Center on the Administration of Criminal Law's Tenth Annual Conference

Disrupting the Cycle 2: Mental Health Reforms in the Criminal Justice System

CLE Materials

1. BJA Report – Indicators of Mental Health Problems

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U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Statistics

SPECIAL REPORT

JUNE 2017

NCJ 250612

Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12

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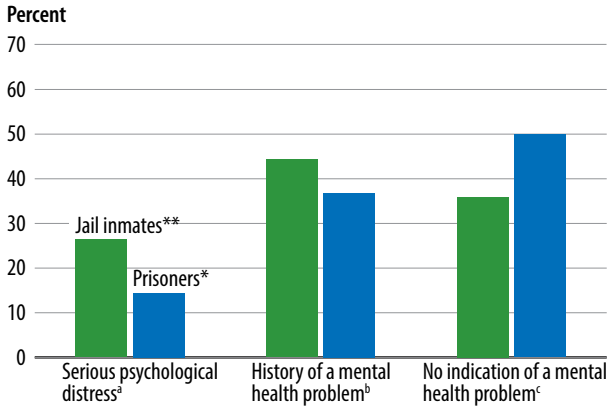
About 1 in 7 state and federal prisoners (14%) and 1 in 4 jail inmates (26%) reported experiences that met the threshold for serious psychological distress (SPD) in the 30 days prior to a survey that was conducted between February 2011 and May 2012 **(figure 1)**. Similarly, 37% of prisoners and 44% of jail inmates had been told in the past by a mental health professional that they had a mental disorder. Half of prisoners (50%) and a third of jail inmates (36%) either did not meet the threshold for SPD or had not been told they had a mental health disorder.

This report presents two prevalence estimates of mental health problems among state and federal prisoners and local jail inmates: met the threshold for SPD and told by a mental health professional as having a mental disorder. The Kessler 6 (K6) nonspecific psychological distress scale was used to assess SPD among prisoners and jail inmates in the 30 days prior to the survey. The estimates are from self-reported data and should not be interpreted as representing a clinical diagnosis of a mental disorder. (See *Measurement of mental health indicators* text box.) In this report, SPD in the past 30 days prior to the interview is defined as a current mental health problem. In this report having ever been told by a mental health professional as having a mental disorder is defined as having a history of a mental health problem.

FIGURE 1
Mental health status of prisoners and jail inmates, by type of mental health indicator, 2011–2012



Note: See appendix table 3 for percentages, standard errors, and significance tests.
*Comparison group.
**Difference with the comparison group is significant at the 95% confidence level.
[a]Includes inmates with a score of 13 or more on the K6 scale. See *Methodology*.
[b]Includes inmates who reported they had ever been told by a mental health professional they had a mental disorder.
[c]Includes inmates with a score of 7 or less on the K6 and who had never been told by a mental health professional they had a mental disorder.
Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

HIGHLIGHTS

- More jail inmates (26%) than prisoners (14%) met the threshold for serious psychological distress (SPD) in the past 30 days.
- Among those who had been told they had a mental disorder, the largest percentage of prisoners (24%) and jail inmates (31%) reported they had a major depressive disorder.
- More prisoners (14%) and jail inmates (26%) met the threshold for SPD in the past 30 days than the standardized general population (5%).
- Prescription medication was the most common treatment type for prisoners and jail inmates who met the threshold for SPD in the past 30 days.
- Fourteen percent of prisoners and 10% of jail inmates who met the threshold for SPD in the past 30 days were written up or charged with assault.
- A larger percentage of females in prison (20%) or jail (32%) than males in prison (14%) or jail (26%) met the threshold for SPD in the past 30 days.
- More white prisoners and jail inmates met the threshold for SPD in the past 30 days than black or Hispanic prisoners and jail inmates.
- Prisoners incarcerated for a violent crime (17%) were as likely as those incarcerated for a property crime (16%) to have met the threshold for SPD in the past 30 days.

This report examines the prevalence of the two mental health indicators by different time periods, demographics, criminal justice history, and current offenses. The percentage of inmates who had a mental health indicator and who received mental health treatment while incarcerated are also presented. Estimates are based on the Bureau of Justice Statistics' (BJS) 2011-12 National Inmate Survey (NIS-3). NIS-3 data were self-reported, and analyses include state and federal prisoners and local jail inmates.

To facilitate comparisons to the general population, data from the National Survey on Drug Use and Health (NSDUH) were standardized to match the prison population and the jail population by age, sex, race, and Hispanic origin (see *Methodology)*. In addition, the general population was divided into three groups based on self-reported involvement with the criminal justice system in the year prior to the interview: no involvement, under supervision (probation or parole), or arrested.

Measurement of mental health indicators

The 2011-12 National Inmate Survey (NIS-3) assessed the prevalence of serious psychological distress (SPD) in the 30 days prior to the interview and the percentage who had ever been told they had a mental disorder by a mental health professional. These two measures are used as indicators that an inmate likely has a current mental health problem or a history of a mental health problem. The estimates are from self-reported data and should not be interpreted as representing a clinical diagnosis of a mental disorder. Findings also should not be used to infer causation between an indicator of a mental health problem and incarceration, because the temporal relationship is unknown.

SPD – The Kessler 6 (K6) nonspecific psychological distress scale was used to assess those who met the threshold for SPD in the 30 days prior to the interview. The K6 is a six-question tool developed to screen for serious mental illness among adults age 18 or older in the general U.S. population, with a score of 13 or higher indicating SPD.[1] Inmates were asked how often during the 30 days prior to the interview they felt—

- nervous
- hopeless
- restless or fidgety
- so depressed that nothing could cheer them up
- everything was an effort
- worthless.

The response options were (1) all of the time, (2) most of the time, (3) some of the time, (4) a little of the time, and (5) none of the time. The responses were recoded from 4 to 0, with 4 assigned to "all of the time" and 0 assigned to "none of the time." A summary scale with a range of 0 to 24 was then produced by combining the responses from all six items. Inmates with a score of 13 or higher were considered to have SPD, inmates with a score of 8 to 12 were considered to have an anxiety disorder (not reported), and inmates with a score of 7 or fewer were considered to not have an indicator of a current mental health problem (see *Methodology*).

History of a mental health problem – This measure is based on the question, "Have you ever been told by a mental health professional, such as a psychiatrist or psychologist, that you had (1) manic depression, bipolar disorder, or mania; (2) a depressive disorder; (3) schizophrenia or another psychotic disorder; (4) post-traumatic stress disorder; (5) another anxiety disorder, such as panic disorder or obsessive compulsive disorder; (6) a personality disorder, such as antisocial or borderline personality; or (7) a mental or emotional condition other than those listed above?" Inmates who answered positively to this question were considered to have a history of a mental health problem.

The time period in which an inmate was told they had a mental disorder is unknown (e.g., told last week or last year). This measure is also affected by a person's access to professional mental health care. These two indicators are not mutually exclusive. An inmate could have met the threshold for SPD and a history of a mental health disorder. Relatedly, an inmate may have met the threshold for SPD, but not have ever been told by a mental health professional that they had a mental disorder. Or, they could have been told they had a mental disorder but did not meet the threshold for SPD.

Trends are not presented because prior inmate surveys did not include the K6 scale. In addition, prior BJS inmate surveys were collected with different modes (e.g., audio computer assisted self-interview versus computer-assisted personal interviewing). This could introduce bias when comparing prevalence estimates of mental health indicators across survey years.

[1]Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., Howes, M., Zaslavsky, A. M., et al. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry, 60*(2), 184–189. Kessler, R. C., Green, J. G., Gruber, M. J., Sampson, N. A., Bromet, E., Cuitan, M., Zaslavsky, A. M., et al. (2010). Screening for serious mental illness in the general population with the K6 screening scale: results from the WHO World Mental Health survey initiative. *International Journal of Methods in Psychiatric Research, 19*(Supp. 1), 4-22.

Prisoners and jail inmates were more likely to have ever been told they had a major depressive disorder than other mental disorders

Prisoners and jail inmates who had been told in the past by a mental health professional that they had a mental disorder were asked to specify the disorder. Nearly a quarter (24%) of the prisoners who had ever been told they had a mental disorder said they were told they had major depressive disorder, a larger percentage than any other mental disorder **(table 1)**. The second most common disorder reported by prisoners was bipolar disorder (18%). An estimated 13% of prisoners reported they were told they had post-traumatic stress disorder (PTSD) or a personality disorder, such as antisocial or borderline personality disorder. Less than 1 in 10 (9%) prisoners said they were told they had schizophrenia or another psychotic disorder.

Of those jail inmates with a history of a mental health problem, 31% had been told they had major depressive disorder, compared to being told they had bipolar disorder (25%), an anxiety disorder (18%), or PTSD (16%). With the exception of personality disorder, jail inmates were more likely than prisoners to have been told they had each type of mental disorder.

TABLE 1

Prevalence of mental health indicators among prisoners and jail inmates, by type of indicator, 2011–2012

Mental health indicator	Prisoners*	Jail inmates
No indication of a mental health problem[a]	49.9%	36.0%**
Current indicator of a mental health problem[b]		
Serious psychological distress[c]	14.5%	26.4%**
History of a mental health problem		
Ever told by mental health professional they had mental disorder	36.9%	44.3%**
Major depressive disorder	24.2	30.6**
Bipolar disorder	17.5	24.9**
Schizophrenia/other psychotic disorder	8.7	11.7**
Post-traumatic stress disorder	12.5	15.9**
Anxiety disorder[d]	11.7	18.4**
Personality disorder[e]	13.0	13.5

Note: See appendix table 4 for standard errors.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]Includes persons with a score of 7 or less on the K6 scale and who had never been told by a mental health professional they had a mental disorder.

[b]Current at time of the interview.

[c]Includes persons with a score of 13 or more on the K6 scale. See *Methodology*.

[d]Includes panic disorder and obsessive compulsive disorder, and excludes post-traumatic stress disorder.

[e]Includes antisocial and borderline personality disorder.

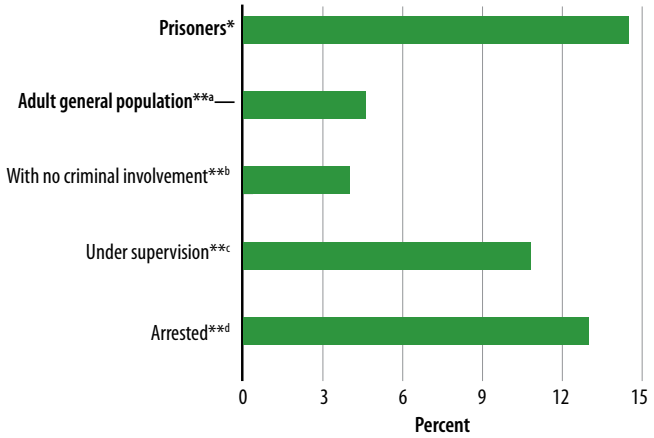
Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

Prisoners and jail inmates were three to five times as likely to have met the threshold for SPD as adults in the general U.S. population

The percentage of prisoners who met the threshold for SPD (14%) was more than three times that of adults in the standardized total U.S. general population (5%) or those in the standardized general U.S. population with no criminal involvement in the past year (4%) **(figure 2)**. However, the percentage of prisoners who met the threshold for SPD was almost the same as those in the standardized general population who had been arrested (13%) in the year prior to the interview.

FIGURE 2

Prisoners and adult general population who met the threshold for serious psychological distress, 2009–2012



Note: Includes persons with a score of 13 or more on the K6 scale. See *Methodology*. See appendix table 5 for percentages, standard errors, and significance tests.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]General population estimates were standardized to the prison population based on sex, race, Hispanic origin, and age.

[b]Includes respondents from the 2009–2012 NSDUH who indicated they had not been arrested or on probation or parole in the past 12 months.

[c]Includes respondents from the 2009–2012 NSDUH who indicated they had been on probation or parole in the past 12 months.

[d]Includes respondents from the 2009–2012 NSDUH who indicated they had been arrested in the past 12 months.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012; and Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2009–2012.

The percentage of jail inmates who met the threshold for SPD (26%) was five times higher than the percentage of adults who met the threshold for SPD in the total standardized general U.S. population (5%) or those in the standardized general population with no criminal involvement in the past year (4%) **(figure 3)**. The percentage of jail inmates who met the threshold for SPD was almost double the percentage of adults in the standardized general population who had SPD who were on probation or parole (11%) or who had been arrested in the past year (14%).

Female prisoners and jail inmates were more likely to have met the threshold for SPD than males

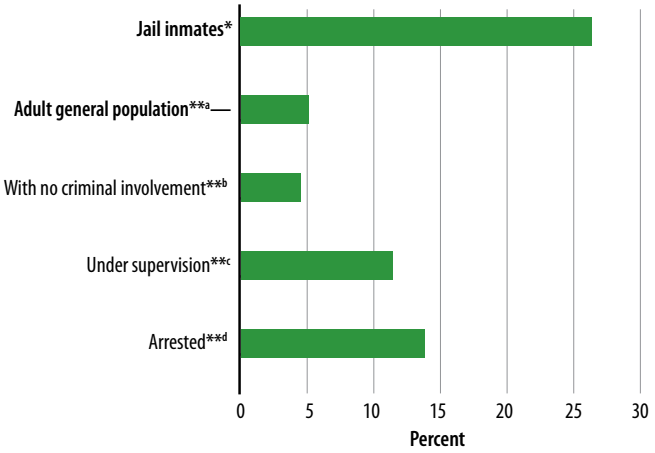
A larger percentage of female prisoners than male prisoners met the threshold for SPD or had been told by a mental health professional that they had a mental health disorder **(table 2)**. Among prisoners, 20% of females and 14% of males met the threshold for SPD. More females (66%) than males (35%) in prison also had a history of a mental health problem. Like prisoners, a larger percentage of female jail inmates (32%) met the threshold for SPD than male jail inmates (26%). Females in jail (68%) were also more likely to have been told they had a mental disorder than males in jail (41%).

Seventeen percent of white prisoners met the threshold for SPD, which was larger than the percentage of black (12%) and Hispanic (12%) prisoners with SPD. Inmates of other races (20%) were more likely than white prisoners to have met the threshold for SPD. White prisoners (50%) were also more likely than black prisoners (30%) to have ever been told they had a mental disorder. An estimated 48% of prisoners of other races had ever been told they had a mental disorder, which did not statistically differ from their white counterparts.

The pattern of SPD among jail inmates by race and Hispanic origin was also similar to that of prisoners. An estimated 31% of white jail inmates met the threshold for SPD, which was larger than the 22% of black jail inmates and 23% of Hispanic jail inmates. White (57%) jail inmates were also more likely than black (36%) or Hispanic (31%) jail inmates to have ever been told they had a mental disorder.

FIGURE 3

Jail inmates and adult general population who met the threshold for serious psychological distress, 2009–2012



Note: Includes persons with a score of 13 or more on the K6 scale. See *Methodology*. See appendix table 6 for percentages, standard errors, and significance tests.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]General population estimates were standardized to the jail population based sex, race, Hispanic origin, and age.

[b]Includes respondents from the 2009–2012 NSDUH who indicated they had not been arrested or on probation or parole in the past 12 months.

[c]Includes respondents from the 2009–2012 NSDUH who indicated they had been on probation or parole in the past 12 months.

[d]Includes respondents from the 2009–2012 NSDUH who indicated they had been arrested in the past 12 months.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012; and Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health (NSDUH), 2009–2012.

TABLE 2

Prevalence of mental health indicators among prisoners and jail inmates, by demographic characteristics, 2011–2012

	Serious psychological distress[a]		History of a mental health problem[b]	
Characteristic	Prisoners	Jail inmates	Prisoners	Jail inmates
All inmates	14.5%	26.4%	36.9%	44.3%
Sex				
Male*	14.0%	25.5%	34.8%	40.8%
Female	20.5**	32.3**	65.8**	67.9**
Race/Hispanic origin[c]				
White*	17.3%	31.0%	50.5%	56.8%
Black	12.5**	22.3**	30.0**	36.2**
Hispanic	11.5**	23.2**	25.6**	31.3**
Other[d]	19.7**	31.5	47.9	55.8
Age				
18–24*	14.9%	26.3%	36.3%	42.3%
25–34	14.8	25.9	37.3	43.6
35–44	14.1	26.1	36.4	44.4**
45–54	15.1	28.8**	37.9	47.7**
55–64	13.1	25.2	37.3	50.4**
65 or older	9.5**	20.2	30.8**	39.9

Note: See appendix table 7 for standard errors.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]Includes inmates with a score of 13 or more on the K6 scale. See *Methodology*.

[b]Includes inmates who reported they had ever been told by a mental health professional they had a mental disorder.

[c]Excludes persons of Hispanic or Latino origin, unless specified.

[d]Includes American Indian or Alaska Natives; Asian, Native Hawaiian, or Other Pacific Islanders; and persons of two or more races.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012; and Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2009-2012.

Prisoners age 65 or older were less likely to have a mental health indicator, compared to other age groups

There was little variation in the prevalence estimates of mental health indicators among prisoners by age group. One in six (15%) prisoners ages 18 to 64 reported experiences that met the threshold for SPD (not shown). Prisoners age 65 or older (10%) were less likely than prisoners ages 18 to 24 (15%) to have met the threshold for SPD. Similarly, the percentage of prisoners who had ever been told they had a mental disorder also varied little across age groups. An estimated 37% of prisoners in each age category, from ages 18 to 64, reported ever being told they had a mental disorder. A smaller percentage of prisoners age 65 or older (31%) than prisoners ages 18 to 24 (36%) had ever been told they had a mental disorder.

Prevalence estimates of SPD among jail inmates varied somewhat by age. An estimated 26% of jail inmates ages 18 to 44 and ages 55 to 64 reported experiences that met the threshold for SPD. Jail inmates ages 45 to 54 (29%) were more likely to have met the threshold for SPD than those ages 18 to 24 (26%). Approximately 42% of jail inmates ages 18 to 24 met the threshold for SPD, compared to those ages 35 to 44 (44%), ages 45 to 54 (48%), and ages 55 to 64 (50%).

Prisoners who were married were less likely to have met the threshold for SPD than prisoners with other marital statuses

Married prisoners (12%) were less likely to have met the threshold for SPD than prisoners who were widowed (18%), divorced (15%), separated (16%), or never married (15%) **(table 3)**. Married prisoners (31%) were also less likely to have ever been told they had a mental disorder than prisoners with other marital statuses.

An estimated 28% of married jail inmates met the threshold for SPD, which was similar to the percentage of widowed (31%), divorced (28%), or separated (29%) jail inmates who met the threshold for SPD. However, the percentage of never married jail inmates who met the threshold for SPD (25%) was less than the percentage of married jail inmates who had SPD (28%).

