community tenure. The measure of interest is the time spent un-incarcerated as an outcome variable. In the first year of follow-up alone, 42% of the non-completers were re-incarcerated compared to 14% among the completers. The median or midpoint amount of time for non-completers to return to jail or prison was 2 years and 5 months after enrollment. That means that half of the members of that group were incarcerated once or

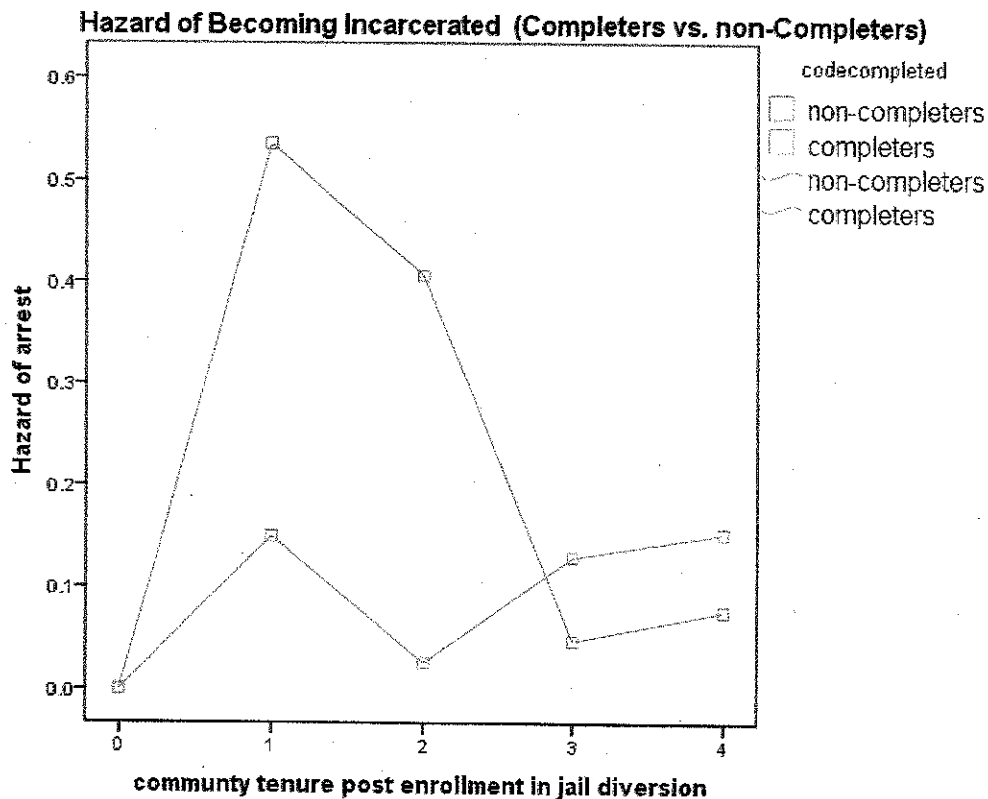
more by that time. By the five-year mark the median for completers had not yet been reached with 67% of the completers still not having been incarcerated at all. In contrast among those who not completed the program, only 33% had not been incarcerated once or more even after 5 years. In Figure 2 below, the differences between completers and non-completers in the follow-up periods is illustrated, with the upper function (red line) representing the cumulative proportion of completers who have not been re-incarcerated and the lower function (blue line) representing the proportion of non-completers not re-incarcerated.

**Figure 2 - Cumulative Proportion of People Not Re-incarcerated
over 60 month follow-up Period**



Below, in Figure 3 the hazard function graph illustrates that those who are non-completers (blue line) are at significantly higher risk for re-incarceration in the follow-up periods after entering the jail diversion program through year three. Indeed during that time period, the risk of incarceration is four to five times higher among non-completers than completers. Around year three the risk for non-completers begins to decline and the risk for completers rises modestly.

Figure 3



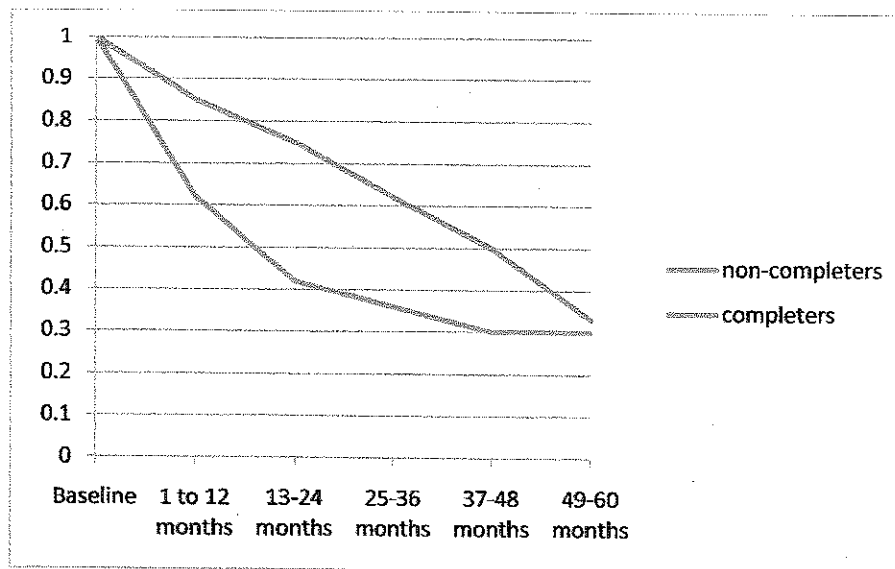
Arrest as an Outcome

In terms of arrest data, completers also have significantly better outcomes. They were less likely to be arrested at all, and if arrested, it was after significantly longer community tenures. Non-completers had an average of more than 2 arrests (mean = 2.02 arrests) up to 5 years post-enrollment in the jail diversion program, whereas completers averaged less than one (mean = .63), ($F(1,124) = 5.62, p < .05$). The median point, that is the point at which 50% of the sample has been re-arrested, among non-completers was 1 year and 7 months, whereas for completers it was 4 years.

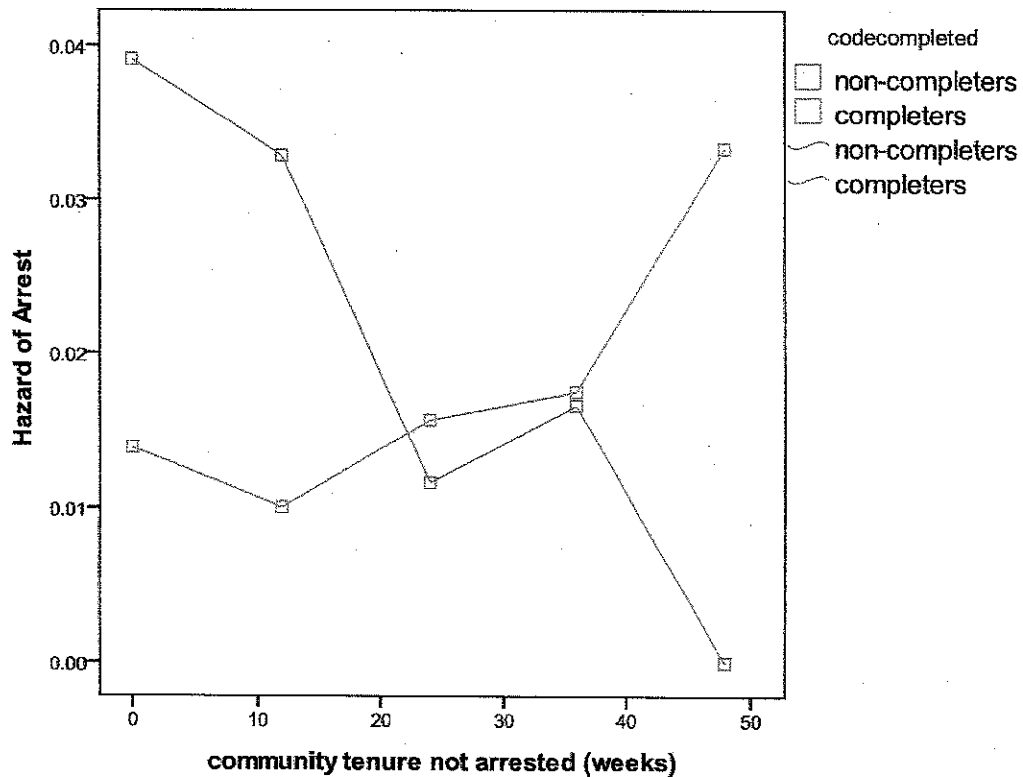
The survival curve illustrates the cumulative proportion of individuals who are not recidivists in terms of arrests on one or more occasions. As noted above, completers are much more likely to *not* be arrested. Consistently a higher cumulative proportion of program completers are maintained in their community without arrest over most of the 60 month period. This remains true until about the 60 month mark, when the proportion remaining in the community without any arrest drops to virtually the same for the members of both groups.