Married jail inmates were the least likely to have ever been told they had a mental disorder (40%) when compared to inmates with other marital statuses. Approximately 58% of jail inmates who were widowed, 51% who were divorced, 50% who were separated, and 43% who were never married had ever been told they had a mental disorder.

Prisoners and jail inmates with a college degree were more likely than high school graduates to have a history of a mental health problem

An estimated 16% of prisoners with less than a high school education met the threshold for SPD. This was larger than the percentage who met the threshold for SPD and who were high school graduates (12%) or who had a college degree or more (13%). An estimated 38% of prisoners with less than a high school degree had ever been told they had a mental disorder, compared to 32% of those with a high school degree. However, prisoners with at least a college degree (41%) were more likely than those without a high school degree or equivalent (38%) to have been told they had a mental disorder.

Among jail inmates, 27% of those with less than a high school education met the threshold for SPD. This did not statistically differ from the percentage of jail inmates with some college education (26%). An estimated 45% of jail inmates with less than a high school degree had ever been told they had a mental disorder, compared to 39% with a high school degree or equivalent, 47% with some college, and 50% of those with a college degree or more.

TABLE 3
Indicators of a mental health problem among prisoners and jail inmates, by marital status and education, 2011–2012

	Serious psychological distress[a]		History of a mental health problem[b]	
Characteristic	Prisoners	Jail inmates	Prisoners	Jail inmates
All inmates	14.5%	26.4%	36.9%	44.3%
Marital status				
Married*	12.2%	28.3%	30.8%	39.8%
Widowed	18.4**	31.3	45.0**	58.2**
Divorced	15.4**	27.9	42.9**	51.2**
Separated[c]	15.8**	28.7	38.1**	49.6**
Never married	14.6**	25.0**	36.6**	43.0**
Education				
Less than high school*	15.6%	27.1%	37.5%	45.2%
High school graduate	12.1**	24.4**	32.1**	38.8**
Some college	13.9	26.4	39.3	47.2**
College degree or more	13.4**	28.2**	40.7**	49.8**

Note: See appendix table 8 for standard errors.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]Includes inmates with a score of 13 or more on the K6 scale. See *Methodology*.

[b]Includes inmates who reported they had ever been told by a mental health professional they had a mental disorder.

[c]For reasons other than incarceration.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

The percentage of prisoners incarcerated for a violent offense who met the threshold for SPD was similar to those incarcerated for a property offense who met the threshold for SPD

Prisoners incarcerated for a violent offense (17%) or a property crime (16%) were equally likely to have met the threshold for SPD (table 4). Likewise, the percentage of prisoners incarcerated for a violent offense who had a history of a mental health disorder (42%) was similar to the percentage of prisoners incarcerated for a property offense (41%) who had a mental health disorder. Prisoners incarcerated for a violent crime were more likely to have met the threshold for SPD than those incarcerated for a drug crime (10%), DWI/DUI (14%), or other public order offense (13%). Among prisoners with a history of a mental health problem, those incarcerated for a drug offense (27%), a DWI/DUI (32%), or other public order offense (36%) were less likely to have ever been told they had a mental disorder than prisoners incarcerated for a violent offense (42%).

TABLE 4

Indicators of a mental health problem among prisoners and jail inmates, by current offense, sentence status and length, and time served, 2011–2012

Offense and time served	Serious psychological distress[a]		History of a mental health problem[b]	
	Prisoners	Jail inmates	Prisoners	Jail inmates
Most serious offense				
Violent*	16.6%	29.2%	41.7%	47.9%
Property	15.6	27.1**	41.4	49.8
Drug	10.2**	24.6**	26.8**	39.8**
DWI/DUI	14.0**	23.5**	32.4**	37.9**
Other public order[c]	13.2**	25.9**	35.6**	45.4**
Sentence status				
Unsentenced*	:	23.3%	:	43.7%
Sentenced	:	29.3**	:	45.1
Sentence length[d]				
Less than 1 year*	14.9%	22.5%	35.7%	42.9%
1–4 years	13.0	22.4	35.9	45.6**
5 years or more	14.5	25.3**	37.3	44.7
Life sentence	17.4	:	38.9	:
Time served since admission to current facility				
Less than 1 month*	16.6%	29.3%	38.4%	43.9%
1–5 months	14.8	25.8**	37.0	45.2
6–11 months	15.2	23.3**	38.9	43.6
1–4 years	13.7**	23.6**	35.5	41.1
5 years or more	14.1	:	37.7	:

Note: See appendix table 9 for standard errors.

: Not calculated.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]Includes inmates with a score of 13 or more K6 scale. See *Methodology*.

[b]Includes inmates who reported they had ever been told by a mental health professional they had a mental disorder.

[c]Excludes DWI/DUI.

[d]Excluded unsentenced inmates.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

An estimated 29% of jail inmates incarcerated for a violent offense met the threshold for SPD. This was larger than the percentage of jail inmates incarcerated for a property offense (27%), a drug offense (25%), a DWI/DUI (24%), or other public order offense (26%). The percentage of jail inmates incarcerated for a violent crime who had ever been told they had a mental disorder (48%) did not statistically differ from the percentage of jail inmates incarcerated for a property offense (50%). However, this was higher than the percentage incarcerated for a drug (40%), DWI/DUI (38%), or other public order (45%) offense.

The percentage of prisoners who met the threshold for SPD did not differ by sentence length

Among sentenced prisoners, those sentenced to 1 to 4 years (13%), 5 years or more (14%), or a life sentence (17%) were as likely to have met the threshold for SPD as prisoners sentenced to less than 1 year (15%). There was no statistical difference across sentence length in the percentage of prisoners who reported they had ever been told they had a mental disorder (about 36% across sentence length categories).

Unsentenced jail inmates (23%) were less likely than sentenced jail inmates (29%) to have met the threshold for SPD. There was no statistical difference between the percentage of unsentenced (44%) and sentenced (45%) jail inmates who had ever been told they had a mental disorder. Compared to jail inmates with a sentence of less than 1 year (22%), those with a sentence of 5 years or more (25%) were more likely to have met the threshold for SPD.

The percentage of inmates who had ever been told they had a mental disorder did not differ by time served since admission

Among prisoners, 17% who had served less than 1 month since admission in the current facility met the threshold for SPD. This percentage was not statistically different than the percentage who had served 1 to 5 months (15%), 6 to 11 months (15%), or 5 years or more (14%). However, prisoners who had served 1 to 4 years (14%) were less likely to have met the threshold for SPD, compared to those with less than 1 month time served (17%). There was no difference by time served and the percentage of prisoners who had ever been told they had a mental disorder, averaging 37% across time served groups.

Jail inmates who had served less than 1 month were more likely to have met the threshold for SPD (29%) than inmates who had been in the current facility for 1 to 5 months (26%), 6 to 11 months (23%), or 1 to 4 years (24%) since admission. As was the case with prisoners, there was no difference by time served and the percentage of jail inmates who reported that they had been told they had a mental disorder (about 43%).

A larger percentage of prisoners and jail inmates with more than one arrest than those with one arrest had been told they had a mental disorder

Prisoners with more than one arrest were more likely to have a mental health indicator than prisoners with one arrest (table 5). Twelve percent of prisoners with one arrest met the threshold for SPD, compared to 14% of those with 2 to 3 arrests, 15% with 4 to 10 arrests, and 18% with 11 or more arrests. Prisoners with one arrest (27%) were less likely to have ever been told they had a mental disorder than all other prisoners. For example, among prisoners who reported 11 or more arrests in their lifetime, 49% had been told at some point that they had a mental disorder.

TABLE 5

Indicators of a mental health problem among prisoners and jail inmates, by criminal history, 2011–2012

	Serious psychological distress[a]		History of a mental health problem[b]	
Criminal history	Prisoners	Jail inmates[c]	Prisoners	Jail inmates[c]
Number of times arrested (lifetime)				
1 time*	12.1%	23.4%	27.0%	30.8%
2–3 times	13.5**	23.8	32.0**	36.7**
4–10 times	14.6**	23.2	39.6**	46.7**
11 times or more	18.1**	25.3	48.9**	55.9**
Total time in a correctional facility prior to current facility[d]				
None*	13.4%	24.6%	28.7%	35.1%
1–5 months	14.3	24.1	35.4**	41.0**
6–11 months	13.7	23.9	37.0**	45.4**
1–4 years	13.4	22.5**	37.8**	46.9**
5 years or more	16.5**	24.9	42.6**	54.0**

Note: See appendix table 10 for standard errors.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]Includes inmates with a score of 13 or more on the K6 scale. See *Methodology*.

[b]Includes inmates who reported they had ever been told by a mental health professional they had a mental disorder.

[c]Includes jail inmates who served 3 months or more since admission to current facility.

[d]Total time incarcerated as an adult or juvenile in a prison, jail, or other correctional facility prior to admission to the current facility.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

Unlike prisoners, the percentage of jail inmates who met the threshold for SPD did not increase with number of arrests. About 24% of jail inmates in each arrest category met the threshold for SPD. Like prisoners, jail inmates with multiple arrests were more likely to have been told they had a mental disorder. More than half (56%) of jail inmates who had been arrested 11 times or more had been told they had a mental disorder, compared to a third (31%) of jail inmates with one arrest.

Prisoners who spent 5 years or more previously incarcerated were more likely to have met the threshold for SPD than those with no prior time served

Total time incarcerated in a correctional facility includes the time spent as an adult or juvenile in a prison, jail, or other correctional facility prior to admission to the current facility. Among prisoners who met the threshold for SPD, there was no statistical difference between those with no prior incarceration time (13%) and those who spent up to 5 years incarcerated (an average of 14%). However, prisoners who spent 5 years or more total time in a prior correctional facility (17%) were more likely than those with no prior incarceration time (13%) to have met the threshold for SPD. Prisoners with no prior incarceration time were the least likely to have been told they had a mental disorder (29%). An estimated 37% of prisoners who were previously incarcerated for 6 to 11 months, 38% of those incarcerated for 1 to 4 years, and 43% of those incarcerated for 5 years or more had been told they had a mental disorder.

Twenty-five percent of jail inmates with no prior incarceration time met the threshold for SPD, which was more than the 22% of jail inmates incarcerated for 1 to 4 years. Jail inmates with no prior incarceration (35%) were less likely than inmates with any prior incarceration (41% to 54%) to have been told they had a mental disorder. More than half (54%) of jail inmates incarcerated for 5 years or more had been told they had a mental disorder.

Almost three-quarters of inmates who met the threshold for SPD had received mental health treatment in their lifetime

Approximately 3 in 4 prisoners (74%) and jail inmates (73%) who met the threshold for SPD said they had received mental health treatment in their lifetime (table 6). About 42% of prisoners and 43% of jail inmates who met the threshold for SPD said they had stayed overnight in a hospital, and about 62% said they had taken prescription medication during their lifetime for a mental health problem.

Of prisoners who had been told they had a mental disorder, 88% said they had received mental health treatment in their lifetime, including 45% had stayed overnight in a hospital, 76% had received prescription medicine, and 75% had received counseling or therapy. Among jail inmates, 90% of those who had ever been told they had a mental disorder received mental health treatment in their lifetimes, including 80% who had received prescription medication.

Prisoners who had a mental health indicator were more likely than similar jail inmates to have received treatment since admission to their current facility

More than half (54%) of prisoners who met the threshold for SPD had received mental health treatment since admission to the current facility, compared to a third (35%) of jail inmates. An estimated 46% of prisoners who met the threshold for SPD had received prescription medication, 42% had received counseling or therapy, and 34% had received prescription medication and counseling or therapy. Among jail inmates who met the threshold for SPD, 30% had received prescription medication, 18% had received counseling or therapy, and 13% had received prescription medication and counseling or therapy since admission.

Prisoners who had ever been told they had a mental disorder (63%) were more likely than jail inmates (44%) to have received treatment since admission. Among those with a mental health problem, a greater percentage of prisoners (49%) than jail inmates (24%) had received counseling or therapy. Likewise, a greater percentage of prisoners (39%) than jail inmates (18%) with a mental health problem had received a combination of counseling or therapy and prescription medication.

About a third of inmates with a mental health indicator were currently receiving treatment

Inmates who had a mental health indicator were also asked if they were currently receiving treatment for a mental health problem. An estimated 36% of prisoners and 30% jail inmates who met the threshold for SPD said they were receiving treatment for a mental health problem as of the time of the interview. There was no statistical difference between the percentage of prisoners and jail inmates who met the threshold for SPD and said they were currently receiving prescription medication (29% of prisoners and 26% of jail inmates). Jail inmates who met the threshold for SPD were half as likely to report receiving counseling or therapy (13%) as prisoners who met the threshold for SPD (26%).

TABLE 6

Mental health treatment received by prisoners and jail inmates with an indicator of a mental health problem, by type of indicator, time period, and treatment type, 2011–2012

	Serious psychological distress[a]		History of a mental health problem[b]	
Time period and treatment type	Prisoners*	Jail inmates	Prisoners*	Jail inmates
Ever received mental health treatment during lifetime	74.2%	72.7%	88.1%	90.3%**
Ever overnight hospital stay[c]	41.8	43.1	44.8	51.3**
Ever taken prescription medication	62.8	61.3	76.4	80.4**
Ever had counseling/therapy from trained professional[d]	60.9	54.9**	74.6	73.9
Mental health treatment since admission	54.3%	35.0%**	63.0%	44.5%**
Prescription medication	45.8	30.0**	52.6	38.3**
Counseling/therapy from trained professional[d]	42.2	17.8**	48.9	23.5**
Prescription medication and counseling/therapy	33.9	12.9**	38.7	17.5**
Currently treated for a mental health problem[e]	35.6%	29.7%**	37.0%	37.8%
Prescription medication	29.1	25.7	29.9	33.0
Counseling/therapy from trained professional[d]	25.8	12.6**	26.7	16.4**
Prescription medication and counseling/therapy	19.5	8.7**	19.7	11.8**

Note: See appendix table 11 for standard errors.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]Includes inmates with a score of 13 or more on the K6 scale. See *Methodology*.

[b]Includes inmates who reported they had ever been told by a mental health professional they had a mental disorder.

[c]Includes inmates who stayed overnight or longer in any type of hospital or other facility to receive treatment or counseling for any problems with their emotions, nerves, or mental health.

[d]Includes a psychiatrist, psychologist, social worker, or nurse.

[e]As of the time of the interview.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

Among inmates who had ever been told they had a mental disorder, 37% of prisoners and 38% of jail inmates said they were currently receiving treatment for a mental health problem. An estimated 30% of each group said they were currently taking prescription medication.

Prisoners and jail inmates who met the threshold for SPD were more likely than those without SPD to be written up or charged with an assault while incarcerated

Prisoners and jail inmates were asked if they had been written up or charged with assaulting an inmate, physically assaulting a correctional officer or staff, or verbally assaulting a correctional office or staff since admission to the current facility.[2] Compared to prisoners without an indicator of a mental health problem (4%), prisoners who met the threshold for SPD (14%), or who had ever been told they had a mental disorder (12%) were more likely to be written up or charged with a verbal or physical assault against a correctional officer, staff, or assault of another inmate **(table 7)**. Three percent of prisoners with no indicator of a mental health problem were written up or charged with assaulting another inmate, compared to 9% of prisoners who met the threshold for SPD and 7% of those who had been told they had a mental disorder.

Among jail inmates with no indicator of a mental health problem, 4% were written up or charged with assault. This group was less likely to be written up or charged with assault than jail inmates who met the threshold for SPD (10%) or who had been told they had a mental disorder (10%).

[2]Estimates derived from the 90% sample only. See *Methodology*.

TABLE 7

Prisoners and jail inmates written up or charged with assault, by mental health status, 2011–2012

	No indicator of mental health problem*[a]		Serious psychological distress[b]		History of a mental health problem[c]	
Type of assault	Prisoners	Jail inmates	Prisoners	Jail inmates	Prisoners	Jail inmates
Total	4.1%	4.2%	14.2%**	9.7%**	11.6%**	9.9%**
Verbal assault of correctional officer or other staff	1.6	1.6	6.8**	4.6**	5.7**	4.6**
Physical assault of correctional officer or other staff	0.4	0.4	2.8**	1.3**	1.9**	1.2**
Assault against another inmate	2.7	2.9	8.5**	6.2**	7.0**	6.6**

Note: Data comes from the 90% sample only. See *Methodology*. See appendix table 12 for standard errors.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]Includes inmates with a score of 7 or less on the K6 scale and who had never been told by a mental health professional they had a mental disorder.

[b]Includes inmates with a score of 13 or more on the K6 scale. See *Methodology*.

[c]Includes inmates who reported they had ever been told by a mental health professional they had a mental disorder.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

Methodology

The 2011-12 National Inmate Survey

The 2011-12 National Inmate Survey (NIS-3) was conducted in 233 state and federal prisons, 358 jails, and 15 special facilities (military, Indian country, and Immigration and Customs Enforcement (ICE) facilities) between February 2011 and May 2012. The data were collected by RTI International under a cooperative agreement with the Bureau of Justice Statistics (BJS).

The NIS-3 administered two questionnaires to inmates: a survey about sexual victimization and an alternative survey about mental and physical health, past drug and alcohol use, and treatment for substance abuse. Inmates were randomly assigned to receive one of the two questionnaires so that, at the time of the interview, the content of the survey remained unknown to facility staff and the interviewers.

A total of 106,532 inmates participated in NIS-3, receiving either the sexual victimization survey or the randomly assigned alternative survey. Combined, the surveys were administered to inmates in state and federal prisons (43,721), jails (61,351), military facilities (605), Indian country jails (192), and ICE facilities (663).

The interviews, which averaged 35 minutes in length, used computer-assisted personal interviewing (CAPI) and audio computer-assisted self-interviewing (ACASI) data collection methods. For approximately the first 2 minutes, interviewers conducted a personal interview using CAPI to obtain background information and the date of admission to the facility. For the remainder of the interview, inmates interacted with a computer-administered questionnaire using a touchscreen and synchronized audio instructions delivered via headphones. Respondents completed the ACASI portion of the interview in private, with the interviewer either leaving the room or moving away from the computer. The entire ACASI questionnaire (listed as the National Inmate Survey-3) is available on the BJS website.

A shorter paper questionnaire (PAPI) was made available for inmates who were unable to come to the private interviewing room or interact with the computer. The paper form was completed by 751 prisoners (1.9% of all prisoner interviews) and 264 jail inmates (0.5% of all jail inmate interviews). Those who completed the PAPI were not asked about their physical health, mental health, past drug and alcohol use, or treatment for substance abuse.

Additional information on the methodology for sample selection of facilities and inmates can be found in *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12* (NCJ 241399, BJS web, May 2013).

Mental health module

The analysis of the mental health module was restricted to adult prisoners or jail inmates. Juvenile inmates who were 16 or 17 years of age and inmates in military, Indian country, or ICE facilities were excluded from this report.

To determine whether inmates had an indicator of a current mental health problem, the NIS-3 included the Kessler 6 scale for nonspecific psychological distress (see *Measurement of mental health indicators* text box). The NIS-3 also included questions to assess whether or not an inmate had a history of a mental health problem, defined as having ever been told by a mental health professional that they had a mental disorder. The mental health indicator questions were contained in a mental health screener that was part of a mental health module.

Among inmates who received the sexual victimization survey (90% of inmates surveyed), all inmates received the mental health screener component. Respondents who completed the core sexual victimization survey in less than 35 minutes were eligible to receive the follow-up mental health component. Respondents who did not indicate a mental health problem legitimately skipped the items in the detailed follow up. Based on these threshold, within prisons 37,359 inmates received the mental health screener questions. Among those respondents, 84% (31,508 prisoners) were eligible to receive the detailed mental health follow-up items. Among jail respondents, 52,384 inmates received the mental health screener items. Among those, 92% (48,338 jail inmates) were eligible to receive the detailed mental health follow-up items.

Among inmates who received the alternative survey on mental and physical health, past drug and alcohol use, and treatment for substance abuse (10% of inmates surveyed), both mental health components were administered to prisoners and jail inmates. All 4,304 prisoners and 6,704 jail inmates who were randomized to the alternative survey received the full mental health module.

Nonresponse bias analysis

Bias occurs when the estimated prevalence of an outcome is different from the actual prevalence of the outcome for a given facility. One potential source of bias is nonresponse. For each survey in the NIS-3, a nonresponse bias analysis was conducted to determine whether inmates did not receive the mental health module due to it only being administered in ACASI. The PAPI respondents were found to have a higher prevalence of sexual victimization and more likely to reside in administrative segregation. These two conditions may be correlated to an inmate's mental health status. Given that the PAPI respondents made up 1.9% of prisoners and 0.5% of jail inmates, it was determined that a weight adjustment could reduce the potential bias due to PAPI respondents not receiving the mental health screener items.

Weighting and nonresponse adjustments

Responses from interviewed inmates were weighted to produce national-level estimates. Each interviewed inmate was assigned an initial weight corresponding to the inverse of the probability of selection within each sampled facility. A series of adjustment factors was applied to the initial weight to minimize potential bias due to nonresponse and to provide national estimates. For the analysis of the mental health module, these adjustments were one of two types:

1. adjustments to account for survey nonresponse
2. adjustments to account for survey mode nonresponse.

Methods to adjust for survey nonresponse are described in detail in *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12* (NCJ 241399, BJS web, December 2014). Bias could result if the PAPI respondents were different from the ACASI respondents. The adjustment for mode nonresponse included a calibration of the weights so that the weight from a PAPI respondent was assigned to an ACASI respondent with similar characteristics. Because both ACASI and PAPI respondents provided demographic and criminal history information, these data were used in weight adjustment. For each inmate, these adjustments were based on a generalized exponential model, developed by Folsom and Singh (2002), and applied to the sexual victimization survey respondents.[3]

The mode nonresponse adjustment maintained the bench marked totals designed to make national-level estimates for the total number of inmates age 18 or older who were held in jails at midyear 2011 or in prison at yearend 2011. These benchmark totals represented the estimated number of inmates by sex, from BJS's 2011 Annual Survey of Jails and 2011 National Prisoner Statistics. The national estimates for state prisons were 1,154,600 adult males and 83,400 adult females; for federal prisons, 190,600 adult males and 13,200 adult females; and for jails (with an average daily population of six or more inmates), 628,620 adult males, and 91,551 adult females.

After the adjustment for potential nonresponse bias, a final adjustment was conducted to combine the data from the sexual victimization survey and the alternative survey. For this adjustment, the weight for each responding inmate was multiplied by the probability of receiving the survey type received. In other words, the survey nonresponse and mode nonresponse adjusted weight for the ACASI respondents were multiplied by 0.90 and for respondents to the sexual victimization survey and alternative survey.

[3]Folsom, Jr., R. E., & Singh, A. C. (2002). The generalized exponential model for sampling weight calibration for extreme values, nonresponse, and poststratification. Proceedings of the American Statistical Association, Survey Research Methods Section, 598-603.

Comparison of estimates by NIS-3 survey type

Prior to producing estimates from the combined set of sexual victimization and alternative survey respondents, a comparison of key estimates was conducted. This was done to ensure that questions on sexual victimization did not alter how inmates responded to the mental health screener items, compared to inmates that were not asked about their sexual victimization status.

Using the analysis weights created for each survey, estimates were produced and tested to determine if they were significantly different. For all key estimates, the sexual victimization and alternative survey respondents had statistically similar estimates. Therefore, it was determined that the combined data could be used for all analyses.

Standard errors and tests of significance

As with any survey, the NIS-3 estimates are subject to error arising from their basis on a sample rather than a complete enumeration of the population of adult inmates in prisons and jails. For each mental health indicator, the estimated sampling error varies by the size of the estimate, number of completed interviews, and intra-cluster correlation of the outcome within facilities.

A common way to express this sampling variability is to construct a 95% confidence interval around each survey estimate. Typically, multiplying the standard error by 1.96 and then adding or subtracting the result from the estimate produces the confidence interval. This interval expresses the range of values that could result among 95% of the different samples that could be drawn.

To facilitate the analysis, rather than provide the detailed estimates for every standard error, differences in the estimates of sexual victimization for subgroups in this report have been tested and notated for significance at the 95% confidence level. For example, the difference in the percentage of female jail inmates who met the threshold for serious psychological distress (SPD) (32.3%) compared to male jail inmates (26.0%) is statistically significant at the 95% confidence level (table 2). In all tables providing detailed comparisons, statistically significant differences at the 95% confidence level or greater have been designated with two asterisks (**).

General population estimates

In the general population, prevalence rates of SPD in the past 30 days come from the National Survey on Drug Use and Health (NSDUH). The NSDUH is an annual nationwide survey that provides national and state-wide estimates on the use of tobacco products, alcohol, illicit drugs, and the prevalence of mental health problems among the general U.S. population. Respondents are randomly selected at the household level.[4] This sampling method is unlikely to capture persons who are homeless, in temporary shelters, transient or highly mobile, or in hospitals or residential rehabilitation or treatment centers—all populations who may have a higher risk for mental disorders, substance use disorders, or both.

To be most comparable to the inmate population included in the NIS-3, the survey years 2009 through 2012 of NSDUH were used in this analysis. While the NIS-3 reference period does not include 2009 or 2010, these years were included to increase the precision in the general population estimates. An analysis of the estimates of general population across the 4 years found that the mental health estimates did not change appreciably during this period. Therefore, including additional years of data to increase precision would not shift the study period estimates enough to alter any comparisons to the 2011-12 inmate population.

The NSDUH includes indicators that measure a person's self-reported past year criminal justice involvement. With this information, the total general population was split into three groups:

- persons not involved in the criminal justice system during the past 12 months
- those on probation or parole during the past 12 months
- those arrested in the past 12 months.

These groups are not mutually exclusive in that a person can be both on probation or parole and have been arrested in the past 12 months. It is assumed that persons in the general population on probation and parole or those arrested in the past 12 months are more similar to the inmate populations than those not involved with the criminal justice system during the past 12 months.

[4]SAMHSA. NSDUH - About the Survey. Retrieved on March 30, 2016 from https://nsduhweb.rti.org/respweb/project_description.html.

Standardization of general population estimates

When comparing two populations, differences found for some characteristics or conditions may be statistically different as a result of a true difference in the populations or due to basic demographics differences that are associated with the outcome of interest. Standardizing the estimates is one method to determine if these demographic differences are the sole cause for differences found in other characteristics or conditions.

Standardization of survey estimates consists of calibrating the survey weights for one population such that, for key demographic characteristics that are known for each population, the distributions are identical. This process was done using SUDAAN's PROC DESCRIPT procedure. The resulting estimates are not a representation of the standardized population by themselves (i.e., generalizations about the population cannot be made from standardized estimates), but are appropriate estimates for comparison with other populations of interest.

In this report, estimates were standardized for each of the four general population types (e.g., the total general population and three criminal justice involvement subgroups). For each general population type, estimates were standardized to the inmate populations' distribution by sex, race, Hispanic origin, and age. Because the inmate populations for prisoners and jail inmates differed, the general population was standardized separately to each inmate population (see appendix tables 1 and 2). Figure 2 includes standardized estimates to the prison population. Figure 3 includes standardized estimates to the jail population.

APPENDIX TABLE 1

Characteristics of prisoners and jail inmates, 2011–2012

Characteristic	Prisoners[a]* Number	Prisoners[a]* Percent	Jail inmates Number	Jail inmates Percent
All inmates	1,441,800	100%	720,200	100%
Sex				
Male	1,345,200	93.3%	628,600	87.3%**
Female	96,600	6.7	91,600	12.7**
Race/Hispanic origin[b]				
White	430,300	30.2%	242,600	34.1%**
Black	506,100	35.5	237,500	33.3
Hispanic	341,400	24.0	158,000	22.2
Other[c]	147,500	10.3	74,100	10.4
Age				
18–24	179,600	12.5%	186,000	25.8%**
25–34	458,500	31.8	251,100	34.9**
35–44	397,800	27.6	150,700	20.9**
45–54	281,800	19.5	102,400	14.2**
55–64	98,800	6.9	26,200	3.6**
65 or older	25,300	1.8	3,800	0.5**
Marital status				
Married	270,800	18.9%	134,900	18.9%
Widowed	26,400	1.8	11,600	1.6
Divorced	286,700	20.0	104,000	14.5**
Separated[d]	87,200	6.1	52,800	7.4**
Never married	761,100	53.1	412,000	57.6**
Education				
Less than high school	825,000	57.4%	382,300	53.4%**
High school graduate	283,400	19.7	166,900	23.3**
Some college	230,100	16.0	120,500	16.8
College degree or more	99,600	6.9	46,500	6.5

Note: See appendix table 2 for standard errors.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]Includes state and federal prisoners.

[b]Excludes persons of Hispanic origin, unless specified.

[c]Includes American Indian or Alaska Natives; Asian, Native Hawaiian, or Other Pacific Islanders; and persons of two or more races.

[d]For reasons other than incarceration.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

APPENDIX TABLE 2

Standard errors for appendix table 1: Characteristics of prisoners and jail inmates, 2011–2012

Characteristic	Prisoners Number	Prisoners Percent	Jail inmates Number	Jail inmates Percent
All inmates	79,900		32,800	
Sex				
Male	79,800	0.68%	29,500	0.74%
Female	8,600	0.68	6,500	0.74
Race				
White	27,300	1.08%	11,400	1.20%
Black	38,600	1.41	15,700	1.30
Hispanic	29,300	1.87	12,800	1.33
Other	10,700	0.39	3,700	0.34
Age				
18–24	13,300	0.72%	8,200	0.38%
25–34	25,300	0.61	11,300	0.41
35–44	25,800	0.47	7,300	0.29
45–54	17,800	0.60	6,100	0.33
55–64	7,500	0.33	1,600	0.14
65 or older	2,300	0.14	400	0.05
Marital status				
Married	15,800	0.78%	7,500	0.44%
Widowed	1,600	0.13	700	0.08
Divorced	19,600	0.59	5,100	0.34
Separated	5,100	0.24	3,000	0.18
Never married	47,400	1.05	18,600	0.62
Education				
Less than high school	46,800	0.82%	17,100	0.61%
High school graduate	17,500	0.53	8,000	0.41
Some college	15,100	0.44	6,700	0.37
College degree or more	6,200	0.25	3,000	0.22

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

APPENDIX TABLE 3

Percentages and standard errors for figure 1: Mental health status of prisoners and jail inmates, by type of mental health indicator, 2011–2012

Mental health indicators	Prisoners* Percent	Prisoners* Standard error	Jail inmates Percent	Jail inmates Standard error
Serious psychological distress	14.5%	0.46%	26.4%**	0.51%
History of a mental health problem	36.9	1.15	44.3**	0.79
No indication of a mental health problem	49.9	1.07	36.0**	0.62

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

APPENDIX TABLE 4

Standard errors for table 1: Prevalence of mental health indicators among prisoners and jail inmates, by type of indicator, 2011–2012

Mental health indicators	Prisoners	Jail inmates
No indicator of a mental health problem	1.07%	0.62%
Current indicator of a mental health problem		
Serious psychological distress	0.46%	0.51%
History of a mental health problem		
Ever told by mental health professional they had mental disorder	1.15%	0.79%
Major depressive disorder	0.95	0.66
Bipolar disorder	0.75	0.62
Schizophrenia/other psychotic disorder	0.45	0.43
Post-traumatic stress disorder	0.60	0.45
Anxiety disorder	0.59	0.54
Personality disorder	0.48	0.32

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

APPENDIX TABLE 5.

Percentages and standard errors for figure 2: Prisoners and adult general population who met the threshold for serious psychological distress, 2009–2012

	Serious psychological distress	
Population	**Percent**	**Standard error**
Prisoners*	14.5%	0.46%
Adult general population	4.6**	0.15
With no criminal involvement	4.0**	0.14
Under supervision	10.8**	1.13
Arrested	13.0	1.12

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12; Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2009–2012.

APPENDIX TABLE 6.

Percentages and standard errors for figure 3: Jail inmates and adult general population who met the threshold for serious psychological distress, 2009–2012

	Serious psychological distress	
Population	**Percent**	**Standard error**
Jail inmates*	26.4%	0.51%
Adult general population	5.1**	0.13
With no criminal involvement	4.5**	0.12
Under supervision	11.4**	0.82
Arrested	13.8**	0.90

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–12; Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2009–2012.

APPENDIX TABLE 7

Standard errors for table 2: Prevalence of mental health indicators among prisoners and jail inmates, by demographic characteristics, 2011–2012

	Serious psychological distress		History of a mental health problem	
Characteristic	**Prisoners**	**Jail inmates**	**Prisoners**	**Jail inmates**
All inmates	0.46%	0.51%	1.15%	0.79%
Sex				
Male	0.49%	0.51%	1.16%	0.77%
Female	1.03	0.89	1.84	1.25
Race/Hispanic origin				
White	0.61%	0.67%	1.26%	0.78%
Black	0.63	0.73	1.27	1.11
Hispanic	0.73	0.70	1.72	1.08
Other	0.99	1.09	1.68	1.23
Age				
18–24	0.99%	0.57%	1.66%	0.82%
25–34	0.64	0.68	1.27	0.96
35–44	0.65	0.80	1.32	1.07
45–54	0.81	0.90	1.47	1.05
55–64	0.87	1.61	1.40	1.79
65 or older	1.32	3.40	2.08	4.52

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

APPENDIX TABLE 8

Standard errors for table 3: Indicators of a mental health problem among prisoners and jail inmates, by marital status and education, 2011–2012

Selected characteristics	Serious psychological distress		History of a mental health problem	
	Prisoners	Jail inmates	Prisoners	Jail inmates
All inmates	0.46%	0.51%	1.15%	0.79%
Marital status				
Married	0.66%	0.94%	1.37%	1.14%
Widowed	1.97	2.44	2.44	2.77
Divorced	0.71	0.96	1.24	1.08
Separated	1.16	1.06	1.70	1.63
Never married	0.53	0.49	1.34	0.81
Education				
Less than high school	0.56%	0.61%	1.09%	0.83%
High school graduate	0.71	0.70	1.49	1.09
Some college	0.83	0.74	1.52	0.94
College degree or more	0.92	1.18	1.44	1.24

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

APPENDIX TABLE 9

Standard errors for table 4: Indicators of a mental health problem among prisoners and jail inmates, by current offense, sentence status and length, and time served, 2011–2012

Criminal justice status and history	Serious psychological distress		History of a mental health problem	
	Prisoners	Jail inmates	Prisoners	Jail inmates
Most serious offense				
Violent	0.52%	0.75%	1.18%	0.96%
Property	0.91	0.64	1.72	1.00
Drug	0.61	0.84	1.46	0.99
DWI/DUI	1.31	1.24	2.82	1.45
Other public order	0.97	0.91	2.08	1.14
Status				
Unsentenced	:	0.56%	:	0.90%
Sentenced	:	0.61	:	0.85
Sentence length				
Less than 1 year	1.47%	0.67%	2.77%	1.08%
1–4 years	0.77	0.81	1.71	1.28
5 years or more	0.44	1.12	1.10	1.52
Life sentence	1.01	4.84	1.78	4.43
Death sentence	7.90	10.31	7.18	11.34
Time served since admission to current facility				
Less than 1 month	1.16%	0.64%	2.11%	0.87%
1–5 months	0.76	0.59	1.43	0.91
6–11 months	0.86	0.76	1.37	1.16
1–4 years	0.57	1.30	1.51	1.83
5 years or more	0.76	3.87	1.37	5.05

: Not calculated.

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

APPENDIX TABLE 10

Standard errors for table 5: Indicators of a mental health problem among prisoners and jail inmates, by criminal history, 2011–2012

Criminal history	Serious psychological distress		History of a mental health problem	
	Prisoners	Jail inmates	Prisoners	Jail inmates
Number of times arrested (lifetime)				
1 time	0.68%	1.34%	1.32%	1.82%
2–3 times	0.52	1.17	1.10	1.31
4–10 times	0.61	0.74	1.30	1.40
11 times or more	0.86	1.08	1.56	1.44
Total time in a correctional facility prior to current facility				
None	0.59%	0.90%	1.34%	1.42%
1–5 months	0.77	1.09	1.46	1.59
6–11 months	0.72	1.29	1.44	1.85
1–4 years	0.65	1.05	1.30	1.46
5 years or more	0.70	1.17	1.29	1.28

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

APPENDIX TABLE 11

Standard errors for table 6: Mental health treatment received by prisoners and jail inmates with an indicator of a mental health problem, by type of indicator, time period, and treatment type, 2011–2012

Time period and treatment type	Serious psychological distress		History of a mental health problem	
	Prisoners	Jail inmates	Prisoners	Jail inmates
Ever received mental health treatment during lifetime	1.25%	0.79%	0.56%	0.35%
Ever overnight hospital stay	1.21	0.84	0.85	0.61
Ever taken prescription medication	1.69	1.01	0.89	0.56
Ever had counseling/ therapy from trained professional	1.31	0.83	0.67	0.43
Mental health treatment since admission	1.71%	1.11%	1.36%	1.06%
Prescription medication	1.92	1.07	1.69	1.07
Counseling/therapy from trained professional	1.49	0.85	1.15	0.81
Prescription medication and counseling/therapy	1.61	0.75	1.33	0.75
Currently treated for a mental health problem	2.16%	1.07%	1.79%	1.07%
Prescription medication	1.92	1.04	1.56	1.07
Counseling/therapy from trained professional	1.73	0.61	1.44	0.64
Prescription medication and counseling/therapy	1.38	0.49	1.13	0.53

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

APPENDIX TABLE 12

Standard errors for table 7: Prisoners and jail inmates written up or charged with assaults, by mental health status, 2011–2012

	No indicator of a mental health problem		Serious psychological distress		History of a mental health problem	
Type of assault	**Prisoners**	**Jail inmates**	**Prisoners**	**Jail inmates**	**Prisoners**	**Jail inmates**
Total	0.31%	0.22%	0.79%	0.47%	0.55%	0.44%
Verbal assault of correctional officer or other staff	0.16	0.13	0.49	0.25	0.32	0.20
Physical assault of correctional officer or other staff	0.08	0.06	0.35	0.16	0.22	0.10
Assault against another inmate	0.23	0.18	0.56	0.39	0.46	0.35

Source: Bureau of Justice Statistics, National Inmate Survey, 2011–2012.