Figure 4 – Cumulative Proportion of People Not Arrested over 60 months:

Completers vs. Non-Completers



In order to better understand the pattern of changes, a hazard function is presented below showing the likelihood of arrest at each stage of the follow-up period. The blue line represents non-completers and the green line completers. For years 1 through 3, non-completers are more likely to be arrested, however, in the fourth year of follow-up, more completers have a risk of re-arrest for mostly disorderly persons' charges.

Figure 5**Risk of Arrest (Hazard Function) of Completers vs. Non-Completers****Positive Changes in Global Level of Functioning**

Global Level of Functioning (GLOF) is a measure developed by NJ DMHS to provide an overall assessment of community functioning and coping with symptomatology. Persons with a 3 or less are typically in institutional settings, those with scores of 4 through 6, are increasing their degree of functioning and coping, although occasionally are hospitalized or in supervised settings. In this study, GLOF increased significantly to 5.31 from a baseline of 4.76, after only six months ($t(81) = 6.72, p < .001$). This indicates significantly increased community integration,

better overall functioning, and management of symptoms. It is a large increase in this scale for a six month period, with a larger increase among those who are completers (change score = .85, $t(41) = 8.70$, $p < .001$), than among non-completers (change score = .25). Although smaller, this difference was nonetheless statistically significant ($t(39) = 2.69$, $p = .01$).

Completers vs. Non-Completers

When the non-completers leave the program, on average they have received 19 weeks fewer of services than those who complete the program (38 weeks vs. 57 weeks, respectively). Their increase in jail days seems to follow termination from the mental health services, spiking in the second years' (13-24 months) follow-up. The reasons for non-completion of the program varied. Approximately 51% refused service or were non-compliant, another 12.5% were lost to contact, with the remainder not completing for other reasons.

Non-completers have histories that are somewhat indicative of a poorer prognosis, that is, a total of 68% of the non-completers have a substance abuse diagnosis, compared to only 42% of the completers ($X^2(1) = 7.06$, $p < .01$). Non-completers compared to completers had significantly more total arrests prior to entry into the Jail Diversion Program, including both disorderly persons and indictable offenses (6.9 vs. 3.15 total arrests), more disorderly persons convictions on average (2.46 vs. .81 convictions), and more total jail admissions (4.2 vs. 2.2).

The Role of Prior History of Criminal Justice Involvement

Consistent with other research findings from the literature, prior history contributes to the explanation of outcomes of jail diversion programs. In this study, the total number of jail admissions in the follow-up period is predicted by three variables in a multiple regression equation (multiple $r(3,121) = .51$), these include: 1) number of lifetime jail admissions prior to entering jail diversion (more lifetime admissions prior predicts more post diversion admissions);

2) whether the individual completed the jail diversion program (completers were incarcerated less); and 3) age (younger people are more likely to be incarcerated more times). The best predictor was number of previous jail admissions, followed by program completion.

Using the outcome variable of ever being incarcerated once or more post-enrollment, there were similar findings in which program completion was the strongest predictor followed by the number of days spent incarcerated during the 12 months prior to the study as the second strongest predictor. In predicting the number of total arrests post jail diversion, the number of disorderly persons arrests pre-enrollment was predictive (logistic $r = .35$), accounting for 12% of the variance, as was the factor of program completion ($r = -.30$), accounting for 9% of the variance.

Thus, as measured by number of previous jails days, disorderly persons arrest or convictions, degree of previous criminal justice involvement is associated with poorer outcomes, and in some cases explains more of the variance in outcomes than program participation.

Maintenance of Gains Associated with Program Participation

There is some question about the sustainability of gains post participation in the Jail Diversion Program, as indicated by the increase in the risk of arrest in the later years. While we saw that the number of days incarcerated continues to decline over time, the hazard function for arrests and jail days seems to be rising for the completers later in the follow-up period, particularly in terms of disorderly persons arrests. Among those who completed the program, the risk of arrests peaks in the fourth year of follow-up (36-48 months) months. In addition, the cumulative proportion of persons still not arrested at 60 months is almost equal to that of non-completers, although their incarceration days remain significantly lower.

Discussion and Conclusions

Jail diversion services result in decreased time in jail and prison, fewer and later arrests, and increased global level of functioning. The decreases in days incarcerated and number of arrests are comparable to that of previous studies. The findings suggest that early involvement in jail diversion services is advisable before individuals develop a cycle of numerous arrests and periods of incarceration. Because completing the jail diversion program is so strongly associated with more positive outcomes, assertive outreach and other attempts to keep service recipients actively participating are recommended.

The findings suggest that longer length of program participation and/or greater continuity of care with other community mental health services would produce better outcomes. Both groups (program completers and non-completers) had their sharpest gains while still actively enrolled in the service and completers, who received services for a longer length of time, sustained these gains longer. In large part, this is not a surprising finding in light of other treatment services research for persons with serious mental illness. All the newer, more effective, evidenced-based community services, including assertive community treatment (ACT), supported housing and supported employment are long-term. They can provide several years of support, though often support is tapered off as need diminishes. (Support can also be increased if need re-emerges). Treatment gains seen when enrolled in ACT, in particular, rapidly diminish if the service is prematurely withdrawn.

Limitations

The study's findings are based on a non-experimental design without the strictest methodological control. Nevertheless its pre-post design was similar to that of other jail diversion studies. Its follow-up period was longer than most studies which typically focus on the

first 12 months, and occasionally as long as 24 months. In this evaluation, program participants were followed up to 5 years.

The data analyzed was not collected prospectively but was based upon existing data sets. The post-hoc grouping of completers vs. non-completers has its difficulties because of the high degree of self-selection and other factors such as pre-existing differences contributing to remaining in the program. In fact, completers and non-completers had significant differences even before entering the service, with non-completers having more extensive criminal justice histories and a higher likelihood of having a substance abuse diagnosis.

Nevertheless, as a naturalistic design studying a real world program over several years of operation, it has strong external validity, that is, generalizability to similar programs.

The study could be strengthened in a number of ways. More complete documentation of the specific community mental health, substance abuse, and housing services provided and their association with specific outcomes would be helpful.

Recommendations

Clearly the project has resulted in very positive outcomes, especially in light of the literature cited. The results indicate that the Union County Jail Diversion Program resulted in decreased jail and prison time, fewer and later arrests, and increased global level of functioning (a measure of community functioning and symptomatology). More evidence of the program's effectiveness is the comparison of those who completed the full program and those who left the program prematurely. Individuals who completed the program were more likely to not be incarcerated throughout the five year follow-up period, and they remained in the community longer before being arrested than those who did not complete the program.

Based on the positive outcomes of the Union County Jail Diversion project we recommend continuing the current program based in the Prosecutor's Office with community mental health partners, and consider its expansion into other New Jersey counties and possibly other states. The greatest benefits of the program are when individuals participate for its full duration. For this reason, we suggest implementing an assertive outreach approach to keep individuals actively participating in the services. Lengthening the service delivery period should be considered. If a longer service period is not an option then greater continuity of care with other community mental health services is needed in order to support the gains made during participation in the program. An integration of drug and alcohol interventions with the mental health services being provided should be fully implemented as we expect that much of the criminal involvement of this group is drug and alcohol related. Lastly, it is recommended that secure long-term stable housing be established for individuals participating in the jail diversion program as the literature supports that individuals with secure housing are less likely to reoffend.

In summary, Union County's Jail Diversion Program shows a promising approach worth continuing in this county and worthy of consideration to be adopted in other New Jersey counties and elsewhere. Further follow-up study of this cohort of individuals is warranted so that the long term follow-up of a greater number of individuals can be completed, as well as a study of those newly entering the services. Findings of this report can assist with refinements of the model to foster desirable results. Providing longer term services or services that provide seamless continuity with the jail diversion program in the community mental health system should be considered.

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- Steadman, H. J., & Naples, M. (2005). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behavioral sciences & the law*, 23(2), 163-70. doi: 10.1002/bsl.640.
- Steadman, H. J., Redlich, A., Callahan, L., Robbins, P. C., & Vesselinov, R. (2010). Effect of Mental Health Courts on Arrests and Jail Days: A Multisite Study. *Archives of general psychiatry*, 68(2), 167-172. doi: 10.1001/archgenpsychiatry.2010.134.