The Bureau of Justice Statistics (BJS) of the U.S. Department of Justice is the principal federal agency responsible for measuring crime, criminal victimization, criminal offenders, victims of crime, correlates of crime, and the operation of criminal and civil justice systems at the federal, state, tribal, and local levels. BJS collects, analyzes, and disseminates reliable and valid statistics on crime and justice systems in the United States, supports improvements to state and local criminal justice information systems, and participates with national and international organizations to develop and recommend national standards for justice statistics. Jeri M. Murlow is acting director.

This report was written by Jennifer Bronson of BJS and Marcus Berzofsky of RTI International. Todd Minton verified the report.

Caitlin Scoville and Jill Thomas edited the report. Steve Grudziecki produced the report.

June 2017, NCJ 250612

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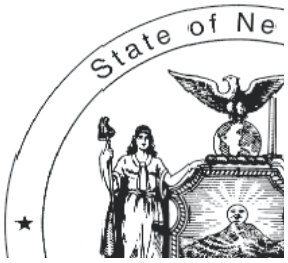
Rethinking the Revolving Door

A Look at Mental Illness in the Courts



SJI

Written by

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2001

This study was developed under grant number SJI-00-N-109 from the State Justice Institute. The points of view expressed are those of the authors and do not necessarily represent the official position or policies of the State Justice Institute, the New York State Unified Court System or the Center for Court Innovation.

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A Look at Mental Illness in the Courts

Introduction

Each day, a disturbingly large number of people with mental illness cycle through the criminal justice system across the nation. While it is difficult to get an accurate read of exact numbers — many defendants are never properly diagnosed — a recent study found that about 16 percent of the national prison and jail population suffer from some form of mental illness (U.S. Department of Justice, 1999). Before arriving in the criminal justice system, these individuals have frequently fallen through the "safety net" of families, hospitals and community-based treatment providers.

Once they reach the courts, defendants with mental illness pose significant challenges for judges. Judges typically lack both the tools necessary to perform meaningful assessments and the connections with mental health service providers necessary to know what kinds of treatment options are available. Given these realities — and given concerns for public safety — judges find that in many cases the safest choice is to sentence mentally ill offenders to jail or prison. The calculus is simple: while incarcerated, there's at least a chance that an offender will receive some form of medication and assistance.

Incarceration may in fact be the right outcome for some mentally ill offenders who pose a serious threat to individual victims or the public welfare. But for many others, particularly those without violent histories, incarceration makes little sense. The drawbacks are obvious. It's expensive both on the front end and the back end. State and local governments incur significant costs when they incarcerate people. Just as significantly, prisons and jails are not designed to be therapeutic environments. All too often, the condition of mentally ill individuals seriously deteriorates in custody. They are then released to the streets with little or no discharge planning. No one links them to needed treatment, housing and other services. And no one checks to make sure they take advantage of these services. Unsurprisingly, many mentally ill defendants find themselves back before the courts in short order, repeating the same process. Everyone loses in this scenario. Defendants with mental illness fail to receive the help they need. The justice system fails to deploy resources either efficiently or effectively. And the community at large fails to address a serious public safety problem.

This study takes a closer look at these challenges. Along the way, it seeks to answer a set of basic questions about defendants with mental illness. How big is the problem? What do judges, attorneys, service providers and other stakeholders

think about the ways that courts currently handle cases involving defendants with mental illness? What efforts have been made to improve the situation? And what kinds of obstacles have these efforts confronted? In answering these questions, this study seeks to provide judges, attorneys and court administrators across the country with new ideas, new tools and new strategies as they grapple with some of the most difficult cases that ever appear in court.

"Rethinking the Revolving Door" is the product of a year-long study performed by the New York State Unified Court System in conjunction with its independent research and development arm, the Center for Court Innovation. The methodology for this research effort was fairly straightforward; it included reviewing the current literature in the field, attending relevant conferences and workshops, making site visits to promising programs and conducting dozens of stakeholder interviews.

The purpose of the study, which was underwritten by a grant from the State Justice Institute, was not to create a work of original scholarship. Nor was it to determine whether specialized "mental health courts" are a good thing or a bad thing. The aspirations for the feasibility study were rather more modest: to provide practitioners with an overview of mental health and the courts, a description of the model projects currently being tested in a number of jurisdictions and an outline of some of the concerns that have been raised by various stakeholders. The findings in this report have already served as the foundation for a proposed mental health court in Brooklyn, providing the planning team with a sense of context and a guide to issues that are worthy of deeper exploration. With any luck, in the days ahead it will continue to provide helpful background information to those with an interest in this field.

Scope of the Problem

Over the last few years, the number of people with mental illness in the criminal justice system has increased steadily. This phenomenon can be traced to various intersecting causes, including law enforcement strategies targeting drugs and low-level, "quality-of-life" offenses and the long-term effects of de-institutionalization (Marasso & Pepper, 2001; Health Foundation of Greater Cincinnati, 2000).

"De-institutionalization" is a term that describes a systematic shift in resources for treating people with mental illness — from large, residential, state-run psychiatric hospitals to community-based treatment (Department of Health & Human Services, 1999). Advances in the effectiveness of psychiatric medications since the 1950s have allowed even the most severe mental disorders to be treated on an outpatient basis, decreasing the need for inpatient institutionalization. And starting in the 1970s, civil libertarians and legislative reformers sought changes in civil commitment statutes and regulations to make it more difficult to place a person with mental illness in a psychiatric hospital involuntarily. In general, the guiding principle of de-institutionalization reformers was to offer appropriate treatment in the least restrictive environment possible (Torrey & Zdanowicz, 1998).

One unintended consequence of this shift in public policy has been that it has become far more difficult for many people with mental illness to access the mental health system. Many states closed or shrank their state psychiatric hospitals without adequately funding community treatment (Kupers, 1999). Accordingly, all too many people with mental illness live in the community, but they do so without adequate support services or medication.

While the number of people with mental illness in state psychiatric hospitals has decreased precipitously over the last thirty years, the number of mentally-ill people in jails and prisons has steadily increased. In 1955, there were 560,000 individuals hospitalized with mental illness in the United States. By 1999, there were less than 80,000 (Kupers, 1999). By contrast, since 1970, the U.S. jail and prison populations have increased fivefold to a total of about 1.6 million people (Bureau of Justice Statistics, 1999). And a recent Department of Justice survey found that 16 percent of the inmates in United States prisons and jails reported having a mental condition or mental health hospitalization. That translates to about a quarter-of-a-million inmates with mental illness (Ditton, 1999). Some critics, drawing a causal link between the rise of incarcerated mentally ill individuals and the decline in mental health hospitals, have labeled this phenomenon "transinstitutionalization" (Torrey & Zdanowicz, 2000; Massaro & Pepper, 2001).

Treatment in the Criminal Justice System

So if jails and prisons have become — de facto — "hospitals of last resort" for people with mental illness, the next question is: What kind of treatment do they receive while they are there?

Jails and prisons offer 24-hour, 7-day-a-week supervision and housing, but they were never intended to be psychiatric hospitals. And they are not typically institutionally equipped, trained or staffed to address the treatment needs of people with mental illness. Of the inmates who report mental illness, only 17 percent of state prisoners and 11 percent of jail inmates receive treatment for mental illness while incarcerated (Ditton, 1999). [A similar story can be told for substance abuse treatment in jail and prison. Of the estimated 70-85 percent of all state inmates who need substance abuse treatment, only 12 percent of them receive some form of treatment (CASA, 1998).]

These statistics are just the tip of the iceberg. The bottom line is that there is a severe shortage of treatment for people with mental illness while they are incarcerated. Even when treatment programs are available, their effectiveness is limited by long waiting lists, lack of incentives to participate, a dearth of trained counselors and the stigmatization of those who participate (CASA, 1998).

The inadequacy of treatment for mental illness and substance abuse in jails and prisons is exacerbated by the lack of adequate discharge planning and aftercare services. (This is a problem that has been the subject of litigation by advocates seeking to improve conditions for the mentally ill — see, for example, the "Brad H." lawsuit in New York City.) The result is that many offenders with mental illnesses

leave jail and prison no better — and sometimes quite worse — than when they were first incarcerated.

Revolving Doors

It comes as little surprise that many ex-offenders with mental illness find themselves back in the criminal justice system again in short order (Barr, 1999). Forty-nine percent of federal prisoners with mental illnesses have three or more prior probations, incarcerations or arrests, compared to 28 percent without mental illnesses (Ditton, 1999). Family members report that the average number of arrests for their relative with mental illness is more than three (McFarland, Faulkner, Bloom & Hallaux, 1989).

Mentally ill individuals with a criminal record are often placed in a lose-lose situation. While incarcerated, their condition tends to worsen (Belcher, 1988). And upon release, they are often unable to access available community treatment because of providers' reluctance to serve them (Lamb & Weinberger, 1998). Many community mental health centers are unprepared or unwilling to treat people who have criminal records (Jemelka, et al., 1989).

The results are painfully clear: many defendants with mental illness churn through the criminal justice again and again, going through a "revolving door" from street to court to cell and back again without ever receiving the support and structure they need (Finkelstein & Brawley, 1997). It is fair to say that no one wins when this happens — not defendants, not police, not courts, not victims and not communities.

Co-Occurring Disorders

One of the factors that complicates any effort to address the problems faced by criminal defendants with mental illness is the prevalence of co-occurring disorders among this population. A diagnosis of "co-occurring disorder" (also known as "dual diagnosis" or "dual recovery") describes the presence of both a mental disorder and a substance abuse disorder (American Psychiatric Association, 1994).

National research suggests that as many as three out of every four defendants in major cities test positive for drugs at the time of arrest (National Institute of Justice, 1998). Mental illness and substance abuse have a symbiotic relationship: people with substance abuse disorders are more likely to develop mental illness and people with mental illness are more likely to develop a substance abuse disorder (Peters & Hills, 1997; Massaro & Pepper, 1994). And people with mental illness who have significant criminal justice histories are more likely to have a co-occurring substance abuse problem than the general population of people with mental illness (Peters & Hills, 1997; GAINS Center, 1997).

Research indicates that people with co-occurring disorders have lower rates of treatment compliance, more severe symptoms and higher relapse rates than those treated for a single disorder (Peters & Hills, 1997). They are three times more likely to be arrested than others with mental disorders (Borum, et al., 1997). And without effective and appropriate treatment, they are more likely to be jailed again and again (Draine & Solomon, 1994).

Why is this? What exactly is the relationship between mental illness and substance abuse? People with mental illness often take alcohol or other drugs to temporarily reduce their symptoms (Peters & Hills, 1997). Using drugs and alcohol to alleviate psychiatric symptoms is at best a short-term solution. Alcohol and drugs can cause significant health consequences. They can also precipitate certain psychiatric symptoms, including anxiety, depression and confusion. Together, mental illness and substance abuse can lead to an ever-intensifying cycle of abuse as relief for symptoms is sought through consuming more and more drugs or alcohol (Pepper, 1992). This cycle is known as "self-medication."

There is a growing recognition among researchers and policymakers that the problem of co-occurring disorders is one that requires significant attention. One sign of this is the creation of a new federal partnership of mental health, substance abuse and justice agencies, called the National GAINS Center for Persons with Co-Occurring Disorders in the Justice System.

Among the issues that the GAINS Center has examined is how to assess people with co-occurring disorders. The reality is that co-occurring disorders are not easy to identify. The residual effects of substance abuse may "mask or mimic psychiatric symptoms such as depression" (Peters & Hills, 1997). And acute psychiatric symptoms may interfere with substance abuse treatment (ibid.). Another complicating factor is the reality that people with co-occurring disorders tend to suffer from a whole host of collateral problems including homelessness, HIV, violent behavior, trauma, and difficulties with employment, social and family relationships (Peters & Hills, 1997; Broner, et al., 2000).

But assessment is far from the only obstacle. More significant is the lack of effective treatment designed to address both mental health and substance abuse disorders in one therapeutic setting. Traditionally, services for mental health and substance abuse have been kept separate (Peters & Hills, 1997). Most programs treat co-occurring disorders sequentially, which means that patients must complete one form of treatment before engaging in another. There is a good deal of evidence that suggests that sequential treatment has proven ineffective for people with co-occurring disorders. Another approach is "parallel" treatment, in which a patient attends mental health and substance abuse treatment simultaneously but with different providers. While parallel treatment is an improvement over sequential treatment, it is far from perfect (Peters & Hills, 1997; GAINS Center, 2001).

In recent years, "integrated" treatment services for co-occurring disorders that address both substance abuse and mental health simultaneously in a continuous and comprehensive fashion have been developed, evaluated, and found to be more effective than nonintegrated programs (Drake, et al., 2001). For example, the New Hampshire-Dartmouth Research Center has created a model for integrated treatment that emphasizes the following elements: case management, group interventions, assertive outreach, education, development of long-term perspective, relapse prevention, family support, and progressive levels of treatment (Mueser, et al., 1997).

Effective integrated treatment must also incorporate a vast array of other supportive services such as health, financial aid and housing (Pepper & Hendrickson, 1996).

While many experts argue that integrated treatment is a promising approach to treating co-occurring disorders, it is rarely used by treatment providers. (Peters & Hills, 1997, GAINS Center, 2001). Why? State and local governments often have separate and inconsistent structures for licensing, regulating and financing mental health and substance abuse treatment services. Service standards, administrative guidelines and quality assurance procedures for integrated treatment have not yet been widely incorporated by public mental health and substance abuse authorities or adopted by service providers, so that many treatment providers are simply not up-to-date on the methodology and potential benefits of this approach. Even where clinicians are interested in moving beyond the traditions of their separate mental health and substance abuse systems, opportunities for cross-training and credentialing have been limited (Drake, et al., 2001; Quadrant IV Task Force, 2001). The result is that there is a genuine scarcity of the kind of treatment most needed by a substantial number of offenders with mental illness.

Mental Health and the Courts

It is difficult to get an accurate read on exactly how many people with mental illness come before the courts each day. The recent Department of Justice survey of inmates with mental illness was based on self-reporting rather than the diagnoses of mental health professionals. And studies of the mentally ill in jails and prisons miss defendants with mental illness who make their way through the court system but whose cases are ultimately dismissed or who receive sentences other than incarceration. Preliminary results from a recent study in Brooklyn suggest that as many as 30 percent of all arraigned defendants may have a serious mental illness (Broner, Owen, Lamon & Karopkin, 2000).

How have courts dealt with mental illness in the past? Not particularly well. Historically, courts have a handful of methods to address problems associated with defendants who appear to be mentally ill. These include pleas of "not guilty by reason of insanity" and "guilty but mentally ill" as well as rulings that a defendant is not competent to stand trial (Parry, et al., 1998). These tools are used very infrequently. For instance, an eight-state study showed that the insanity defense was used in less than 1 percent of all cases and was successful only 26 percent of the time despite the fact that 90 percent of those invoking the defense had been diagnosed with a mental illness (American Psychiatric Association, 2001). On the civil side, judges may order involuntary treatment for people with severe mental illness who are found to be a danger to themselves or others. However, the impact of civil commitment proceedings is sharply limited by the tiny numbers of inpatient beds available and the many procedural safeguards that permit patients to obtain their own release after a short time.

More often than not, defendants with mental illness receive no special treatment whatsoever from the court — they are treated just like any other defendant. In fact, many are treated worse, because they are stigmatized by criminal justice officials

with little experience dealing with mental illness. It should come as no surprise that the existing approaches have not been effective in reducing recidivism, improving the health of defendants with mental illness or protecting communities.

New Directions

In recent years, many state courts have come to realize that business as usual isn't working. Out of this recognition has come a wave of new criminal justice interventions for defendants with mental illness, including post-booking diversion programs, enhanced mental health services in jails and programs that link participants to intensive treatment after release (Watson, et. al., 2001).

One judicial experiment in particular has attracted a great deal of attention: the development of specialized "mental health courts" that seek to link defendants to long-term treatment as an alternative to incarceration. The goal of these new model courts — which, along with drug courts, community courts, domestic violence courts and re-entry courts, are often called "problem-solving courts" — is to move beyond standard case processing to address the underlying problems that bring people to court. In the process, they seek to shift the focus of the courtroom from weighing past facts to changing the future behavior of defendants (Feinblatt, et al., 2000-A).

In many respects, mental health courts are built on the foundation of an earlier problem-solving court model: drug courts. In 1989, Dade County, Florida created the first drug court in the country. The drug court sentences addicted defendants to long-term, judicially-supervised drug treatment instead of incarceration. Participation in treatment is closely monitored by the drug court judge, who responds to progress or failure with a system of graduated rewards and sanctions, including short-term jail sentences. If a participant successfully completes treatment, the judge will reduce the charges or dismiss the case (Drug Courts Program Office, 1997).

The results of the Dade County experiment have attracted national attention — and for good reason. A study by the National Institute of Justice revealed that Dade County drug court defendants had fewer re-arrests than comparable non-drug court defendants (U.S. Department of Justice, 1993). Based on these kinds of results, drug courts have become an increasingly standard feature of the judicial landscape across the country (Feinblatt, et al., 2000-B). At last count, there were more than a thousand drug courts nationwide, including ones in operation or being planned in every state (Drug Court Clearinghouse and Technical Assistance Project, 2001). In addition, several states, including New York and California, have begun to look at how some of the principles of drug courts might be institutionalized throughout a state court system (New York State Commission on Drugs and the Courts, 2000; Kaye, 2001; Feinblatt, et al., 2000-B).

Based on the success of the drug court model, a handful of jurisdictions across the country have developed specialized courts to address mental illness. Like drug courts, the central goal of mental health courts is to reduce the recidivism of defendants by providing them with court-monitored treatment. The first of these courts opened in June 1997 in Broward County, Florida.