CURRICULUM VITAE

NAME: Kenneth J. Gill, Ph.D., C.P.R.P.

HOME ADDRESS: 109 Madison Avenue
Fanwood, New Jersey 07023
(908) 490-0929

EDUCATION: Columbia University
New York, New York
Ph.D., 1996
Measurement, Evaluation & Statistics in Psychology

Columbia University
New York, New York
M. Phil., 1995
Measurement, Evaluation & Statistics in Psychology

Marquette University
Milwaukee, Wisconsin
M.S., 1984
Clinical Psychology

Columbia College-Columbia University
New York, New York
B.A., 1982
Psychology

CERTIFICATIONS

Certified Psychiatric Rehabilitation Practitioner
United States Psychiatric Rehabilitation Association
International Association of Psychosocial Rehabilitation Services
2001-present

Registered Psychiatric Rehabilitation Practitioner
International Association of Psychosocial Rehabilitation Services
1997-2001

EMPLOYMENT:

2003- Present Chairperson/Professor
Dept. of Psychiatric Rehabilitation and Counseling Professions
UMDNJ-SHRP

1997- 2003 Chairperson/Associate Professor
Dept. of Psychiatric Rehabilitation and
Behavioral Health Care
UMDNJ-SHRP

1995- 1997	Acting Program Director/Assistant Professor M.S. Psychiatric Rehabilitation B.S. Psychiatric Rehabilitation UMDNJ-SHRP
1992 - 1997	Program Director A.S. Psychosocial Rehabilitation and Treatment, UMDNJ-SHRP
1988 - 1992	Director, Psychiatric Day Treatment Services Mount Carmel Guild CMHC Newark, New Jersey
1987 - 1988	Supervisor, Partial Care Mount Carmel Guild CMHC
1984 - 1987	Psychologist I Mount Carmel Guild CMHC

ACADEMIC APPOINTMENTS:

Professor (tenured)
2003 to Present

Associate Professor (tenured)
2000 to 2003

Associate Professor
School of Health-Related Professions
University of Medicine and Dentistry of New Jersey
Newark, NJ
1996-2000

Assistant Professor of Clinical Interdisciplinary Studies
University of Medicine and Dentistry of New Jersey
Newark, NJ
1992 - 1996

Adjunct Instructor
Department of Psychology
Montclair State College
Upper Montclair, New Jersey 07043
1989 - 1991

GRANT HISTORY:**Principal Investigator**

"Education of Peer Special Wellenss Coaches" Transformation Transfer Initiative, NASMHPD-NJ Division of Mental Health Services Jan.-Sept., 2009, \$205,000

"Mutli-disciplinary Education and Skills Development for Adutls with Serious Mental Illness and Metabolic Syndrome" Foundation of UMDNJ, \$30,000.

New Jersey Division of Mental Health Services,
NJ Department of Human Services

Specific Projects:

- Integrated Employment Institute	\$685,000
- Anti-stigma public education (schools & community)	\$25,000
- Trenton Psychiatric Hospital Consultation Project	\$180,300
- Illness Management and Recovery Implementation	\$520,000

Contract award #40011

FY08, \$1,294,800

FY09 1,415,000

FY10 1,412,000

FY11 1,446,000

Post-Doctoral Fellowships in Psychiatric Rehabilitation

Advanced Rehabilitation Research Training Program

Funded by National Institute for Disability Rehabilitation Research

FY05-FY10, \$750,000

Developing an Educational Program for Peer Support Technicians and Specialists

Veteran Administration New Jersey (VANJ)

2007-2008, \$80,000

"A Random Assignment Evaluation of the Circles of Support Intervention to Improve Job Retention." Funded by National Institute for Disability Rehabilitation Research, subcontracted from University of Pennsylvania RRTC on Community Integration,

October 2003-October 2008. \$138,000.

"Graduate Programs in Psychiatric Rehabilitation"

Funded under Long-Term Training Projects

Rehabilitation Services Administration,

U.S. Dept. of Education

FY 05- FY 10, \$500,000.

Public Education Stigma Reduction Grant. NJ Division of Mental health Services, NJ Dept. of Human Services,
FY04 \$25,000, FY05 \$25,000, FY06 \$25,000, FY07 \$25,000

Co-Principal Investigator:

Integrated Employment Institute, funded under NJ Division of Mental Health Services Employment Resource Center Initiative. NJ Department of Human Services.
FY01 \$150,000, FY02 \$615,000, FY03 \$618, 000, FY04 \$618,000, FY05 \$639,000, FY06, \$656,000

“Clinical Affiliation: Greystone Park Psychiatric Hospital, Ancora Psychiatric Hospital and UMDNJ: Towards the Improvement of Patient Care.”

Jan. 1, 1999 - June 2006

\$2,200,000 annually, NJ Dept. Of Human Services

\$290,000 annually for SHRP, \$1.6 million to date
(with C. Kosseff, B. Caldwell)

“Rehabilitation Counselor Education”

Funded under Long-Term Training Projects

Rehabilitation Services Administration,

U.S. Dept. of Education

FY 00 - FY 04, \$500,000.

BIBLIOGRAPHY

Books

Pratt, C.W., Gill, K. J., Barrett, N.M., and Roberts, M.M. (2007) Psychiatric Rehabilitation, 2nd Edition, San Diego, CA: Academic Press.

Swarbrick, M. & Schmidt, L. Gill, K.J. (eds.) (2010) Peers as Providers of Psychiatric Rehabilitation, 2nd ed., United States Psychiatric Rehabilitation Association, in press.

Pratt, C.W., Gill, K. J., Barrett, N.M., and Roberts, M.M. (1999) Psychiatric Rehabilitation, San Diego, CA: Academic Press.

Guest Editor

Gill, K.J. (2006) Special Issue: The Role of Hospitals in Psychiatric Rehabilitation Today, American Journal of Psychiatric Rehabilitation, 8 (3).

Gill, K.J. (2005a) Special Issue: Recent Developments in Supported Employment & Employment Services. American Journal of Psychiatric Rehabilitation, 8 (1).

Gill, K.J. (2001a) Special Issue: Psychiatric rehabilitation curriculum in higher education. Psychiatric Rehabilitation Skills, 5 (3), 432-571.

Monographs

Burns-Lynch, B., Murphy, A., Gill, K., Brice, G. (2009). *Report to the New Jersey Division of Mental Health Services: Peer Crisis Intervention Literature Review, Semi-Structured Survey, and Recommendations for Peer Crisis Alternative Services in New Jersey*. Scotch Plains, NJ: University of Medicine & Dentistry of New Jersey.

Gill, K. (2006) "The Mapping of the Job Tasks of Behavioral Health Care Direct Service Positions" District 1199c Training and Upgrade Fund.

Book Chapters

Pratt, C. W., & Gill, K.J. (in press). Educating practitioners and researchers in person-centered principles related to serious mental illness. In D. R. A. Rudnick (Ed.), *Person-Centered Care*. London: D. Radcliffe Publishers

Gill, K.J. & Pratt, C.W. (2005) Developing the Evidence-Based Practitioner in Drake, R.E., Merrens, M.R., & Lynde, D.W. Evidence-Based Mental Health Practice: A Textbook. New York: W.W. Norton & Co, pp. 95-122.

Pratt, C. & Gill, K. (2005) What are Community Mental Health Services in Drake, R.E., Merrens, M.R., & Lynde, D.W. Evidence-Based Mental Health Practice: A Textbook. New York: W.W. Norton & Co, in press., pp. 21-44.

Pratt, C. & Gill, K. (1994) Sharing Research Knowledge to Empower the Chronically Mentally Ill, in Anthony, W. & Spanoil, L. Readings in Psychiatric Rehabilitation. Boston, MA: Center for Psychiatric Rehabilitation, pp. 53-59

Pratt, C. & Gill, K. (1994) Interagency In-Service Training, in Spanoil, L. et al. (eds.) Introduction to Psychiatric Rehabilitation. Columbia, Maryland: International Association of Psychosocial Rehabilitation Services, pp. 332-338.

JOURNAL ARTICLES (Peer reviewed)

Spagnolo, A.B., Dolce, J., Roberts, M. M., Murphy, A. A., Gill, K. J., Librera, L., & Lu, W. (2011). A study of the perceived barriers to the implementation of circles of support. *Psychiatric Rehabilitation Journal*, 34, 233-242.

Swarbrick, M., Spagnolo, A., Zechner, M., Murphy, A., & Gill, K. (2011). Peer Wellness Coach: A New Role for Peers. *Psychiatric Rehabilitation Journal* (34), 328-331.