There are many points of entry into the Broward County Mental Health Court, but primarily candidates are identified during intake by jail staff within 24 hours of arrest. Jail psychiatrists evaluate each defendant's mental health. If a defendant is found to pose a danger to himself or others, the psychiatrist will seek a judge's order to transport the defendant to a crisis center for symptom stabilization. Defendants charged with misdemeanor offenses who are found to have mental health problems and who are deemed stable are referred to clinicians from the public defender's office who perform an additional screening. If symptoms of mental illness are again found during this second screening, the defense attorney informs a magistrate presiding over the bail hearing, who refers the case to Mental Health Court.

At the Mental Health Court, the judge will recommend pre-adjudication diversion into treatment. The judge will monitor defendants in treatment for up to one year. The length of judicial supervision and level of treatment vary depending on the treatment needs of the individual defendant. For defendants who agree to participate in treatment diversion, the State's Attorney may either dismiss charges immediately or hold prosecution in abeyance, depending on the seriousness of the offense. Upon completion of the treatment, the charges held in abeyance will be dismissed or reduced. However, certain defendants with serious criminal histories may be required to plead guilty and get credit for time served in treatment in lieu of incarceration.

Proliferation of Mental Health Courts

Shortly after Broward opened its doors, several other municipalities began to plan mental health courts. Today, there are mental health courts in Seattle and Vancouver, Washington; San Bernardino, Santa Barbara and Santa Clara, California; Anchorage, Alaska; Marion County, Indiana; St. Louis, Missouri; Akron, Ohio; and Jefferson County, Alabama. A number of other mental health courts are in the planning stages. A recent study by the Crime and Justice Research Institute documented the practices of the first four mental health courts — Broward, King County (Seattle), San Bernardino and Anchorage (Goldkamp & Irons-Guynn, 2000). While each mental health court is unique, this study — and independent research on the other mental health courts — highlighted a set of common procedures and goals that typify the mental health court approach:

Problem-Solving Mental health courts mark an attempt by court systems to address a systemic problem, taking a critical look at the issues that defendants with mental illness pose for the courts and crafting a new set of responses. Put simply, these courts are not satisfied with continuing with business as usual — standard case processing or out-sourcing the solution to some other agency. (Finkelstein & Brawley, 1997).

Public Safety By responding to widespread concerns about how courts deal with defendants with mental illness, mental health courts attempt to shore up public trust and confidence in the justice system. Indeed, many mental health courts have been created in response to a specific local crisis involving mentally ill defendants — for

instance, the murder of a retired firefighter in Seattle, Washington by a person with mental illness (Goldkamp & Irons-Guynn, 2000).

Therapeutic Jurisprudence In linking defendants with mental illness to treatment alternatives, many mental health courts see themselves as practicing "therapeutic jurisprudence" (Lurigio et al., 2001; Lerner-Wren, 2001; Wexler & Winnick, 1996). In one way or another, mental health courts are testing the extent to which the law can be a therapeutic agent — a social force producing positive life changes for defendants.

Identification Mental health courts develop new systems to identify defendants with mental illness. The point in the criminal justice process at which this intervention occurs varies by jurisdiction. Usually, identification takes place within 24 hours of arrest while defendants are still in custody. The primary sources of identification are jail staff, family members and defense attorneys.

Targeting After identification, each court has created eligibility criteria that target a certain type of defendant. Almost all programs require that defendants have symptoms of severe mental illness and face non-violent, misdemeanor charges. San Bernardino's court has handled some non-violent felonies on a case-by-case basis. In general, mental health courts specify that the defendants' mental illnesses must be "Axis I disorders" as designated in the Diagnostic Statistics Manual IV (American Psychiatric Association, 1994).

Dedicated Staff Each mental health court has a dedicated judge and some additional specialized staff. The specialized staff are usually mental health clinicians who screen cases for eligibility, prepare treatment plans, and report to the judge on defendants' progress in treatment. In some cases, this staff is hired by the court system using new funding sources. In other cases, this staff is assigned from a collaborative government agency or from a local treatment provider. In general, mental health courts have been planned and overseen by interdisciplinary teams composed of a variety of criminal justice and behavioral health stakeholders. For instance, the Santa Clara Mental Health Court "team" includes the judge, district attorney, public defender, and mental health caseworkers (Santa Clara Bar Association, 2001). The team meets to discuss every case, with each representative providing input from their unique institutional perspective.

Non-Traditional Roles Mental health courts — like drug courts before them — have altered the dynamics of the courtroom, including, at times, certain features of the adversarial process. For example, in some courts defenders and prosecutors come together to discuss their common goals for each defendant. Mental health courts may engage judges in unfamiliar roles as well, asking them to convene meetings and broker relationships with service providers.

Voluntariness Participation in mental health court is voluntary — defendants must affirmatively "opt-in" to receive treatment. For instance, the King County Mental Health Court in Washington gives defendants two weeks in a treatment placement to help them decide whether to participate in the program or not (during this time, their attorneys can also investigate the strength of the case against their client) (Goldkamp & Irons-Guynn, 2000).

Plea Structure Once a defendant opts into a mental health court, one of two things happens: either prosecution is "frozen" and charges are dropped after the defendant successfully completes treatment, or a plea is taken and later vacated (or charges reduced) after treatment is completed. All of the mental health courts require a longer period of time in treatment than the defendant would have served in jail or prison if they had plead guilty to the crime charged, and most courts require participating defendants to spend a minimum of one year in treatment. The rationale behind this is two-fold. First, mandated treatment involves many fewer restrictions than being incarcerated (many defendants are even released to their own residences). Second, mental health courts are willing to invest in treatment only if there is real promise of reducing symptom severity (and thereby reducing recidivism). Experience indicates that it takes at least a year to successfully engage people with mental illness in treatment. Accordingly, many mental health courts reserve the right to extend offenders' period of treatment in the event of non-compliance.

Judicial Monitoring Mental health courts require participants to return frequently to court to enable the judge to monitor the progress of treatment. Court appearances are made less frequently as participants demonstrate consistent compliance over a sustained period of time.

System Integration Mental health courts seek to promote reform with partners outside of the courthouse as well as within. For instance, mental health courts have encouraged mental health and drug treatment providers to come together to improve service delivery for offenders.

Results

What does the record show about mental health courts? Are they working? The short answer is that it is too early in the development of mental health courts to say whether they are achieving their goal of reducing the recidivism of participating defendants — there's simply not enough evidence to make the case one way or another.

At this point, most of the available evidence about mental health courts comes from a University of South Florida evaluation of the Broward County Mental Health Court and an evaluation of the first two years of the King County Mental Health Court performed by the University of Washington.

From July 1997 to June 2000, the Broward Mental Health Court evaluated 1,530 defendants for participation, 652 of whom were found to be eligible. While long-

term treatment results are not yet available, researchers have documented some basic information about participants:

- Fifty-four percent of defendants presented with mental illness only, 16 percent with co-occurring disorders, 2 percent with substance abuse disorders alone, 2 percent with development disabilities and 26 percent with an undetermined diagnosis (but still believed to be mentally ill).
- Thirty-six percent of defendants reported one or more psychiatric hospitalizations in the past.
- About 26 percent of defendants were homeless.
- Sixty-nine percent of defendants were male. The average age was about 40 years old. Fifty-five percent of defendants were white, 3 percent Black, 5 percent Hispanic, less than 1 percent Asian and 6 percent unspecified (Broward County 2000-A).

Meanwhile, an evaluation of the 236 defendants who have been referred to the King County Mental Health Court over the last two years revealed that:

- Forty-one percent of defendants referred to the King County Mental Health Court opted to participate.
- Eighty-five percent of those referred were diagnosed with severe mental disorders such as psychotic disorders, bipolar disorder, major depression, and organic brain dysfunction.
- Those defendants who opted into the King County Mental Health Court received more hours of treatment per month after contact with the court than they had received in the past.
- Participants in the program spent fewer days in detention than those who did not participate.
- Most significantly, researchers found that there was a sharp drop in the rate of new arrests for opt-in defendants compared to those who chose not to participate (Trupin, et al., 2001).

More substantial information from the independent evaluations of King County and Broward should become available in the months ahead. In the meantime, it is possible to look at the self-reported results from the first wave of mental health courts. Perhaps predictably, these results are almost uniformly encouraging. For example, the Santa Clara Mental Health Court had graduated 56 participants as of January 1, 2001. During the 2 years prior to their entry into the Santa Clara Mental Health Court, these 56 graduates were held in custody for a total of 19,040 days, at a cost of approximately $1,252,832. Court officials estimate that the effect of moving these 56 clients from jail custody into community treatment over a one-year period saved 6,013 jail days, for a cost savings of approximately $395,655. And during the

period of involvement with the court, there were no new arrests for this first group of graduates (Santa Clara Bar Association, 2001).

While these results are promising, there is a need for more rigorous research about the impacts of mental health courts. This is especially true given that the proliferation of these experiments shows no sign of slowing down any time soon.

Challenges, Questions and Tensions

Perhaps because they offer a provocative new approach to defendants with mental illness, mental health courts have attracted a fair amount of scrutiny from judges, prosecutors, defenders, mental health advocates and others with an interest in what happens to mentally-ill offenders. What follows is a brief overview of some of the concerns and questions these experiments have generated:

Defining Success How do you define success in a mental health court? How realistic are the goals of reduced recidivism and stable community living when working with offenders who are severely ill? Some offenders with serious mental illnesses will need treatment throughout their lives. At what point can the court say that treatment has been successful? When should the involvement of the court begin and end?

Proportionality Traditionally, the gravity of an offender's crime determines how much leverage the court has to impose conditions for release or probation. This poses a dilemma for mental health courts, which tend to focus on low-level cases involving defendants who require long-term therapeutic interventions. How do mental health courts determine the right proportion between charge severity and the length of mandated treatment? Finding this balance is crucial to winning the support of both prosecutors and defenders.

Case Targeting Mental health courts have used various criteria for determining eligibility. Some exclude offenders with histories of violence. Others exclude offenders with co-occurring disorders. Still others exclude defendants charged with felonies or violent crimes. Targeting misdemeanors may make political sense, particularly during a project's pilot phase, but this approach does little to address the problem of "transinstitutionalization" for the more serious offenders who are headed for longer stays in jails and prisons. And it runs the risk of lower success rates due to proportionality problems. What approach to case targeting makes the most sense given the goals of mental health courts?

Sanctions and Rewards Building on the drug court model, some mental health courts apply a series of graduated sanctions and rewards to help improve compliance with treatment mandates. Does this structure work with mentally ill defendants? Do some mentally ill defendants lack the capacity for consequential thinking that is required for this approach to work? If so, what sanctions and rewards are most effective in promoting compliance?

Use of Jail Many mental health court practitioners struggle with the issue of whether it is ever appropriate to use jail as a sanction for defendants who fail to take their medications or participate in treatment. In drug court, there's a certain logic to sending offenders to jail for dirty urine because they're violating the law — there's a clear connection between the incarceration and the violation. When a mentally ill defendant stops taking his medications, he may have violated the court's order but no law has been broken. What kinds of sanctions are appropriate in this case? And apart from appropriateness, there are questions about the effectiveness of jail for offenders with mental illness. For instance, the King County Mental Health Court tries to avoid using jail sanctions because offenders' mental condition often deteriorates in jail, making it harder for them to re-engage in treatment upon release (Cayce, 2000). The San Bernardino Mental Health Court also seeks to avoid the use of jail, but for a different reason. Interestingly, they found that offenders with mental illness were simply not motivated by the threat of jail. Many regarded a stay in jail as a welcome relief from the difficulties of life in treatment or in the community (Morris, 2000). As a result, San Bernardino has aggressively employed community service sanctions instead.

Beyond Legal Competency Legal competency statutes and rulings set a very low standard for participation in criminal proceedings. Even if defendants meet the standard for legal competency to stand trial, their mental disorders may impair their abilities to make effective treatment decisions (Grisso & Applebaum, 1998). Given this, what expectations of competency should mental health courts adopt? One approach to this difficult question is offered by King County, which permits defendants to enter treatment for a short period of time pre-plea to stabilize their condition and maximize their ability to make competent decisions about their legal and treatment options.

Treatment Availability/Effectiveness Mental illnesses are various and complicated. Are certain mental illnesses less susceptible to treatment than others? How do you handle defendants for whom medication simply has no effect? Are there some illnesses for which treatment will have no impact on recidivism? Is there enough "integrated" treatment available for defendants with co-occurring disorders?

Public Safety A single sensational story about a participant committing a violent act could be enough to sink the entire mental health court movement. Courts must always balance the desire to rehabilitate with the need to preserve public safety. How can mental health courts quickly and effectively assess the public safety risks posed by defendants with mental illness? How reliable are the available risk assessment instruments? How should they be used?

Stigma and Confidentiality Do mental health courts run the danger of stigmatizing defendants with mental illness? What happens if a defendant decides not to opt in

to mental health court and the case is transferred to a conventional court? What information should the new judge and prosecutor receive about that defendant's mental illness, if any? And would this information have the potential to prejudice the way that the prosecutor and judge treated the defendant in subsequent proceedings? More generally, what kinds of confidentiality protections are appropriate for the information that defendants reveal as part of their involvement with mental health court?

Housing Many defendants with mental illness are homeless — they need housing in addition to treatment. And the effectiveness of treatment may be seriously compromised without adequate housing (Ades, 2001). How will mental health courts ensure access to housing for those defendants who require it?

Public Benefits The vast majority of participants in mental health courts will require public benefits — Medicaid, Social Security Insurance or Social Security Disability Insurance — for their subsistence and treatment. These federal benefits are often terminated or suspended when a person is jailed. As a result, when defendants are released, they must re-apply for benefits. It often takes several weeks before benefits applications are processed and payments begin. This leaves many defendants with mental illness in limbo, unable to meet their basic support and health needs (GAINS Center, 1999). What, if anything, can mental health courts do to address this problem?

The Role of the Courts Many individuals who end up in mental health courts have already been in the mental health system at some point in their lives. What evidence is there that courts can bring about different results? What do they bring to the table that's unique? Is it simply coercion? Or is it something else? Can courts promote enhanced system integration, bringing together criminal justice, mental health and drug treatment agencies?

Answering these questions will go a long way toward coming to terms with a more fundamental question: Are mental health courts a good thing or a bad thing? This is a question that can only be answered over time, with the help of solid, independent research and more practice on the ground.

While mental health courts have raised difficult legal, ethical, practical and therapeutic concerns, it is important to note that many of these issues are not entirely new. Drug courts, community courts, domestic violence courts and other problem-solving courts have been grappling with these issues for years. And the record has shown that on a local level, many problem-solving courts have managed to figure out answers to thorny issues of confidentiality, proportionality, case targeting and public safety. Mental health courts must figure out how to build on the best of the existing problem-solving courts while formulating new responses to issues that are unique to the mental health field.

Stakeholders

Mental health courts have not emerged in a vacuum, of course. To forge a new response to mentally-ill offenders inevitably requires the active engagement of a variety of stakeholders — judges, defenders, prosecutors, mental health advocacy groups and others. What do each of these groups think about the way that courts have traditionally handled cases involving mentally ill defendants? What would they do differently if they could? What do they think of the mental health court experiment? What are their primary concerns with this new model?

The following pages sketch out answers to these questions based on the results of dozens of interviews with each of these stakeholder groups. It is important to note that these sections are not intended to provide a definitive look at what these groups think about mental illness in the courts. Rather, the goal is to take a snapshot of a moment in time, offering impressions gleaned from months of interviews and focus group research.

Judges

Interviews with criminal court judges around the country reveal a consistent theme: defendants with mental illness pose special problems.

In general, judges feel that the standard options available in the criminal justice system are not a good fit for the majority of cases involving people with mental illness (Karopkin, 2000; Cayce, 2000). Judges in arraignment parts and courts that deal with misdemeanors and violations say that a substantial portion of their core business involves repeat offenders who appear to have mental illness (Broward County, 2000-B; Karopkin, 2000; Cayce, 2000; Norko, 2000; Rosenberg, 2001). The same holds true in lesser volume in courts that deal with felonies (Ferdinand, 2000; Morris, 2000; Leventhal, 2000). For this reason, one judge dubbed defendants who appeared to have mental illness as "frequent flyers" (Cayce, 2000).

Judges say that defendants "appear" to have mental illness because, in most circumstances, they do not really know for sure (Karopkin, 2000; Landsberg et al., 2000). Judges report that they usually lack the capacity to identify whether defendants have mental illness in any kind of systematic way (Anderson, 2000). More often than not, a judge will receive information from jail staff, defense attorneys or prosecutors about the possibility of a defendant's mental illness based on signs of strange behavior. According to James Cayce, the first presiding judge at the King County Mental Health Court: "This ad hoc approach certainly misses many defendants who suffer from mental illnesses but who do not have florid and obvious symptoms" (Cayce, 2000).

Even if judges in conventional courts could identify defendants with mental illness, they still lack the kinds of connections with community-based service providers that are necessary to place people in appropriate treatment programs (Broward County, 2000-B). According to Martin G. Karopkin, a judge in Brooklyn's criminal court, "Without a mental health professional they can turn to for reliable information, judges don't have any confidence that treatment is going to be effective for any

given defendant, so they won't risk it. Simply put, it's a frustrating situation that makes sense to no one" (Karopkin, 2000).

Problem-Solving Judges

In contrast, judges in problem-solving courts report that they have more time and resources to address the underlying problems of defendants. This includes staff to perform meaningful assessments, connections with treatment providers, and procedures for monitoring defendants in treatment. Despite these advantages, problem-solving judges say that defendants with mental illness often don't fit the mold. Some drug courts have simply excluded defendants with co-occurring disorders from program participation (Anderson, 2000). For drug courts that do accept defendants with co-occurring mental illness, it is estimated that these cases account for about one-third of their total caseload (Ferdinand, 2000). Domestic violence courts judges estimate that about one in ten defendants suffer from a mental illness (Leventhal, 2000). And much of the core business of community courts involves defendants with mental illness and substance abuse problems who are homeless (Koretz, 2000; Norko, 2000). In all of these settings, judges have noticed that defendants with mental illnesses tend to fail to satisfy the court's requirements at a higher rate than those without such problems.

In drug courts, judges have found that "defendants with co-occurring disorders are harder to place in treatment than defendants with a single disorder" (Ferdinand, 2000). Choosing the appropriate mode of treatment is also difficult for judges, even when relying on expert advice. First of all, co-occurring disorders are not easy to diagnose properly. Especially at or near the time of arrest, identifying a co-occurring disorder often requires a subtle differential diagnosis that is capable of separating out symptoms (Broner, et al., 2000). And mental illness is not a one-size-fits-all problem — not all mentally ill defendants are alike. Some have thought disorders like schizophrenia that can cause delusions. Others suffer from mood disorders like severe depression. Making an accurate diagnosis for placement in treatment requires a highly-trained mental health professional that even most drug courts do not have on staff and could not afford to retain.