Swarbrick, M., Zechner, M., Gill, K., Murphy, A., & Spagnolo, A. (in press). Peer wellness coaching: A workforce innovation. *Psychiatric Rehabilitation Journal*.

Gao, N., Gill, K., Schmidt, L.T., & Pratt, C.W. (2010). The application of human capital theory in vocational rehabilitation for individuals with mental illness. *Journal of Vocational Rehabilitation*, 32(1), 25-33.

Gao, N., Schmidt, L. T., Gill, K., & Pratt, C. W. (in press). Building Human Capital to Increase Earning Power among People Living with Mental Illnesses. *Psychiatric Rehabilitation Journal*.

Gill, K., & Barrett, N. (2009). Psychiatric rehabilitation: An emerging academic discipline. *Israeli Journal of Psychiatry*, 46(2), 94-102.

Gill, K. J., Murphy, A.A., Zechner M.R., Swarbrick, M., & Spagnolo, A.B. (2009). Co-morbid psychiatric & medical disorders: Challenges & strategies. *Journal of Rehabilitation*, 75(3), 32-40.

Gill, K. J., Burns-Lynch, W., Murphy, A.A., & Swarbrick, M. (2009). Delineation of the job role of peer support specialists in the Veterans Administration. *Journal of Rehabilitation*, 75(3), 23-31.

Gill, K. J. (2009) The audacity of psychiatric rehabilitation. (editorial), *Psychiatric Rehabilitation Journal*, 32, 4, 255-256.

Gill, K. J. (2008) The virtues of dissent and dialogue. (editorial), *Psychiatric Rehabilitation Journal*, 32, 7-8.

Schmidt, L. T., Gill, K. J., Solomon, P. & Pratt, C. W. (2008). Comparison of service outcomes of case management teams with and without a consumer provider. *American Journal of Psychiatric Rehabilitation*, 11, 4, 310-329.

Gill, K. J. (2008). The persistence of stigma and discrimination. *Psychiatric Rehabilitation Journal*, 31(3), 183-184.

Swarbrick, M., Hutchinson, & Gill, K. (2008) The Quest for Optimal Health: Can Education Cure What Ails Us? *International Journal of Mental Health*, 37(2), 69-88.

Gill, K. J. (2007). Who Is Not Ready? *Psychiatric Rehabilitation Journal*, 30(3), 169-170.

Roe, D., Rudnick, A., & Gill, K. J. (2007). The Concept of "Being in Recovery" *Psychiatric Rehabilitation Journal*, 30(3), 171-173.

Gill, K.J. (2006) Introduction to Special Issue on Public Psychiatric Hospitals, *American Journal of Psychiatric Rehabilitation*, 9(2), 81-84.

Caldwell, B.A., Gill, K. J., Fitzgerald, E., Sclafani, M., & Grandison, P. (2006) The Association of Ward Atmosphere with Burnout and Attitudes of Treatment Team Members in a State Psychiatric Hospital *American Journal of Psychiatric Rehabilitation*, 9(2) 11-129.

Gill, K.J (2006) With Recovery Now in Public Policy: Is it in danger? Psychiatric Rehabilitation Journal, 30(1), 7-8.

Birkmann, J. C., Sperduto, J.S., Smith, R.C., Gill, K.J. (2006). A collaborative rehabilitation approach to the Improvement of inpatient treatment for persons with a psychiatric disability. Psychiatric Rehabilitation Journal, 29(3), 157-165.

Patrick, V., Schleifer, S.J. Nuremberg, J. & Gill, K. (2006). An initiative to curtail the use of antipsychotic polypharmacy in a state psychiatric hospital." Psychiatric Services, 57(1), 21-23.

Gill, K. J. (2005). "Editorial." Psychiatric Rehabilitation Journal, 29(2), 87-88.

Gill, K. J. (2005). Introduction to Special Issue on the Role of Employment Interventions in the Lives of Persons with Severe and Persistent Mental Illness. American Journal of Psychiatric Rehabilitation, 8(1), 9-12.

Hoge, M. A., Paris, M., Jr., Adger, H., Jr., Collins, F. L., Jr., Finn, C. V., Fricks, L., Gill, K.J. et al. (2005). Workforce Competencies in Behavioral Health: An Overview. Administration & Policy in Mental Health, 32(5-6), 593-631.

Gill, K. J., Bagherian, P., Ali, D. & Turjancik, M. (2005) Evaluation of a Master's Degree Program in Psychiatric Rehabilitation. American Journal of Psychiatric Rehabilitation 8, 165-174.

Gill, K. (2005) Experience is not always the Best Teacher: Lessons from the Certified Psychiatric Rehabilitation Practitioner Certification Program. . American Journal of Psychiatric Rehabilitation 8, 151-164.

Gill, K.J., Murphy, A.A. & Birkmann, J.C. (2005) Developing Attitudes: The Role of Psychiatric Rehabilitation Education. American Journal of Psychiatric Rehabilitation, 8, 135-149

Gill, K. J. (2005). Introduction to Special Issue on the Role of Employment Interventions in the Lives of Persons with Severe and Persistent Mental Illness. American Journal of Psychiatric Rehabilitation, 8(1), 9-12.

Hoge, M. A., Paris, M., Jr., Adger, H., Jr., Collins, F. L., Jr., Finn, C. V., Fricks, L., Gill, K.J. et al. (2005). Workforce Competencies in Behavioral Health: An Overview. Administration & Policy in Mental Health, 32(5-6), 593-631.

Gill, K. J., Bagherian, P., Ali, D. & Turjancik, M. (2005a) Evaluation of a Mater's Degree Program in Psychiatric Rehabilitation. American Journal of Psychiatric Rehabilitation 8, in press.

Gill, K.L., Murphy, A.A. & Birkmann, J.C. (2005b) Developing Attitudes: The Role of Psychiatric Rehabilitation Education. American Journal of Psychiatric Rehabilitation, 8,

- Casper, E.S., Oursler, J., Schmidt, L.T., & Gill, K. (2002) Measuring Practitioners Beliefs, Goals, and Practices, Psychiatric Rehabilitation Journal, 25(3), 223-234.
- Gill, K.J. (2001c) Introduction. Psychiatric Rehabilitation Skills, 5 (3), 432-436.
- Pratt, C.W., & Gill, K.J. (2001). Psychiatric Rehabilitation Education: A Government, Service Provider, and Academic Collaboration. Rehabilitation Education, 15, 191-199.
- Barrett, N.M., Pratt, C.W., Basto, P.M. & Gill, K.J. (2000) Integrating consumer providers into a service delivery system: The role of education and credentials. Psychiatric Rehabilitation Skills, in press.
- Basto, P.M., Pratt, C.W., Gill, K.J. & Barrett, N.M. (2000) The assimilation of consumer providers in a statewide system: Organizational Commitment and Perceived Organizational Support. Psychiatric Rehabilitation Skills, in press.
- Gill, K.J., Pratt, C.W., Librera, L.A. (1998) The effects of consumer vs. staff administration on the measurement of consumer satisfaction with psychiatric rehabilitation. Psychiatric Rehabilitation Journal, 21(4), 365-370.
- Gill, K.J., Pratt, C.W., Barrett, N. (1997) Preparing psychiatric rehabilitation specialists through undergraduate education. Community Mental Health Journal 33(4), 323-329.
- Gill, K. (1996) Social psychological artifacts in the measurement of consumer satisfaction with health care. Dissertation Abstracts International: Section B: the Sciences & Engineering, 57(2-B), 1495.
- Hansburg, F., Nelson, L. Connors, C., Gill, K., Grande, P., and Lutzky-Paley, N. (1996) Two sides of a crisis: Consumer and professional views of screening services. Psychiatric Rehabilitation Journal, 19, (4), 19-24.
- Pratt, C.W. & Gill, K.J. (1996) Measuring Consumer Satisfaction in a Psychiatric Milieu. Psychiatric Rehabilitation Journal, 19, (3), 29-35.
- Gill, K. J. & Pratt, C.W. (1994) Le partage des profits: une strategie de prise en charge psychiatrique. Sante Mentale au Quebec, XIX (1), 105-116.
- Gill, K.J., & Pratt, C.W. (1993) Profit Sharing in Psychiatric Rehabilitation: A five-year evaluation. Psychosocial Rehabilitation Journal, 17(2), 33-41.
- Pratt, C. & Gill, K. (1992) Interagency In-Service Training. Psychosocial Rehabilitation Journal, 16, No. 1, 3-12.
- Pratt, C. & Gill, K. (1990) Sharing Research Knowledge to Empower the Chronically Mentally Ill. Psychosocial Rehabilitation Journal, 13, No.3, 75-79.
- Lueger, R. J, & Gill, K. J. (1990) Frontal-lobe cognitive dysfunction in conduct disorder

adolescents. Journal of Clinical Psychology. Vol 46(6), 696-706.

Lueger, Robert J; Albott, William L; Hilgendorf, William A; Gill, Kenneth J. (1985) Neuropsychological and academic achievement correlates of abnormal WISC-R verb-performance discrepancies. Journal of Clinical Psychology, 41(6), Nov. 1985, 801-805.

BOOK REVIEW

Gill, K. (1997) Review of Vinograd, S. (1995) Treating Schizophrenia. San Francisco: Jossey Bass, in Psychiatric Rehabilitation Journal, 20(4), pp. 99-101.

SELECTED ABSTRACTS AND PRESENTATIONS

Gill, K.J. (2007) Developing an Orientation and Educational Program for Peer Support Technicians. Keynote address at the National Veterans Administration Conference, "The Evolving Role of Peers in the VA Mental health System", Chicago, IL, August 3, 2007.

Swarbrick, M., Hutchinson, & Gill, K. (2007) The Quest for Optimal Health: Can Education Cure What Ails Us?, Paper presented at the SAMHSA National Wellness Summit, Bethesda MD, Sept. 17-18, 2007

Gill, K.J. (2007) Transforming New Jersey's Mental health System, "*New Wine in Old Skins*" or "*Being the Changes You Wish to See*". Keynote address, NAMI-NJ, Somerset, NJ, June 2, 2007.

Gill, K. J. & Pratt, C.W. (2007) Prioritizing Management, Supervision, and Organizational Training Needs within Self-help Centers. UMDNJ and CSP-NJ, July 24-26, Freehold, NJ.

Gill, K.J. & Spagnolo, A. (2006) "Reducing stigma by meeting and learning from people with serious mental illness." Symposium presented at World Congress of Psychosocial Rehabilitation Meeting, Athens, Greece, October 13, 2006.

Pratt, C., Gill, K. et al. (2006) "Symposium on Dissemination of Psychiatric Rehabilitation Education Globally," presented at World Congress of Psychosocial Rehabilitation Meeting, Athens, Greece, October 13, 2006.

Roberts, M.M., Gill, K. et al. (2006) "Enhancing Employment Services for Persons with Psychiatric Illnesses" presented at World Congress of Psychosocial Rehabilitation Meeting, Athens, Greece, October 14, 2006.

Gill, K. J. Language, Stigma, & Recovery, presentation at "Recovery in Action" VISN 3 Mental Health Care Line and VISN 3 MIRECC, Parsippany, NJ, Sept. 28-29, 2006.

Gill, K. J. & Pratt, C.W. (2006) Management, Supervision, and Organizational Factors in Leadership within Self-help Centers. UMDNJ and CSP-NJ, July 24-26, Scotch Plains, NJ.

MEMBERSHIPS, OFFICES AND COMMITTEE ASSIGNMENTS:**Professional**

2010- 2011	Governor's Task Force on Mental Health Facilities
2005 - 2009	Co-editor-in-chief, <i>Psychiatric Rehabilitation Journal</i>
2003 - Present	Associate Editor, <i>American Journal of Psychiatric Rehabilitation</i>
2006 to 2009	President
2002 to 2006	Vice President Commission for the Certification of Psychiatric Rehabilitation Practitioners Chair, Test Oversight Committee
2000-2003	Trustee Matrix Research Institute
1998 - 2002	Chairman, Certification Committee International Association of Psychosocial Rehabilitation Services
1996 - Present	Mental Health Coalition of New Jersey
1996 - Present	Registry Narrative Reviewer, International Association of Psychosocial Rehabilitation Services
1995 - 1999	President, New Jersey Psychiatric Rehabilitation Association
1995 - 1997	Standards Advisory Panel Psychiatric/Psychosocial Rehabilitation Services Council on Accreditation, New York, NY
1994 - Present	Chapter Representative, Board Member International Association of Psychosocial Rehabilitation Services
1994 - Present	Training and Certification Committee International Association of Psychosocial Rehabilitation Services

1993 - 1994	Co-Chair, Conference Committee 1993 Conference committee 1994 Conference committee New Jersey Psychiatric Rehabilitation Association
1993 - 1995	Vice President Staff Development New Jersey Psychiatric Rehabilitation Association
1991 -	Advisory Committee on Psychiatric Rehabilitation Department of Psychology Upper Montclair, New Jersey
1991 - 1994	Member, Eastern Evaluation Research Society
1990 - Present	Member, Board of Directors, New Jersey Psychiatric Rehabilitation Association
1989 - 1993	Regional (Essex-Union counties), Inter-Agency, In-service training Committee, New Jersey Psychiatric Rehabilitation Association
1988 - 2003 2003-Present	International Association of Psychosocial Rehabilitation Services United States Psychiatric Rehabilitation Association

Community

2006 to 2010	Advisor Leadership Retreat Convener Implementation Committee Member Wellness and Recovery Transformation New Jersey Division of Mental Health Services
2005	Committee Member Wellness and Recovery Subcommittee Governor's Task Force on Mental Health
2000-Present	President, Treasurer, Trustee Triple C Housing New Brunswick, NJ
2005-Present	Advisory Board Member Mental Health Programs Volunteers of American of Northern, New Jersey Rahway, New Jersey
1999	Outpatient Commitment Study Group

New Jersey Division of Mental Health Services

1998-2003	Direct Care Salary Coalition
1998-2000	Coalition for Full Mental Health Parity
1992 - 1994	Community Mental Health Academic Linkage New Jersey Division of Mental Health
1989 - 2000	Trustee
1990-1995	Secretary and Treasurer Project Live I and Project Live II, Inc., Newark, New Jersey
1991	New Jersey Division of Mental Health and Hospitals 450 Census Reduction/Community Expansion Plan Essex County Committee

Institutional

2007 to Present	Committee on Research Integrity UMDNJ New Brunswick - Piscataway Campus Committee
2005 to Present	Member, Management Negotiating Team NJEA Faculty and Program Supervisor Locals
2000-2003	Institutional Review Board for all Newark Campus Research
1998-2009	UMDNJ-Greystone Park Psychiatric Hospital Affiliation Leadership Group
1998-2003	Member, Chair Committee on Appointment and Promotions UMDNJ-SHRP
1997-Present	SHRP Management Council
1997-Present	Committee on Appointment and Promotions UMDNJ-SHRP
1994- Present	SHRP Executive Council

AWARDS AND HONORS:

John Beard Award
United States Psychiatric Rehabilitation Association
May, 2005

Career Service Award for Leadership in Psychiatric Rehabilitation
Project Live, Inc.

December, 2002

UMDNJ President's Departmental Award for Academic Excellence
and Innovation
September, 2002

Mort Gati Award
NJPRA Award for the Embodiment of Principles of Psychiatric Rehabilitation
November, 2001

NJPRA Leadership Award
June 14, 2001

IAPSRS Board Service Award
May 2001 (1994-2001)

Advocacy Award- Mental Health Parity Law
Mental Health Association in New Jersey
Sept. 30, 1999

Community Partnership Award
Bridgeway Psychiatric Rehabilitation Services
Elizabeth, New Jersey
1997

Dean's Award for Excellence in Research
UMDNJ-SHRP
1996-97

Excellence and Innovation in Human Resource Development
National Association of State Mental Health Program Directors
November, 1995

Pratt, C. & Gill, K. "Empowering Members through Education and Program Evaluation." Presentation at IAPSRs, Philadelphia, PA, July, 1988.

Gill, K. & Pratt, C. "Program Evaluation: A Consumer Endeavor." Presentation at NJPRA annual conference, North Brunswick, NJ, November, 1987.

Gill, K. "Client Empowerment through Program Structure." Presentation at the NJPRA annual conference, North Brunswick, NJ, December, 1986.

Gill, K. "Frontal Lobe Cognitive Functioning in Conduct Disorder Adolescents." Presentation at National Academy of Neuropsychologists annual meeting, Philadelphia, PA, November, 1985.

Other

"Social Psychological Artifacts in the Measurement of Consumer Satisfaction with Health Care Services." Doctoral Dissertation, Columbia University, December, 1995.

"Effect of Medicaid Managed Care Mental Health Services to Persons with Severe and Persistent Mental Illness." Oral and written testimony at New Jersey Department of Health and Department of Human Services Public Hearing, July 15, 1995.