In domestic violence courts, defendants with mental illness are often involved in crimes against their parents with whom they reside (Leventhal, 2000). Usually, parents do not want to cooperate with prosecution of the case, fearing it will result in punishment of their child (ibid.). But they have been scared by their child's violent behavior. They often implore the judge to use his or her powers to leverage and mandate treatment. The problem for domestic violence courts is that linking defendants to mental health treatment is not part of their core business (ibid.). Diagnosing a defendant, finding appropriate treatment and monitoring his or her progress is time-consuming, requires additional expertise and reduces the number of cases a judge can handle. Judges in domestic violence courts expressed a desire to be able to refer these defendants to a court that specializes in addressing mental health issues (ibid.).

Community courts handle a steady stream of low-level, quality-of-life offenses. Defendants are often repeat offenders who have co-occurring disorders (Koretz, 2000; Norko, 2000). Community courts emphasize neighborhood restoration through community service while helping defendants access basic services to address their underlying problems. This program design does not work very well with defendants suffering from serious mental illnesses (Koretz, 2000). Many defendants with mental illness are disorganized and confused, especially after being arrested and jailed pending arraignment. "They tend to miss court appointments to perform community service or to attend short-term treatment readiness programs" says Eileen Koretz, the presiding judge of the Midtown Community Court in New York. As a result, many community courts are searching for new approaches to defendants with mental illness.

By contrast, judges presiding in mental health courts feel like they have finally gotten a chance to address the issues of defendants with mental illness in an appropriate manner (Cayce, 2000; Anderson, 2000). Judge Ginger Lerner-Wren of the Broward County Mental Health Court has described her experience this way: "We view the Mental Health Court as a 'strategy' to bring fairness to the administration of justice for persons being arrested on minor offenses who suffer from major mental disability. We have seen time and time again true successes. Persons with major psychiatric disorders and/or mental disabilities can live and thrive in the community with individualized care, treatment and community support" (Lerner-Wren, 2001). Similarly, Judge Cayce has written about the King County Mental Health Court: "We see a positive difference in the defendants' personal level of satisfaction with their role in the system, the use of our limited jail resources, and in protecting public safety" (Cayce & Burrell, 1999).

Defense Attorneys

In many cases, defense attorneys are the first to discover that a client suffers from mental illness when they interview them after arrest (Saucedo, 2001). Defenders report a variety of challenges that accompany these clients. For instance, impaired mental functioning may make it much more difficult for clients to understand their attorneys' advice or for attorneys to clearly discern their clients' wishes (Bock, 2000).

Many defenders believe that their clients' mental illness drives their criminal conduct (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000; Finkelstein & Brawley, 1997). Some defenders believe that the system "criminalizes" mental illness — arresting people with mental illness for quality-of-life crimes, like disorderly conduct, that are the direct result of symptoms of their untreated illness (Schreibersdorf, 2001). "If they're acting 'weird' in the opinion of the police, then they get arrested. That 'weird' is a symptom of mental illness not criminal conduct," explains Lisa Schreibersdorf of Brooklyn Defender Service. And in the past, many people with mental illness would have been taken by the police for inpatient hospitalization rather than being arrested, booked and jailed (Finkelstein & Brawley, 1997). As a result, defenders tend to think that charges against their mentally ill clients are unfair and should be dismissed (Saucedo, 2001; Schreibersdorf, 2001).

What happens when a defender believes that his or her client with mental illness would benefit from treatment? Defenders talk about some daunting obstacles that they must then face. Their clients may not be "clean" enough or rational enough to accept that they are suffering from a mental illness. In this state, clients often won't accept the necessity of treatment (Bock, 2000). Or even if clients accept that they are ill, they may not want to engage in treatment, having become so used to serving short terms in jail or prison and so averse to treatment with its medications and their potentially negative side effects (Saucedo, 2001). Clients' resistance to treatment complicates defenders' ability to act in those clients' best interest. Finally, defenders worry about setting their clients up for failure by entrusting them to a behavioral health system that has failed to adequately treat and monitor people with mental illness who end up in the criminal justice system (Finkelstein & Brawley, 1997; Schreibersdorf, 2001).

In addition, defenders are not satisfied with the standard plea options available to their clients with mental illness. For instance, defenders almost never recommend the defense of "not guilty by reason of insanity" (Bock, 2000). They only recommend seeking this verdict in serious felonies, usually murders, which make up a minute amount of their overall caseload (Schreibersdorf, 2001). Defense attorneys explain that defendants will serve less time behind bars in most cases than they would spend hospitalized under an insanity defense, except when facing a sentence of death or life in prison (ibid.).

The same logic usually applies to seeking a ruling of incompetency. In misdemeanors, defense attorneys may raise incompetency if the charges will be dropped (ibid.). But not in all cases. Defendants found guilty of misdemeanors are usually given time served, probation or very short jail sentences, all of which may be shorter than the hospitalization required under competency regimes. In felony cases, defenders may seek a ruling of incompetency as a strategic device to buy time or to improve their ability to communicate with a difficult client (ibid.). For a felony charge, incompetency usually means staying in a hospital until the defendant stabilizes enough to return to court and face trial. Finally, defense attorneys are mixed on the defense of guilty but mentally ill because it often requires inpatient treatment only. This leads defenders to recommend this plea only in cases involving serious charges.

Across the board, defense attorneys expressed reluctance to employ these traditional judicial solutions out of concern over the intense negative stigma placed upon criminal defendants with mental illness (Schreibersdorf, 2001; Saucedo, 2001). This fear of stigma extended to their perceptions about mental health courts as well. Defense attorneys believe that prosecutors, judges, juries and some of their own colleagues need to become better educated about mental illness. They point to the fact that prosecutors may seek and judges may agree to withhold bail, increase sentences and extend probation for defendants with mental illness (Schreibersdorf, 2001; Finkelstein & Brawley, 1997). Some defenders may even see this reaction as understandable and fail to protest. Some defenders have expressed concern that the deci-

sions by these system actors are often based on myths about mental illness rather than any individualized assessment of the defendant in front of them. This concern leads many defendants to keep their client's mental illness to themselves whenever possible (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000).

Defenders expressed a cautious optimism about mental health courts and mental health treatment diversion. After all, obtaining treatment as an alternative to incarceration is something that many defenders have wanted for years (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000) Some defenders hope mental health courts will act as a kind of catalyst "to spotlight the paucity of treatment in the community and... spark an interest in creating the treatment programs for the mentally ill that the law mandates as a matter of right, which up until now have been denied them" (Finkelstein & Brawley, 1997).

In assessing the mental health court model, defenders' opinions vary based on whether participation takes place pre- or post-plea. Defenders are concerned that courts mandating treatment prior to adjudicating guilt could be too coercive. Some feel that the charges should be dropped after a client is diverted into treatment, in recognition of the fact that a client lacks culpability for an offense fueled by symptoms of an untreated mental illness. In addition, some defenders contend that holding the threat of prosecution over a client's head while in treatment is unfair and potentially a violation of due process principles (Schreibersdorf, 2001; Saucedo, 2001; Bock, 2000).

Many of these arguments drop away in the post-plea context. Once the issue of guilt has been adjudicated, defenders agree that the court may exercise broad sentencing authority and mandate defendants into treatment (Schreibersdorf, 2001; Feinblatt & Denckla, 2001). Some mental health court pleas explicitly lay out the defendants' potential exposure to jail in the event of consistently failing to comply with program requirements. While defenders think this approach is fair in the post-plea context, they are concerned about how much jail time would be faced by their clients (Schreibersdorf, 2001). For instance, defenders think it is unfair to make offenders who fail out of a treatment program serve a longer sentence than they would have served under a standard plea agreement (Feinblatt & Denckla, 2001). Other defenders believe that the "back-up time" for failure should decrease as the offenders' time in treatment increases, giving them credit for time served.

A general concern voiced by defenders about problem-solving courts involves how much authority judges will exercise over treatment decisions (Feinblatt & Denckla, 2001). Defenders like the idea that judges are becoming more educated about mental illness, but they fear that judges might be tempted to become "psychologists with black robes" (ibid.).

Prosecutors

Chief among prosecutors' concerns about defendants with mental illness is public safety. Mentally ill offenders tend to be repeat offenders. Consequently, some prosecutors have been attracted to alternatives in these cases, hoping that new solutions

might help reduce recidivism (Newman, 2001; Schrunk, 2001; Hynes, 2001; Clark, 2000; Raybon, 1997).

Unfortunately, many prosecutors who support alternatives to incarceration are often frustrated with the limits of treatment providers' capacity and willingness to treat defendants with mental illness. Some prosecutors complain that admissions standards are used to reject more defendants than they include. (Swern, 2000; Landsberg, et al., 2000). Given their mission to protect the public, prosecutors are particularly interested in residential treatment for offenders with mental illness. Many express concern about the dearth of residential treatment slots (Clark, 2000; Swern, 2000; Landsberg, et al., 2000).

Put simply, prosecutors want mental health courts to ensure the accountability of defendants linked to treatment. Prosecutors fear that a defendant with mental illness who is released for treatment will commit a violent crime (Clark, 2000). "Not only would this be tragic for potential victims but it could attract negative media attention that might be used to shut down alternative programs like the mental health court," says Daniel Clark, a prosecutor from King County (Clark, 2000). Given this concern, prosecutors focus a great deal of attention on risk assessment and case targeting (Swern, 2000, Monahan, 2001). "We have a responsibility to the public to assess the risk of violence and assure ourselves that the risk is as little as possible," says Anne Swern of the Brooklyn District Attorney's Office. "We are making an investment in treatment in order to prevent the re-occurrence of crime — particularly violent crime — by offenders with mental illness." Defining who is and is not eligible for a mental health court based on the risk of violence may be crucial to addressing prosecutorial priorities.

Defendants and Ex-Offenders with Mental Illness

In general, ex-offenders and defendants with mental illness who were interviewed at Howie the Harp Advocacy Center, Pathways to Housing, Odyssey House, Harbor House and the Brooklyn Arraignment Part in New York City Criminal Court thought that they had not been served well by the standard case processing of the criminal justice system. Ex-offenders baldly state that their mental illness (and, in many cases, their substance abuse) helped drive their criminal activity. Many reported that they committed their crimes under the influence of drugs or alcohol during a period in which they also failed to take prescribed psychiatric medications. Most had been arrested more than once. Many had served time in jail or prison.

Interestingly, ex-offenders expressed a good deal of ambivalence about their defense attorneys. While many had positive things to say about the legal counsel they had received, others felt that their attorneys were more focused on pursuing short-term strategies necessary to close the case than in preventing their return to the criminal justice system. One ex-offender put it this way: "Defense attorneys aren't thinking about me as an individual who has a mental illness. They're not thinking about my best interests, my need for long-term treatment or how to keep me from coming back to court tomorrow. They are thinking about the short-term of this case. If they knew more about mental illness, they would do things differently." This criti-

cism was fueled by the fact that the ex-offenders interviewed for this study had managed to stay out of the criminal justice system once they obtained treatment. (Many admitted that they had to try a number of different treatment modalities — and get arrested again — before they were able to stabilize.)

None of the ex-offenders interviewed had ever sought a verdict of "not guilty by reason of insanity" or "guilty but mentally ill." Some of them had been referred by their defense attorneys for a competency hearing. Some had also taken advantage of substance abuse treatment as an alternative to incarceration. It had worked for only a few of them because the treatment offered failed to address their mental illness as well.

While none of the ex-offenders interviewed had participated in a mental health court, most of them thought that this type of program was a good way to prevent recidivism. While many said that they would be willing to accept services at the time of arrest, there were some who, even with the benefit of hindsight, stated that would not avail themselves of treatment. Clearly, overcoming resistance to treatment is an issue that any mental health court must take seriously.

Ex-offenders thought that any treatment alternative should be mandated for a period of time longer than what a defendant would face in jail or prison. They repeated stories about how they and others like them didn't realize their own need for treatment even after they were arrested or incarcerated. They would resist treatment, especially if it involved psychiatric medications which carried negative side effects. And repeat offenders stressed that even several months in jail was considered a "skid bid" that was easier to serve rather than enter unwanted treatment.

As to case targeting, some ex-offenders thought that misdemeanor charges did not carry enough of a threat of incarceration to deliver long-term engagement in treatment. One ex-offender explained it in the following fashion:

> *Look, misdemeanors aren't going to be enough to get these guys [with mental illness] into treatment. If you're facing a misdemeanor, you're not going to do more than a year. Now, for most guys who've been through the system, they can do [that time] standing on their head. It's nothing. It's a 'skid bid' — fast and smooth. So they are not going to take treatment unless it is less than [a year], especially if they don't think they have a mental illness. And your program isn't going to want them to go to three months or six months or even a year of treatment. It takes a minimum of two years — maybe three — for treatment to work. So, I think you've got to take felons only. If you're facing a [sentence of] three-to-five [years in prison], two years in treatment is going to sound good.*

Ex-offenders offered suggestions about how to engage defendants with mental illness in treatment: "They are not going to listen to anybody except someone who has been through what they've been through and changed. That's why you need peer educators. It's the only way you'll get through to them." When asked about their experiences with judges, court officers, clerks and district attorneys, ex-offenders reported that these court personnel could benefit from training in the the mental

health recovery process ("relapse is part of recovery"). The ex-offenders also pointed to the need for training about the dangers of free time: "If I'm just sitting around in my house, watching the TV, that's when I start to get into trouble. My thoughts wander to the drugs, to the street, to whatever. Really, I'm just bored. But when I'm doing something all day — volunteering, working, even sightseeing — I'm not going to get into trouble."

What sanctions and rewards would be effective with defendants with mental illness? Interviewees stated that treatment plans should be re-evaluated to see if non-compliance is due to either an inappropriate treatment modality or truly willful behavior. One consumer put it this way: "You want [defendants] to think about the consequences — stay on track, you get a reward; mess up, you get punished. But what if they're confused and can't think straight because their medication is wrong? That's not their fault. It's not right to punish them then." They expressed the need to separate legal issues from treatment issues. The ex-offenders also suggested that a defendant's failure to comply should trigger the court to review whether the provider delivered the agreed upon services. And one consumer urged courts to use privacy as a sanction and reward: "Take away their [defendants'] privacy or give them more privacy. Everyone wants to be left alone. Reward them with more privacy."

The ex-offenders suggested various ways to reward/sanction with privacy. The consumers believed that increasing monitoring visits and calls, particularly at home, would be more effective than increased office visits, which can be easily ignored. They noted that privacy can be increased or decreased within a treatment facility (e.g., sharing a room with one person versus ten). However, they did not think short terms in jail would be effective as a sanction. Why? "In jail you lose the progress you made in treatment. Your self-esteem goes down. You think you can't get well. And you're afraid for your life. You don't want to go to the MO [Mental Observation Unit]. They dope you up on the wrong drugs. You fall apart." The consumers also proposed taking control of a defendant's income as another sanction. "Without spending money, you can't get into much more trouble."

Families

What about the families of criminal defendants with mental illness? In many cases, family members have been victimized by mentally ill offenders, suffering abuse, theft and harassment. Nevertheless, many families are extremely concerned over the incarceration of their relatives (Finkelstein, 2001; Saler, 2001). Organizations such as the National Alliance for the Mentally Ill (NAMI) have begun to explore solutions to this problem (Honberg, 2000; Corliss, 2000; Flynn, 1999). Family members feel trapped by unappealing alternatives. On the one hand, there is the mental health treatment system, which has failed to engage their relative in effective treatment. And on the other hand, there is the criminal justice system, which is certain to punish their relative for behavior that stems from their untreated illness (Corliss, 2000). But at least in jail or prison, their relative will be restrained from hurting themselves or others. And many offenders with mental illness have long, complex histories of resisting treatment, including failing to take their prescribed psychiatric

medications (Saler, 2001). Families want their mentally-ill relatives to get help, but in many cases they don't know how to do it (ibid.).

Families of mentally ill defendants are divided over the use of coercion to engage their relatives in treatment. Many lean towards the use of coercion because they have often been victimized by their relatives' criminal activity and their failure to remain in treatment (Saler, 2001; Corliss, 2000; Landsberg, et al., 2000). As a result, many families support outpatient civil commitment statutes, such as "Kendra's Law" in New York State, as a way to promote treatment compliance (Corliss, 2000). Similarly, many families have reacted positively to mental health courts (Finkelstein, 2001; Saler, 2001; Honberg, 2000; Corliss, 2000). They see these new experiments as providing their relative with a powerful incentive to remain engaged in treatment (Honberg, 2000; Corliss, 2000).

Mental Health Advocacy Groups

Mental health advocacy groups such as the Urban Justice Center's Mental Health Project in New York City and the Bazelon Center for Mental Health Law in Washington, D.C., engage in lobbying, public education and litigation on behalf of people with mental illness. Similar to defense attorneys, these advocacy groups believe that over the last decade or so law enforcement priorities combined with the effects of significant gaps in community mental health services have resulted in a "criminalization" of people with mental illness. (Barr, 2001; Bernstein, 2000).

Mental health advocates believe many defendants with mental illness commit crimes because their illness has not been effectively treated (Barr, 2001; Bernstein, 2000). Accordingly, advocates argue that defendants with mental illness should be diverted out of the criminal justice system and into treatment as early as possible. They believe that prosecuting most defendants with mental illness is fundamentally unfair. These advocates favor pre-booking diversion programs (sometimes called Crisis Intervention Teams) like the one employed with the police in Memphis, Tennessee (Barr, 2001). "The mental health system needs to develop more appropriate responses to people in psychological crises that will help avoid any criminal justice involvement," says Heather Barr, a staff attorney at the Urban Justice Center. If a defendant must go to court, they favor a diversion to treatment at arraignment and a dismissal of charges (Barr, 2001; Bernstein, 2000).

Mental health advocates are not very favorably inclined towards certain attributes of mental health courts. They share many of the same concerns voiced by defense attorneys. They see court-mandated treatment as an invasion of defendant's liberty and privacy (Barr, 2001; Bernstein, 2000). "Coercion by the courts," explains Barr, "is only appropriate when a defendant chooses that option freely and the offense is one that would lead to a substantial period of incarceration in the normal sentencing marketplace of the criminal justice system" (Barr, 2001). As a matter of principle, advocates tend to believe that individuals with mental illness should access treatment voluntarily on their own after charges against them have been dismissed.

In addition, mental health advocates are concerned about the use of confidential treatment information by prosecutors and judges in mental health courts (Bernstein,

2000). They describe occasions when prosecutors and judges have used psychiatric information disclosed in the course of advocating for a treatment disposition to justify a greater period of incarceration (Barr, 2001). They also fear that prosecutors (or other government agencies) will collaterally prosecute or impeach a witness on cross-examination using information obtained by the court during its mental health evaluation of the defendant (ibid.).