"Marlboro Hospital Closure and Community Services Expansion". Oral and written testimony given at New Jersey Department of Human Services hearing, March 27, 1995.

"Frontal Lobe Cognitive Functioning in Conduct Disorder Adolescents." Master's Thesis, Marquette University, Aug. 1984.

CURRICULUM VITAE

NAME: Ann A. Murphy, M.A., CPRP

HOME ADDRESS: 40-5 Prospect Street
Metuchen, NJ 08840

OFFICE ADDRESS: University of Medicine and Dentistry of New Jersey (UMDNJ)
School of Health Related Professions
Department of Psychiatric Rehabilitation
1776 Raritan Road, Rm. 313
Scotch Plains, New Jersey 07076
(908) 889-2734

EDUCATION: University of Medicine and Dentistry of New Jersey
Scotch Plains, New Jersey
Ph.D., Anticipated Graduation 2012
Psychiatric Rehabilitation

The College of William and Mary
Williamsburg, Virginia
M.A., 2003
Psychology

Susquehanna University
Selinsgrove, Pennsylvania
B.A., 1998
Psychology and Philosophy

EMPLOYMENT:

2006 – Present Assistant Professor
Department of Psychiatric Rehabilitation
UMDNJ- School of Health Related Professions (SHRP)
Scotch Plains, NJ 07076

2004 – 2006 Instructor
Department of Psychiatric Rehabilitation
UMDNJ-School of Health Related Professions (SHRP)
Scotch Plains, NJ 07076

2003 – 2004 Case Manager
High Point Partial Care
Flemington, NJ 08822

2001 – 2003	Research Assistant Eastern State Hospital Williamsburg, VA 23187
1998 – 2001	2000 – 2001 Unit Leader 1998 – 2000 Case Manager High Point Partial Care Flemington, NJ 08822
1996 – 1998	Psychology Tutor Susquehanna University Selinsgrove, PA 17870

ACADEMIC APPOINTMENTS:

Assistant Professor
UMDNJ- School of Health Related Professions
Department of Psychiatric Rehabilitation
2006 - Present

Instructor
UMDNJ- School of Health Related Professions
Department of Psychiatric Rehabilitation
2004 – 2006

CERTIFICATIONS:

Certification for Psychiatric Rehabilitation Practitioners (CPRP)
2010 – present

AWARDS AND HONORS:

Susquehanna University Departmental Honors
Department of Psychology
B.A. Program, 1998

Susquehanna University Department Award
Department of Philosophy
B.A. Program, 1998

Summa Cum Laude, Susquehanna University
B.A. Program, 1998

PROFESSIONAL MEMBERSHIP:

2004 – Present	New Jersey Psychiatric Rehabilitation Association (NJPRA)
2007 – Present	United States Psychiatric Rehabilitation Association (USPRA)

PROFESSIONAL AND/OR COMMUNITY SERVICE ACTIVITIES:

Research Poster Presentation at UMDNJ-SHRP Research Day
Peer Wellness Coaching: A New Role to Improve Health
Outcomes
Scotch Plains, NJ, May 2011

Presenter and Exhibitor at Wellness and Recovery Conference
Peer Wellness Coaching
Edison, NJ, April 2011

Exhibitor at United States Psychiatric Rehabilitation Association
(USPRA) Annual Conference
Boise, ID, June 2010

Presenter and Exhibitor at Wellness and Recovery Conference
The Development of a Peer Wellness Coaching Program: Lessons
Learned
Edison, NJ, March 2010

Presenter and Exhibitor at United States Psychiatric Rehabilitation
Association (USPRA) Annual Conference
Role Delineation and Course Development for VA Peer Support
Specialist Training
Norfolk, VA, June 2009

Presenter and Exhibitor at United States Psychiatric Rehabilitation
Association (USPRA) Annual Conference
Web-based Recovery Curriculum Development
Lombard, IL, June 2008

Presenter and Exhibitor at Wellness and Recovery Conference
Impact of Support on Employment
Long Branch, NJ, March 2008

Presenter and Exhibitor at New Jersey Psychiatric Rehabilitation
Association (NJPRA) Annual Conference
Enhancing Employment Services for People with Psychiatric
Disabilities and Wellness Management and Recovery
Edison, NJ, November 2007

Presenter at New York Association of Psychiatric Rehabilitation
(NYAPRS) Annual Conference
Enhancing Employment Services for People with Psychiatric
Disabilities and Reducing Stigma by Meeting and Learning from
People with Mental Illness
Ellenville, NY, October 2007

Presenter at COMHCO Conference, CSP-NJ Wellness Conference,
and Project Live Wellness Conference
Circles of Support: How to Make Your Supports Work for You
Long Branch, NJ, February 2007; Long Branch, NJ, March 2007;
and Newark, NJ, June 2007

Poster Presenter at SHRP Annual Poster Day
Social Networks Among People with Psychiatric Disabilities
Newark, NJ, May 2007

Content expert and presenter in a train-the-trainer session to staff
and consumers of Newton Memorial Hospital
Reducing Stigma by Meeting and Learning from People with
Mental Illness
Newton, NJ, March 2007

Presenter at UMDNJ-SHRP, Department of Psychiatric
Rehabilitation Colloquium series
The FACIT Project
Scotch Plains, NJ, February 2007

Presenter to 7th graders in Bayonne, NJ
Reducing Stigma Toward Mental Illness Among the Early
Adolescent Population
Bayonne, NJ, December 2006

Presenter and Exhibitor at New Jersey Psychiatric Rehabilitation
Association Annual Conference
Transformation of Community Attitudes and the Champions of
Anti-discrimination: The Impact of an Anti-Stigma Project
Edison, NJ, November 2006

Presenter in Interstate Panel Discussion and Exhibitor, NYAPRS
Annual Conference
Increasing Employment Rates for People with Psychiatric
Disabilities
Ellenville, NY, October 2006

Presenter and Exhibitor at UPenn Collaborative on Community
Integration, National State of the Knowledge Conference
Circles of Support in Behavioral Health
Philadelphia, PA, September 2006

Exhibitor at New Jersey Conference on Employment
Building Independence through Career Development and Supports
Iselin, NJ, July 2006

Exhibitor at Combating Mental Health Stigma Conference
Governor's Council on Stigma
Eatontown, NJ, June 2006

Presenter at United States Psychiatric Rehabilitation Association
Annual Conference
"Some Call it 'Short Job Tenure', We Call it a 'Smart Career
Move!' Strategies that Promote Career Development"
Phoenix, AZ, June 2006

Exhibitor at United States Psychiatric Rehabilitation Association
Annual Conference
Phoenix, AZ, June 2006

Presenter at Singapore Anglican Community Services
Review of Psychiatric Rehabilitation Basics and CPRP Test
Preparation
Singapore, May 2006

Exhibitor at Wellness and Recovery Conference
Long Branch, NJ, March 2006

Presenter at South Beach Psychiatric Center Conference
"Keeping a Job: Community Oriented Strategies"
Staten Island, NY, June 2005

Exhibitor at New Jersey Conference on Employment,
Employment: Gateway to the Community
Iselin, NJ, June 2005

Exhibitor at United States Psychiatric Rehabilitation Association
Annual Conference
Pittsburgh, PA, May 2005

Trainer in Employment Strategies for NJDMHS funded Supported
Employment Programs, on the topics "Career Planning", "Self-
Employment: An Alternative Worth Another Look", and

"Employment for People with Legal Issues", Clifton and Scotch Plains, NJ, 2005, 2006 and Aberdeen, NJ, 2004.

Trainer in Person Centered Planning for NJDMHS funded Supported Employment Programs, Camden, NJ, 2005 and Newton and Denville, NJ 2004.

Exhibitor at Recovery and Wellness: Essential for Living, Working, and Learning Conference
Long Branch, NJ, June 2004

Paper presented at Southeastern Psychological Association (SEPA) "Social Cognition and Symptom Syndromes of Schizophrenia", Atlanta, GA, Spring 2004 (with Glenn Shean).

RESEARCH HISTORY:

PRINCIPLE INVESTIGATOR:

"Social Cognition and the Syndromes of Schizophrenia", College of William and Mary,
9/02 – 5/03.

"Predicting Discharge to the Community Versus Discharge to Continued Treatment from Patient Factors Assessed at Admission", College of William and Mary,
9/01 – 4/02.

RESEARCH COORDINATOR:

"The FACIT (Fidelity Assessment Common Ingredients Tool) Instrument Validation Project"
UMDNJ
2009 – present.

"Impact of Peer Delivered Illness Management and Recovery (IMR) on the Recovery of Persons with Serious Mental Illness", UMDNJ,
2005 – present.

"A Study of Job Retention Strategies in Supported Employment", UMDNJ,
2004 – 2009.

"Reducing Stigma by Meeting and Learning from People with Serious Mental Illness", UMDNJ,
2004 – present.

"Supported Employment Services for Persons with Psychiatric Disabilities: Determinants of Success", UMDNJ, 2004 – 2006.

BIBLIOGRAPHY:

Journal Articles:

1. Pratt, C., Murphy, A., Lu, W., & Swarbrick, M. (under review). Group delivery of Illness Management and Recovery facilitated by peer and non-peer providers. *American Journal of Psychiatric Rehabilitation*.
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3. Spagnolo, A., Swarbrick, M., Zechner, M., Gill, K., & Murphy, A. (under review). The peer wellness coach role: Focus group feedback informs training curriculum. *American Journal of Psychiatric Rehabilitation*.
4. Swarbrick, M., Murphy, A.A., Zechner, M., Spagnolo, A.B. & Gill, K.J. (2011). Wellness coaching: A new role for peers. *Psychiatric Rehabilitation Journal*, 34, 328-331.
5. Spagnolo, A.B., Dolce, J., Roberts, M. M., Murphy, A. A., Gill, K. J., Librera, L., & Lu, W. (2011). A study of the perceived barriers to the implementation of circles of support. *Psychiatric Rehabilitation Journal*, 34, 233-242.
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13. Murphy, A.A., Mullen, M.G., & Spagnolo, A.B. (2005). Enhancing individual placement and support: Promoting job tenure by integrating natural supports and supported education. *American Journal of Psychiatric Rehabilitation*, 8, 37-61.

ADDENDUM

ADMINISTRATIVE RESPONSIBILITIES:

Unit Leader
High Point Partial Care
2000 – 2001

Assist director with administrative activities.
Meet with Unit staff to identify problems and communicate problems to director.
Develop solutions to programmatic problems and present them to director.
Supervise and educate student interns and volunteers.
Oversee interviewing and hiring of new staff.

RESEARCH and TEACHING RESPONSIBILITIES:

Assistant Professor
UMDNJ-SHRP
2006 – present

Coordinate employment retention study and implement its activities including: presentation of Circles of Support and Control group trainings to Supported Employment Agencies' staff, development of study database, development of Quality Indicator assessment, interviews with participants in study, oversee management of data, and conduct data analysis.
Coordinate IMR study and implement its activities including: recruiting group facilitators, recruiting subjects, training of group facilitators, conducting subject assessments, development of study database, and oversight of student research assistant.
Coordinate data entry and analysis for several department research projects.
Contribute to the writing of research grants and scholarly papers and chapters.
Present at professional conferences.
Teach PSRT 4280, Research in Psychiatric Rehabilitation, beginning Spring 07.
Teach PSRT 1103 Group Dynamics, beginning Spring 2008.
Teach PSRT 5030 Statistics and Research, beginning Fall 2008
Co-Teach IDST 6121 Data Analysis and Interpretation, beginning Fall 2009, Fall 2010
Co-Teach IDST 6200 Research Methods for the Health Sciences
Teach additional undergraduate and graduate courses as needed by the department.
Provide program evaluation services to external community agencies.
Provide supported education services to students of the Psychiatric Rehabilitation department.

Instructor
UMDNJ-SHRP
2004 - 2006

Coordinate employment retention study and implement its activities including: presentation of Circles of Support and Control group trainings to Supported Employment Agencies' staff, development of study database, development of Quality Indicator assessment, interviews with participants in study, oversee management of data, and conduct data analysis.
Coordinate data entry and analysis for several department research projects.
Conduct literature reviews and write article summaries for department grants and scholarly papers.
Contribute to the writing of research grants and scholarly papers.
Edit research grants and textbook chapters.
Review Center for Recovery grant proposals.
Supervise students involved in department research projects.

Research Assistant
Eastern State Hospital
2001 - 2003

Coordinate data collection for several research projects. Interview patients and conduct medical record reviews as part of data collection efforts.
Develop and manage data files using SPSS. Perform statistical analyses of data.
Conduct literature reviews and assist in preparing scholarly articles.
Prepare research project for conference presentation.

CLINICAL RESPONSIBILITIES:

Case Manager
High Point Partial Care
2003 - 2004 and 1998-2000

Provide individual supportive counseling, develop and document treatment plans, and connect individuals affected by mental illness to community services.
Develop and facilitate Psychoeducational and Prevocational groups.
Participate in treatment team meetings.

Research Assistant
Eastern State Hospital
2002 - 2003

Participate in clinical interviews and treatment team meetings.

APPENDIX D

Survey of Mental Health Services in New Jersey Jails

MENTAL HEALTH SURVEY

Updated: 2012

COUNTY	RESPONSE
ATLANTIC	<p>Psychiatrist and psychologist are available “when their services are needed”, per jail contract.</p> <p>Jewish Family Services: \$600,000 grant for work with the Atlantic County Jail. Jewish Family Services emphasizes re-entry and diversion for people with mental health issues. When appropriate, they even accompany people to court.</p>
BERGEN	<p><u>Programs</u></p> <ul style="list-style-type: none"> • Dedicated Mental Health Unit for mentally ill inmates • Complete Psychological evaluations at intake • Acute Stabilization via an affiliation agreement with Bergen Regional Medical Center • Medicine management • Art Therapy (currently being offered via an intern) • Self-Help Support Group • Family-Support Group • Male and Female Drug Rehabilitation Program (DRC) for co-occurring disorders • Classes with Bergen Community College (as available) • NA/AA groups • Jail Diversion Program (run via CAREPLUS) • 262-Release (so that inmates w/mental health issues are screened for dangerous before release) <p><u>Personnel</u></p> <ul style="list-style-type: none"> • Two full-time social workers • Three part-time psychiatrists • On-site psychiatric services 24/7

	BCJ mental health staff <u>does not</u> write reports or evaluate any inmate for anyone - court or otherwise. They also have successfully fought to keep the court and prosecutors from accessing client records.
BURLINGTON	<p>1 psychologist (full time)- sees all inmates with psychiatric histories and does crisis evaluations.</p> <p>1 consulting psychiatrist at the jail three days a week, for a total of nine hours.</p> <p>1 consulting psychiatrist at the Minimum Security Facility, which houses females, two times per week, for a total of five hours.</p> <p>Mental health specialist with a master's in psychology covering both facilities, BCJ and MSF, on the weekends, for a total of eight hours.</p> <p>Community health case managers under the jail diversion program come into the jail, but only sporadically.</p> <p>Screenings at SCIP, the community crisis center, for possible hospitalization average only six a year. So far this year, the jail has referred only one inmate to SCIP (the same inmate was referred twice).</p>
CAMDEN	<p>Private contract with CFG (Center for Family Guidance) provides:</p> <p>1 psychologist</p> <p>4 full-time social workers all with mental health backgrounds</p> <p>1 nurse practitioner-20 hours per week</p> <p>1 psychiatrist- 14 hours per week.</p> <p>Twin Oaks -jail diversion program providing case management services to individuals who meet their very restrictive qualifications.</p>
CAPE MAY	1 psychiatrist two days per week. The doctor's schedule is generally full, however, the social worker believes that he is able to adequately deal with the jail's population in two days.
CUMBERLAND	1 psychiatrist, 1 psychologist and 1 RN who see inmates and prescribe meds when necessary.