The Treatment Community

The behavioral health "treatment community" consists of state and county agencies of mental health, mental retardation and substance abuse and the programs they fund, including psychiatric hospitals and community-based service providers. Historically, the treatment community has been reluctant to address the issue of people with mental illness who have repeated contacts with the criminal justice system (Osher, 2001). Recently, that has begun to change. For one thing, research has documented that a significant number of people with mental illness cycle back and forth from treatment to incarceration. Even though the treatment community is starting to come to grips with this issue, the solutions are not easy ones. Addressing the needs of defendants with mental illness requires intricate cooperation among government agencies not used to collaboration with each other (ibid.).

Even though many of their clients have had criminal justice contacts in the past, many treatment providers do not have an expertise in treating these clients (often known as "forensic" clients). In general, where treatment providers are able to choose their clients, they tend to select clients who do not pose the kinds of treatment challenges associated with forensic clients (McCormick, 2000). Treatment providers often associate forensic clients with disruptive or violent behavior (Tsemberis, 2000; McCormick, 2000). As a result, many treatment providers will not treat people coming directly from the criminal justice system, fearing for the safety of their own staff and other clients (Tsemberis 2000). Further, some treatment providers also express concern about the complexity of forensic cases, explaining that clients from the criminal justice system usually have a host of very severe problems that are very difficult to treat effectively (Wertheimer, 2000).

In addition, many community treatment providers are concerned that forensic clients may require more frequent hospitalizations because of the severity of their mental health issues, thus impairing the provider's overall treatment performance statistics (there is even the potential that the failures of forensic clients will jeopardize funding from government sources that require performance-based contracts). "Evaluations of mental health services often regard hospitalization as a negative outcome when it may actually be a positive outcome when compared to being inappropriately placed in jail or prison," says C. Terence McCormick of the New York State Office of Mental Health (McCormick, 2000).

Hospitalization is a tricky problem. In jurisdictions that use a managed care system to deliver mental health services, psychiatric hospitalization initiated by community treatment providers is sometimes discouraged because of its expense (McCormick, 2000). Hospitals have an impact on the front end as well. Many

refuse to admit forensic patients, which makes it more likely that a police or parole officer will exercise his discretion to detain that person in the criminal justice system (Landsberg, et al. 2000).

Treatment providers share the view of many defenders and mental health advocates that mental illness has been "criminalized" in recent years, resulting in more and more criminal justice contacts for their clients (Wertheimer, 2000; Tsemberis, 2000). They also report that people with mental illness do not respond well to the stresses associated with arrest, courtroom appearances and incarceration (Tsemberis, 2000).

Treatment providers have mixed responses to the mental health court model. Some like it because it guarantees on-going court involvement with difficult clients. It gives them a greater sense of assurance that they can call upon the court to help engage forensic clients in treatment (Unterbach, 2001; Wertheimer, 2000). "Treatment outcomes are usually much better when the client, case managers and treatment staff maintain a close relationship with the court" explains Arnold Unterbach, director of mental health services at Odyssey House in New York City (Unterbach, 2001). Indeed, despite their concerns with forensic clients, treatment providers tend to believe that treatment works or can be made to work for just about any person with mental illness. Moreover, many believe that effective treatment can prevent recidivism (Wertheimer, 2000).

Some mental health service providers are encouraged that the courts have begun to realize that their conventional responses to defendants with mental illness are not working. Some believe that the courts may be taking the lead — ahead of the treatment community — in pushing for integrated treatment for co-occurring disorders (Osher, 2001). Other treatment providers express doubts. They worry that courts will intrude into the treatment process without developing a real understanding of either the day-to-day realities of providers' work or the challenges that people face in treatment (Stoller, 2000). And they fear that their need to report confidential information to the court could jeopardize their ability to gain clients' trust, reducing the chances that treatment will be successful (Tsemberis, 2000). "Our concern is that mental health courts may perpetuate the public's unrealistic expectation that when a court mandates someone to do something they actually do it. In reality, when people are told that they have to do something, paradoxically, they often do the opposite. That's human nature — whether you have a mental illness or not," says Ellen Stoller of FEGS, the largest community mental health treatment provider in New York City (Stoller, 2000). Finally treatment providers worry that without specific relationships with treatment providers and priority access to services, mental health courts will face difficulties placing forensic clients in treatment (McCormick, 2000).

Conclusion

While judges, attorneys, service providers and defendants with mental illness come at the issue from different perspectives, there is a consensus that criminal defendants with mental illness pose a major problem for courts in the United States. Standard case processing methods have proven to be neither efficient nor effective in dealing

with these defendants. Given this reality, state court systems have begun to test new approaches in an effort to protect communities and prevent defendants with mental illness from returning to court over and over again at great cost. Most notable among these approaches are mental health courts.

Mental health courts are creating a great deal of discussion around the country. They have provoked a surprising variety of responses from stakeholders in the criminal justice system and the mental health system. For instance, offenders with mental illness and their families appear to differ from defense attorneys and mental health advocates about whether or not coerced treatment is ever appropriate. Further, offenders with mental illness report that their attorneys sometimes fail to pursue case outcomes (e.g., treatment alternatives) that might involve the short-term loss of liberty but might also keep them out of the criminal justice system over the long haul. Defenders and mental health advocates have responded with ambivalence to mental health courts — worrying over the possibility of increased state coercion while applauding the system's interest in expanding access to treatment.

Meanwhile, many prosecutors and judges seem willing to risk the possibility of failure to test whether treating symptoms of mental illness will reduce recidivism and improve public safety. Strikingly, they have encountered some of the most solid resistance from treatment providers, who lack the capacity (and, in many cases, the knowledge about effective treatment regimes) to serve this difficult population. Courts are not an institution known for innovation. But if mental health courts are to succeed, it is clear that they will have to take a leadership role, both in building public support for treatment an alternative to incarceration and in encouraging treatment providers to work with forensic clients.

As mental health courts move forward, they will test three ideas. Primarily, mental health courts explore the connection between defendants' symptoms of mental illness and their criminal conduct, asking whether intensively monitored treatment can reduce recidivism. They also aim to evaluate whether coercion helps improve accountability by engaging defendants with mental illness in long-term treatment. And they tackle the question of system integration: Can the systems of mental health and criminal justice craft collaborative approaches to mental illness and in the process improve the delivery of services to defendants with mental illness and co-occurring disorders? In the years ahead, the answers to these questions will go a long way towards determining both the course of mental health treatment and the future of individuals with mental illness in the criminal justice system.

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APPENDIX H

Crisis Intervention Team Training and the Memphis Model

Crisis Intervention Team
Core Elements

The University of Memphis
School of Urban Affairs and Public Policy
Department of Criminology and Criminal Justice
CIT Center[1]

September, 2007

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Table of Contents

SECTION 1

CIT Model
Core Elements: Summary

The Crisis Intervention Team (CIT) is an innovative first-responder model of police-based crisis intervention with community, health care, and advocacy partnerships. The CIT Model was first developed in Memphis and has spread throughout the country. It is known as the "Memphis Model." CIT provides law enforcement-based crisis intervention training for assisting those individuals with a mental illness, and improves the safety of patrol officers, consumers, family members, and citizens within the community.

CIT is a program that provides the foundation necessary to promote community and statewide solutions to assist individuals with a mental illness. The CIT Model reduces both stigma and the need for further involvement with the criminal justice system. CIT provides a forum for effective problem solving regarding the interaction between the criminal justice and mental health care system and creates the context for sustainable change.

Basic Goals:

- *Improve Officer and Consumer Safety*
- *Redirect Individuals with Mental Illness from the Judicial System to the Health Care System*

In order for a CIT program to be successful, several critical core elements should be present. These elements are central to the success of the program's goals. The following outlines these core elements and details the necessary components underlying each element.

CORE ELEMENTS

Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health
2. Community Ownership: Planning, Implementation & Networking
3. Policies and Procedures

Operational Elements

4. CIT: Officer, Dispatcher, Coordinator
5. Curriculum: CIT Training
6. Mental Health Receiving Facility: Emergency Services

Sustaining Elements

7. Evaluation and Research
8. In-Service Training
9. Recognition and Honors
10. Outreach: Developing CIT in Other Communities

SECTION 2

CIT Model
Core Elements: Outline

Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health
    A. Law Enforcement Community
    B. Advocacy Community
    C. Mental Health Community

2. Community Ownership: Planning, Implementation & Networking
    A. Planning Groups
    B. Implementation
    C. Networking

3. Policies and Procedures
    A. CIT Training
    B. Law Enforcement Policies and Procedures
    C. Mental Health Emergency Policies and Procedures

Operational Elements

4. CIT: Officer, Dispatcher, Coordinator
    A. CIT Officer
    B. Dispatch
    C. CIT Law Enforcement Coordinator
    D. Mental Health Coordinator
    E. Advocacy Coordinator
    F. Program Coordinator (Multi-jurisdictional)

5. Curriculum: CIT Training

    A. Patrol Officer: 40-Hour Comprehensive Training
    B. Dispatch Training

6. Mental Health Receiving Facility: Emergency Services
    A. Specialized Mental Health Emergency Care

Sustaining Elements

7. Evaluation and Research
    A. Program Evaluation Issues
    B. Development Research Issues

8. In-Service Training
    A. Extended and Advanced Training

9. Recognition and Honors
    A. Examples

10. Outreach: Developing CIT in Other Communities
    A. Outreach Efforts

SECTION 3

CIT Model
Core Elements: Detailed

3.1 Ongoing Elements

1. Partnerships: Law Enforcement, Advocacy, Mental Health

A. Law Enforcement Community

Participation and Leadership within the Law Enforcement Community

Central to the formation and success of CIT is the role of the law enforcement community. Trained CIT Officers are able to interact with crisis situations using de-escalation techniques that improve the safety of the officer, consumer, and family members. In addition, the law enforcement community is able to provide care and help to consumers by transporting individuals in need of special treatment to appropriate facilities. It is also critical that all law enforcement participate in the formation of CIT and engage in all elements of the planning and implementation stages. Often those involved in the formation of the CIT program will become or help select the CIT coordinator for a particular law enforcement agency. The two main components within the law enforcement partnership are the operational Crisis Intervention Team within a law enforcement agency and general criminal justice system participants.

1) Law Enforcement: CIT Operational Component
   - Police Department
   - Sheriff's Department

2) Law Enforcement: Criminal Justice Partnership Component
   - Corrections
   - Judiciary
     Public defender, State Attorney, Judges, Probation/Parole
   - Crime Commission/Public Safety Commission

3) Law Enforcement: Policy Development Component
   - Law enforcement command staff
   - Training and Standards

1. Partnerships: Law Enforcement, Advocacy, Mental Health

B. Advocacy Community

Participation and Leadership within the Advocacy Community

Participation from the Advocacy Community is critical to the success of CIT. This partnership provides strong support from passionate and dedicated people whose goal is to improve the quality of life for individuals affected by a mental illness. Leadership roles should develop in the form of liaisons that help voice the support, ideas, and concerns of consumers and family members. This aspect of CIT brings the program to life by adding insight from those directly affected. This important partnership should be established early in the planning process and should continue as an ongoing operational element of CIT.

1) Consumers/Individuals with a Mental Illness
   The personal accounts of individuals with a mental illness greatly enhance the planning process, officer training, and on-going support for CIT. Officers are able to gain an improved understanding and more realistic view of mental illness through these first-hand presentations. As a result, the involvement of individuals with a mental illness in the development, implementation, and ongoing sustainability of CIT is essential.

2) Family Members
   Due to their first-hand knowledge and experience in dealing with mental illness, family members have a great deal to offer CIT. Family members also have much to gain from CIT, as the program encourages treatment instead of incarceration. In both the development and implementation phases of building a CIT program, this interdependency allows family members to provide direct guidance and assistance to the planning process, training and community education. Therefore, the involvement of family members is a critical hallmark of the CIT program.

3) Advocacy Groups
   Advocacy groups may consist of family members, consumers, friends, and/or other individuals or groups that advocate for important issues surrounding mental illnesses and aim to improve the quality of life for those affected. Partnerships with advocacy groups, much like the partnerships with consumers and family members, are critical to the success of CIT. They provide strong support systems not only for members of the community, but also for law enforcement and mental health communities, as well as consumers. Advocacy groups may help by providing a voice for individuals with a mental illness; they also assist family members and consumers by providing services and guidance.

3) Advocacy Groups (continued)

Below is a list of some of the advocacy groups that have been critical to the initial development of CIT programs across the nation.

- National Alliance on Mental Illness (NAMI)
  NAMI is a nonprofit, grassroots, advocacy organization whose mission is to eliminate mental illnesses and improve the quality of life for those who are affected. NAMI members consist of consumers, family members, and friends of individuals with a mental illness. www.nami.org

- National Mental Health Association (NMHA)
  NMHA is a nonprofit organization that seeks to address all aspects of mental health and mental illness. NMHA works to improve the mental health of all Americans through advocacy, education, research, and service. www.nmha.org

- *Many other advocacy groups have participated in the initial development of CIT programs throughout the nation. These groups include those representing individuals with mental illness, as well as those representing local and state government, mental health agencies, and the judiciary.*

1. Partnerships: Advocacy, Law Enforcement, Mental Health

B. Mental Health Community

Participation and Leadership within the Mental Health Community

The mental health community plays an important role in the successful implementation, development, and ongoing sustainability of CIT. These professions provide treatment, education and training that result in a wide dissemination of knowledge and expertise to both individuals with a mental illness and patrol officers undergoing CIT training. This partnership is essential to maintaining access to the health care system and quality treatment.

1) **Providers, Educators, Practitioners, and Trainers**

- Professionals
  Psychologists, Psychiatrists, Physicians, Social Workers, Counselors, Pastoral Counselors, Alcohol/Drug Counselors, Educators, Trainers, and Criminologists

- Public, Non profit & Private Agencies; Institutions; & Universities
  Hospitals, Mental Health Centers, Emergency Intake Facilities, Universities, Colleges, and Medical Schools

- Trainers
  Local professionals and agencies are encouraged to provide instruction during CIT training voluntarily as a service to the community. This is strongly suggested in an effort to minimize the training costs for local law enforcement agencies.

2. Community Ownership: Planning, Implementation & Networking

Communities both large and small are seeking solutions to crisis issues and situations. Community collaborations and partnerships are essential to this effort. Additionally, it is important to establish community ownership, which may be described as a dedicated investment that individuals within the community have in the CIT program. Individuals and organizations within the community must have a stake in the initial planning stages; the implementation of the CIT program and its training curriculum; and ongoing feedback in order to maintain, improve, and ensure the success of CIT. Also, local professionals and agencies, who dedicate their time without charge to assist in training the patrol officers, help to increase the sense of community ownership for CIT.

A. Planning

1) Advocates
2) Citizens
3) Consumers/Individuals with a Mental Illness
4) Family Members
5) Government
6) Judiciary
7) Law Enforcement Community
8) Mental Health Community

B. Implementation

1) Leadership from Law Enforcement, Mental Health, and Advocacy Community
2) Training Curriculum

C. Networking

1) Feedback
2) Problem Solving

3. Policies and Procedures

Policies and procedures are a necessary component of CIT. They provide a set of guidelines that direct the actions of both law enforcement and mental health officials. Due to the large number of stakeholders in CIT, it is important that these guidelines be designed by all those affected. Within the law enforcement community, policies exist in order to provide guidelines regarding how to properly transport consumers and how to develop an infrastructure through a system of partnerships and inter-agency agreements. These law enforcement policies address the actions of both emergency dispatchers and CIT patrol officers. The emergency dispatchers identifies the nearest available CIT Officer to respond to the crisis. The CIT Officer then responds to the crisis event and leads the intervention. CIT Officers should be allowed to integrate their wide range of law enforcement training when handling CIT calls. Within the mental health community, policies exist in order to provide guidelines regarding how to handle referrals from CIT Officers. The mental health community also plays a key role in training and feedback for the CIT program. The role of the advocacy community in policies and procedures are often more informal but involve the critical element of networking and feedback for the overall program.

A. CIT Training

1) Inter-Agency Agreements
2) Size and Scope

   The number of trained CIT officers available to any shift should be adequate to meet the demand load of the local consumer community. Experience has shown that a successful CIT program will have trained 20-25% of the agency's patrol division. There are differences that exist between large urban communities and small rural communities. Smaller agencies may need to train a higher percentage of officers. Ultimately, the goal is to have an adequate number of patrol officers trained in order to ensure that CIT-trained officers are available at all times.

   All dispatchers should be trained to appropriately elicit sufficient information to identify a mental health related crisis.

B. Law Enforcement Policies and Procedures

1) Dispatch Policies and Procedures

   The nearest CIT Officer is identified and dispatched to the crisis event.

2) Patrol Policies and Procedures

   Policies that maximize the officer's discretion are critical. In addition, a policy should address the issue of the lead CIT Officer, who guides the resolution of the crisis event.

3. Policies and Procedures (continued)

C. Mental Health Emergency Policies and Procedures

1) Law Enforcement Referral Policies

The policies in place should allow for a wide range of inpatient and outpatient referral sources in order to accommodate law enforcement agencies with a CIT program. Barriers that prevent officers from accessing immediate mental healthcare for an individual with mental illness should be eliminated. This should be a priority as important as any other in the CIT process. In addition, policies should be set to ensure minimal turnaround time for the CIT Officers, so that it is less than or equivalent to the turnaround time in jail.

4. CIT: Officer, Dispatcher, Coordinator

Individuals within the law enforcement community primarily consist of CIT Officers, Dispatchers, and a CIT Coordinator. The following core element addresses the personnel required to effectively operate a CIT program.

A. CIT Officer

Officers within a patrol division should voluntarily apply for CIT positions. Each candidate then goes through a selection process, which is assessed according to the officer's application, recommendations, personal disciplinary police file, and an interview. Once selected, each of the CIT Officers maintains their role as a patrol officer and gains new duties and skills through the CIT training, serving as the designated responder and lead officer in mental health crisis events.

1) Voluntary
2) Selection Process
3) Patrol Role
4) CIT Role
5) CIT Training and CIT Skills
6) Safety Skills

B. Dispatch

Emergency dispatchers are a critical link in the CIT program and may include call takers, dispatchers, and 911 operators. The success of CIT depends on their familiarity with the CIT program, knowledge of how to recognize a CIT call involving a behavioral crisis event, and the appropriate questions to ask in order to ascertain information from the caller that will help the responding CIT Officer. Finally, dispatchers should know how to appropriately dispatch a CIT Officer. Dispatchers should receive training courses (a minimum of 8-16 hours) in CIT and additional advanced in-service training.