	<p>The Cumberland Guidance Center Jail Reentry Program-serves chronically and severely mentally ill (those with an Axis I diagnosis). There is also a program to provide medication to the inmate as they are being discharged into the community so that they have medication to last shortly after they are released.</p>
ESSEX	<p>1 part-time psychologist consultant (4hrs/wk), 4 full-time clinical assistants 1 substance abuse counselor, 1 full-time psychiatrist position (presently unfilled; per diems beings used)</p> <p>The Mental Health Association Collaborative Justice Program - diversionary program: 1 Director, 1 senior forensic case-manager (supervisor), and 3 forensic case-managers (1-located in the jail and 2 doing community team work with clients after release).</p>
GLOUCESTER	<p>Private contractor provides psychiatric services to inmates, 2 social workers</p> <p>The Bridge Program: Run by the local mental health provider. Their objective is to secure services for inmates with mental health problems upon their release.</p>
HUDSON	<p>CFG Health Systems, LLC contracts with the county and provides: (2) Psychiatrists, a Licensed Psychologist, and four (4) Therapists (Master Level Mental health assessment is done at the initial intake assessment or a referral may be made to a psychiatrist at the HCCC. After the assessment an inmate may be returned to the general population, with or without psychotropic medications, with recommended follow-up treatment or may be housed separately in the Forensic Psychiatric Unit of the HCCC.</p> <p>Community Re-Integration Program (CRP): accepts referrals from internal departments at the HCCC, external programs, and the Court. The CRP utilizes the 364 Day Sentence List to develop a pool of potential candidates. The general requirements for acceptance into the CRP are as follows:</p> <ol style="list-style-type: none"> 1. Clients cannot have a history of significant violent offenses or murder charges; 2. Have documented proof the client will be entering the Community directly from the HCCC;

	<ol style="list-style-type: none"> 3. Has a history of mental health issues; 4. Has a history of substance abuse issues; 5. Is not currently incarcerated or have a history of crimes which are sexual in nature; 6. Client must be able to comply with a job readiness program; 7. The client was not receiving SSI or SSD benefits before entering the HCCC; 8. The client demonstrates a motivation for change. <p>The HCCC performs an assessment for eligible participants utilizing Social Rehabilitation Therapists who perform clinical interviews to determine eligibility for CRP. Further, the Social Rehabilitation Therapists make a determination regarding internal and external services that may be appropriate.</p> <p>Internal services include mental health treatment, medical treatment, educational services (GED classes), TABE testing, ADKINS Life skills training, literacy programming, as well as inpatient substance abuse treatment and substance abuse educational interventions. External services include partnering with community based medical providers for inmates with chronic medical, mental health, and medication needs. The stated goal is to continue treatment compliance outside the HCCC and maintain a higher level of functioning.</p> <p>Caridad Castro-Segura is the Criminal Case Management (CCM) Judicial Mental Health Coordinator in Hudson County. Although CCM does not directly provide mental health services to our clients at the HCCC, Caridad alerts our office regarding mental health cases which need attention. Further, Caridad contacts the Deputy Public Defender and/or Staff Attorney regarding clients that have been transferred from the HCCC to mental health facilities, and advises the Deputy Public Defender and/or Staff Attorney regarding mental health clients that require intervention. She has been an excellent resource in assisting our mental health clients.</p>
HUNTERDON	<p>1 psychiatrist: once a week for 3 hours.</p> <p>1 mental health counselor: 3 or 4 times a week for a total of 10 hours per week.</p> <p>A request to see the psychiatrist or mental health counselor can be made by the inmate, the medical unit or an officer.</p>
MERCER	CFG (Center for Family Guidance) contracts with county for:

	<p>1 clinical psychiatrist, 1 psychologist, 2 clinical social workers. There is a medical staff of 38 who provide medical services 24/7. If a client is exhibiting mental health issues, he is immediately diverted for a mental health assessment and either medication is prescribed or he is referred to the Crisis Center at Helene Fuld Medical Center.</p> <p>In addition to medication, the mental health unit conducts regular anger management classes. Severely disturbed individuals are held in monitored cells in the medical unit subject to transfer to Anne Klein Forensic Center for treatment by the jail or the Office of the Public Defender.</p>
MIDDLESEX	<p>A private contractor screens all inmates for mental health services upon arrival at the jail. A nurse completes a 30 question mental health screening form reviewed by a mental health provider usually within 24 hours during normal business hours on regular workdays to determine what services an inmate may need</p> <p>1 psychologist on duty during normal business hours (present a minimum of two days a week). 1 psychiatrist a minimum of two days a week to manage/monitor the medication of existing inmates.</p> <p>If an inmate appears to be in a state of acute psychiatric crisis and can't be managed at the jail then they are referred to a more acute care facility for evaluation and treatment.</p> <p>Annual suicide prevention training program for correctional officers and civilian staff who come into contact with inmates performed by mental health services contractor.</p> <p>Justice Assistance Grant Program (JAG): UMDNJ pilot program providing services to individuals incarcerated for non-violent offenses as described below: Justice Assistance Grant Program (JAG) Population Served: Adults (ages 18 and over) with mental illness in Middlesex County Jail being released into the community. Referral Source: Middlesex County Jail Service Provided: Pre-release screening and aftercare planning, referral and linkage to mental health or co-occurring substance abuse treatment programs, coordinating release planning with Prosecutor, Public Defender, criminal justice system personnel and family; case management and community-based support</p>

	<p>after release from jail, assistance with housing placement and employment counseling with 24/7 crisis intervention.</p> <p>Funding Source: New Jersey Division of Mental Health Services</p> <p>Number Served: Case load capacity is 40 individuals.</p> <p>Length of Service: Up to 12 months</p>
MONMOUTH	1 psychiatrist and 1 psychologist. The jail also has an infirmary area where the severely mentally ill are separated from general population and constantly monitored.
MORRIS	<p>1 full time psychiatrist on site 7.5 hours four days per week and on call 24 hours every day.</p> <p>2 full time clinical psychologist (master's degree required) who provide one on one therapy to individual inmates.</p> <p>2 penal counselors (bachelor's degree required) meet with every inmate shortly after incarceration. They prepare a 10 page "Objective classification document" with each inmate. This document is then fed into a computer which designates inmates as minimum, medium or maximum security risk. The document is also designed to field medical, psychiatric and psychological issues. The document is also provided to the jail psychiatrist who evaluates each inmate for treatment.</p> <p>All mental health workers, including nurses and social workers, meet once a week to discuss the status of all inmates receiving. Although not specifically designated as mental health workers, there are 16 nurses and 5 social workers who participate in the treatment of inmates. These are the only mental health workers on site over weekends.</p>
OCEAN	The jail has a dedicated mental health wing, with a psychiatrist and social workers. There is also a step down unit that is utilized for those who do not need a dedicated mental health environment, but are not ready/suitable for general population. The step down unit is male only.
PASSAIC	<p>The prisoners are evaluated when they first come to the jail and there is an assessment made for level of need.</p> <p>Lowest level: leaves the inmate in general population. The inmate would receive counseling once a week or once every 8 weeks depending on need. They would be given medication if necessary. They would see</p>

	<p>a psychiatrist within 7 days and then at least once within a 90 day period. Their symptoms were usually depression or anxiety.</p> <p>More severe mental health issues: Inmates are housed in a separate dorm and are under observation of a corrections officer 24/7. The social worker sees them once every 7 days and will walk through the dorm every day to see if there are any special issues for any inmate. They receive counseling once every week. They see the psychiatrist once every 30 days. If there are any issues of competency, the court is notified to determine what if any action should be taken. There can be a hearing with defense counsel present.</p> <p>Diversions Program St. Mary's Hospital in Passaic: They will write letters to the Judge to recommend alternatives to jail awaiting disposition of the case or sentencing alternative in lieu of jail. This usually applies to inmates with minor charges; a DP or 3rd or 4th degree offense. Assessment of the inmate is made at the jail.</p> <p>St. Joseph's Hospital: screening contract with the county. There are the more serious cases where the defendant is a danger to himself or others. The inmate usually has to attempt suicide and not just talk about it. Another example would be the defendant banging his head against the wall which would result in an intervention. The inmate would be put in isolation and a full suicide watch which would be constant surveillance. St. Joseph's unit after screening could recommend that the inmate should be sent to Ann Klein for a period of observation and treatment when necessary. The inmate's condition would be extreme before he was sent to Ann Klein. It is the exception and not the rule when clients are sent to Ann Klein. Ann Klein would determine when the client is fit to return to the county jail.</p>
SALEM	<p>Inmates are screened for mental health problems at initial intake. If a problem is detected, they are placed on a mental health watch and would be further examined by a mental health professional to decide what steps should be taken.</p> <p>There is a doctor on staff 2 days a week, and a therapist There is a social worker but they do not handle mental issues.</p>
SOMERSET	<p>Richard Hall Community Mental Health Center contracts with the county providing a psychiatrist who is on-site 2 times per week for 4.5 hours per day.</p> <p>Also, through the jail there is 1 full time jail-based psych/social worker, 1 full time discharge planner/case manager and 24/7 nursing coverage.</p>

SUSSEX	In-Health Associates contracts with the county for 8 hours per week of mental health services as they conduct medication reviews and psychiatric/psychological evaluations.
UNION	The jail provides 1 psychiatrist, who is available several hours every day and 1 social worker, who is there everyday. There is also a screening team for those in crisis, who are diverted to Trinitas Hospital or to Ann Klein depending upon the circumstances. Little or no therapy is provided except for distribution of medication.
WARREN	A "telepsychologist" is available to meet with a client via video hookup after which meds may be prescribed. For severe problems he/she would be transported to the hospital for evaluation.