1) CIT Training
2) Familiarity with CIT
3) Recognize Call as CIT Crisis Event
4) Ask Caller Appropriate Questions
5) Dispatch Nearest CIT Officer
6) Additional/Advanced In-Service Training

4. CIT: Officer, Dispatcher, Coordinator

C. CIT Law Enforcement Coordinator

The CIT coordinator is part of the law enforcement community and acts as a liaison by maintaining partnerships with program stakeholders in order to ensure the success of CIT. The coordinator's involvement with CIT should start from the beginning and continue through the planning, implementation, and evaluation stages. The CIT coordinator provides support to CIT officers through training and feedback. The qualifications should include leadership ability and experience as a law enforcement officer. The job responsibilities include program development, training coordination, and maintenance of relationships with community partnership. The CIT coordinator also is a point of contact with the law enforcement agency for the community and brings stability to the program.

D. Mental Health Coordinator

The mental health coordinator is part of the mental health community who provides leadership and serves as a liaison with the advocacy and law enforcement communities. This position may be established or developed informally. When it is left as an informal liaison there may be several individuals who serve this function. It is important that each of them work with the overall community effort. This position has a significant operational component involving the training, curriculum and the function of the receiving facility or receiving facilities

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E. Advocacy Coordinator

The advocacy coordinator is part of the advocacy community, which includes advocates, family members, and individuals with mental illness. As with the mental health coordinator, the position may be established or developed informally. When it is left as an informal liaison there may be several individuals who serve this function. It is important each of them work with the overall community effort. This position often involves the operational components such as training, curriculum and ongoing problem solving.

F. Program Coordinator

Multi-agency CIT programs may have a need for a Program Coordinator who is largely responsible for the day to day logistics of inter-departmental communication, data collection and management, records keeping and scheduling training. This person should be familiar with the roles of three primary components of the CIT program and comfortable and effective in communicating in all three environments. Much of the role of this person will be diplomatic in nature. They may have additional duties in identifying and securing sustaining programmatic resources.

5. Curriculum: CIT Training

The CIT program is an innovative national model of police-based crisis intervention with community mental health care and advocacy partnerships. Police officers receive intensive training to effectively respond to citizens experiencing a behavioral crisis. Patrol officers already have training and a basic understanding of the proper safety skills. Officers are encouraged to maintain these skills throughout the course, while incorporating new de-escalation techniques to more effectively approach a crisis situation. It is important that the individuals from the mental health, law enforcement, and advocacy communities play a critical role in the training curriculum in order to bring experience, ideas, information, and assistance to the CIT Officers in training. Additionally, all training faculty are encouraged to complete the 40-hour comprehensive course and participate in a ride-along in order to fully understand the complexities and differences that exist between mental health care and law enforcement.

A. Patrol Officer: 40-Hour Comprehensive Training

The 40-hour comprehensive training emphasizes mental health-related topics, crisis resolution skills and de-escalation training, and access to community-based services. The format of a 40-hour course consists of didactics/lectures, on-site visitation and exposure to several mental health facilities, intensive interaction with individuals with a mental illness, and scenario based de-escalation skill training. Experience has shown this is a minimum level of training hours. The material covered is complex. The desired learning outcomes go beyond simple cognitive retention of material. The outcome desired is the retention of behavioral changes learned as part of the training.

1) Didactics and Lectures/Specialized Knowledge

- Clinical Issues Related to Mental Illnesses
- Medications and Side Effects
- Alcohol and Drug Assessment
- Co-Occurring Disorders
- Developmental Disabilities
- Family/Consumer Perspective
- Suicide Prevention and Practicum Aspects
- Rights/Civil Commitment
- Mental Health Diversity
- Equipment Orientation
- Policies and Procedures
- Personality Disorders
- Post Traumatic Stress Disorders (PTSD)
- Legal Aspects of Officer Liability
- Community Resources

5. Curriculum: CIT Training

A. Patrol Officer: 40-Hour Comprehensive Training (Continued)

2) On-Site Visits and Exposure

    - On-Site Visits

3) Practical Skill Training/Scenario Based

    - Crisis De-Escalation Training Part I
      Basic Strategies
    - Crisis De-Escalation Training Part II
      Basic Verbal Skills
    - Crisis De-Escalation Training Part III
      Stages/Cycle of a Crisis Escalation
    - Crisis De-Escalation Training Part IV
      Advanced Verbal Skills
    - Crisis De-Escalation Training Part V
      Advanced Strategies: Complex Scenarios

4) Questions and Answers

5) Commencement and Recognition

B. Dispatch Training

All dispatchers receive a specialized course detailing the structure of CIT. The training course also addresses how to properly receive and dispatch calls involving individuals with a mental illness and crisis situations. Additional and advanced in-service training courses should also be incorporated. Topics that are covered in the dispatcher's training course are listed below.

1) Recognition and Assessment of a CIT Crisis Event

2) Appropriate Questions to Ask Caller

3) Identify Nearest CIT Officer

4) Policies and Procedures

6. Mental Health Receiving Facility: Emergency Services

A designated Emergency Mental Health Receiving Facility is a critical aspect of the CIT Model. It provides a source of emergency entry for consumers into the mental health system. To ensure CIT's success, the Emergency Mental Health Receiving Facility must provide CIT Officers with minimal turnaround time and be comparable to the criminal justice system. The facility should accept all referrals regardless of diagnosis or financial status. Additionally, the facility will need access to a wide range of emergency health care services and disposition options, as well as, alcohol and drug emergency services. Finally, the Emergency Mental Health Receiving Facility is part of the operational component of the CIT Model that provides feedback and engages in problem solving with the other community partners, such as Law Enforcement and Advocacy Communities.

A. **Specialized Mental Health Emergency Care**

1) Single Source of Entry (or well-coordinated multiple sources)
2) On Demand Access: Twenty-Four Hours/Seven Days A Week Availability
3) No Clinical Barriers to Care
4) Minimal Law Enforcement Turnaround Time
5) Access to Wide Range of Disposition Options
6) Community Interface (Feedback and Problem Solving Capacity)

3.3 Sustaining Elements

7. Evaluation and Research

Evaluation and research can help measure the impact, continuous outcomes, and efficiency of a community's CIT program. More specifically, it may help to identify whether the program is achieving its objectives and should be an ongoing part of CIT. Outcome research has shown CIT to be effective in developing positive perceptions and increased confidence among police officers; providing very efficient crisis response times; increasing jail diversion among those with a mental illness; improving the likelihood of treatment continuity with community-based providers; and impacting psychiatric symptomatology for those suffering from a serious mental illness, as well as substance abuse disorders. This was all accomplished while significantly decreasing police officer injury rates. The following components are being studied within CIT, some currently and others in the planning stages of evaluation.

A. Research and Evaluation Issues

1) Development of Community Consensus
2) Improved Law Enforcement Perception of Individuals with Mental Illness
3) Increased Confidence in Interacting with Individuals with Mental Illness
4) Decreased Crisis Response Times
5) Decreased Law Enforcement Injury Rates
6) Decreased Citizen Injury Rates
7) Improved Health Care Referrals
8) Decreased Arrest Rates
9) Jail Diversion Impact
10) Increased Treatment Continuity
11) Improved Treatment Outcomes
12) Decreased Psychiatric Symptomatology
13) Impact on Recidivism Rate
14) Improved Community Perception of Law Enforcement

8. In-Service Training

In-service training provides CIT Officers with additional knowledge and skills. In-service trainings should be offered regularly for current CIT Officers who have completed the 40-Hour Comprehensive Crisis De-Escalation Training course. The following is a list of several topics that have been used in previous In-service trainings:

A. Extended and Advanced Training

1) Extended/Advanced Suicide Crisis Intervention Training
2) Advanced Developmental Disabilities
3) New Developments in Psychiatric Medications
4) Advanced Verbal Skill Training (*Crisis Hotline)*
5) Advanced Scenario Training

9. Recognition and Honors

Recognizing and honoring CIT Officers provides a sense of accomplishment and ownership toward the program. It also gives officers an incentive to continue in their line of work. Recognition and honors can be awarded through local media, newsletters, program websites, or annual banquets. Such honors should be given to CIT Officers who have served the community in crisis situations with exceptional care and compassion, while ensuring the safety of themselves and others.

A. Examples

1) Awards
   Departmental commendation for successfully de-escalating a crisis event

2) Certificate of Recognition
   During monthly advocacy meetings, CIT Officers may be introduced to the community and given a Certificate of Recognition.

3) Annual Banquet
   CIT Officers may be recognized and honored at an Annual CIT Banquet. The following are examples of the awards that can be given:

   - CIT Officer of the Year
   - Precinct CIT Officer of the Year
   - Five- or Ten-Year CIT Service Awards
   - New CIT Officer of the Year
   - Certificate of Appreciation/Recognition
     For Individuals within the Mental Health Community
     For Individuals within the Advocacy Community
     For Other Individuals within the Community

10. Outreach: Developing CIT in Other Communities

Developing CIT programs in other communities, through partnerships and outreach efforts, will help to ensure that individuals who suffer from a mental illness receive the proper care needed, while increasing the safety of the community, patrol officers, family members, and consumers. Outreach efforts may include the involvement of other local communities in a 40-Hour CIT Comprehensive Training Course. The following are possible outreach efforts:

A. Outreach Efforts

1) Local Communities/Agency Development
   Provide 40-Hour CIT Comprehensive Training Course for local communities and agencies.

2) Regional Community/Agency Development
   Help other communities develop a CIT program and their own 40-Hour CIT Comprehensive Training Course.

3) Statewide CIT Development
   Develop a statewide CIT effort to establish CIT programs in police and sheriff's departments.

4) Legislative Development
   Develop a strong lobbying effort to educate policy makers and help secure adequate funding for program development

NIJ's Multisite Evaluation of Prosecutor-Led Diversion Programs

Strategies, Impacts, and Cost-Effectiveness

By Michael Rempel, Melissa Labriola, Priscillia Hunt, Robert C. Davis, Warren A. Reich, and Samantha Cherney

Center for Court Innovation
RAND CORPORATION
ASSOCIATION OF PROSECUTING ATTORNEYS
POLICE FOUNDATION

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This project was supported by Award No. 2012-IJ-CX-0036, awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this publication are those of the author(s) and do not necessarily reflect those of the Department of Justice.

Acknowledgements

This project was supported by Grant Number 2012-IJ-CX-0036 awarded by the National Institute of Justice of the U.S. Department of Justice. For their support and assistance, we thank Linda Truitt, Senior Social Science Analyst at the National Institute of Justice, and Nadine Frederique, who served as our grant manager when the project began.

This study was implemented as a collaboration among the Center for Court Innovation, the RAND Corporation, the Association of Prosecuting Attorneys, and the Police Foundation. At the Association of Prosecuting Attorneys, which played an integral role in the formative stages of the project, we are deeply grateful to Steven Jansen, former Vice President and Chief Operating Officer, and to Robert Hood, Director of the Community Prosecution and Violent Crime Division. At RAND, we specifically thank Sarah Greathouse.

At the Center for Court Innovation, we thank Greg Berman for his comments on an earlier version of the final report. We also thank our colleagues Julius Lang and Sarah Fritsche for their many insights regarding prosecutor-led diversion programs and policies.

We also thank the many prosecutors, judges, court administrators, public defenders, probation officers, and treatment professionals from eleven jurisdictions around the country for participating in interviews, sharing documents, answering follow-up questions, helping with data collection, and allowing us to observe their programs in action. We are especially indebted to the following points of contact from each prosecutor's office:

- **Cook County State's Attorney's Office:** Mark Kammerer, Director of Court Diversion.
- **Chittenden County State's Attorney Office:** Emmet B. Helrich, Community Coordinator, Rapid Intervention Community Court.
- **Philadelphia District Attorney's Office:** Derek Riker, Chief, Diversion Courts Unit.
- **Maricopa County District Attorney's Office:** Douglas Kramer, CEO, TASC.
- **City of Phoenix Prosecutor's Office:** Martha Perez Loubert, Diversion Programs and Victim Services Administrator (Retired).
- **Hennepin County Attorney's Office:** Paul Scoggin and former director of Operation De Novo, T. Williams.

- **Milwaukee County District Attorney's Office**: Jeff Altenburg, Deputy District Attorney for Community Prosecution and Early Intervention.

- **Dallas County District Attorney's Office:** L. Rachael Jones, former Chief of Community Prosecution and former Dallas County District Attorney, Craig Watkins.

- **San Diego City Attorney's Office:** Michael S. Giorgino, Chief Deputy City Attorney.

- **San Francisco District Attorney's Office:** Katherine Weinstein Miller, Chief of Alternative Programs & Initiatives.

- **Los Angeles City Attorney's Office:** Camilo Cruz, Director of the Community Justice Initiative.

We also thank representatives from Statistical Analysis Centers and other state agencies for providing aggregate and case-level data. The methodology used and results reported using data obtained from data sources are solely the responsibility of the research team. Specifically, thanks to:

- **Vermont Crime Information Center:** Jeffrey Wallin, Director.

- **Illinois Criminal Justice Information Authority:** Christine Devitt Westley and Ernst Melchior, Research and Analysis Unit.

- **Milwaukee:** Jeff Altenburg, Milwaukee County District Attorney's Office; and representatives from the County District Court Administration.

- **San Francisco District Attorney's Office:** Katherine Miller, Maria McKee, Jackson Gee, Carmen Aguirre, and Michael Corriere.

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Executive Summary

In recent years, a growing number of prosecutors have established pretrial diversion programs, either *pre-filing*—before charges are filed with the court—or *post-filing*—after the court process begins but before a disposition. Participating defendants must complete assigned treatment, services, or other diversion requirements. If they do, the charges are typically dismissed. With funding from the National Institute of Justice, the current study examined 16 prosecutor-led diversion programs in 11 jurisdictions across the country, and conducted impact evaluations of five programs and cost evaluations of four programs.

Goals of Prosecutor-Led Diversion

- **Multiple Goals:** Diversion programs of the 1970s tended to prioritize defendant rehabilitation and recidivism reduction. Today, these goals occupy a less preeminent role. The most commonly endorsed goals in our sample of programs were: (1) administrative efficiency/cost savings—by routing many cases away from traditional prosecution and redirecting resources to other more serious cases; and (2) reducing convictions and collateral consequences for defendants.

Target Populations

- **Timing of Diversion Participation:** Of 15 programs in the study, eight were post-filing, three were pre-filing, and four programs enrolled participants either prior to or after filing charges with the court depending on case specifics (*mixed model*).

- **Misdemeanors and Felonies:** Unlike programs of the 1970s, current models are not exclusively focused on the lowest level cases. Instead, nine of 15 programs we examined either targeted felonies or a mix of misdemeanors and felonies.

- **Specialist Programs:** Six of 15 programs targeted specific types of crimes, most often drug or marijuana possession, although one program in Hennepin County, MN targeted both felony-level drug and property cases and another program in Phoenix, Arizona targeted misdemeanor prostitution cases.

- **Risk-Informed Decision-Making:** The programs we examined generally made eligibility determinations based on charge and criminal history, not validated risk assessments. A notable exception was in Milwaukee, which adopted a universal risk-informed screening protocol, leading low-risk defendants to be routed to a brief, pre-

filing program and medium-risk defendants to be routed to a more intensive post filing program, with services tailored to each defendant's needs.

Program Mandates

- **Standardized vs. Individualized:** Of 15 programs examined, five utilize a "one size fits-all" approach, whereas ten programs use individualized mandates to some degree, assigning different types of services based on defendants' needs.

- **Educational vs. Therapeutic Models:** Thirteen of the 15 programs link at least some participants to educational classes about the relevant problem behavior, including classes about drugs, driving, theft, prostitution, weapons, health, and/or parenting. Staff at only one program cited the consistent use of evidence-based cognitive-behavioral approaches, although two additional programs use these approaches with some cases.

- **Community Restoration:** Ten of the 15 programs order at least some participants to perform community service. In addition, four programs use restorative justice groups with at least some participants., Restorative justice represents a core organizing principle of the model for San Francisco's Neighborhood Courts diversion program and Los Angeles' newly created Neighborhood Justice Initiative.

Case Outcomes, Recidivism, and Cost

- **Case Outcomes:** All five programs participating in impact evaluations (two in Cook County, two in Milwaukee, and one in Chittenden County, VT) reduced the likelihood of conviction—often by a sizable magnitude. All five programs also reduced the likelihood of a jail sentence (significant in four and approaching significance in the fifth program).

- **Re-Arrest:** Four of five programs reduced the likelihood of re-arrest at two years from program enrollment (with at least one statistically significant finding for three programs and at least one finding approaching significance in the fourth). The fifth site did not change re-arrest outcomes.

- **Cost:** All four programs whose investment costs were examined (two in Cook County and one each in Chittenden and San Francisco) produced sizable cost and resource savings. Not surprisingly, savings were greatest in the two pre-filing programs examined, which do not entail any court processing for program completers. All three programs whose output costs were examined (i.e., omitting the San Francisco site) also produced output savings, mainly stemming from less use of probation and jail sentences.

Chapter 1

Introduction

The traditional role of the prosecutor is to seek justice by convicting those who engage in criminal behavior and obtaining a legally proportionate sentence, selecting from a range of longstanding sentencing options, including jail or prison time, probation, or a fine. However, recent years have seen the rise of an array of initiatives in which prosecutors have embraced a broader role through activities such as engaging community members directly to identify and solve local crime problems; collaborating intensively with law enforcement on intelligence gathering and crime prevention; leading the expansion of alternatives-to-incarceration; and reimagining the meaning of prosecutorial success. Well-known models that exemplify aspects of the new prosecutorial role include community prosecution (Boland 2007; Goldkamp, Irons-Guynn, and Weiland 2003; Wolf and Worrall 2004); intelligence-driven prosecution (Tallon, Labriola, and Spadafore 2016); drug courts (Mitchell et al. 2012; Rempel 2014); mental health courts (Rossman et al. 2012); and an assortment of pretrial diversion models that allow defendants to avoid a criminal conviction in exchange for performing community service or attending social services or treatment for their needs. The current study focuses on this last category—prosecutor-led pretrial diversion programs. Through a multi-site study of 16 diversion programs in 11 prosecutorial jurisdictions, we seek to illuminate the goals, policies, impacts, and cost ramifications of this emerging approach.

Prosecutor-Led Diversion

Today's prosecutor-led diversion programs take place either *pre-filing* (after law enforcement forwards a case to the prosecutor but before the prosecutor files formal charges) or *post-filing* (after the court process has begun but before a final case disposition). In a post-filing program, completing diversion requirements typically leads all charges to be dismissed. With pre-filing programs, completion leads a case never to be brought to court. Diversion programs seek to save scarce system resources and allow defendants to avoid the well-known collateral consequences of a conviction or incarceration, including the potential loss of housing or employment, risk of deportation for non-citizens, or a myriad of other deleterious effects on long-term income prospects, employment, or psychological well-being.

Diversion is by no means a new phenomenon. By 1977, over 200 pretrial diversion programs were estimated to exist nationwide (Feeley 1983). After significant growth in the 1970s, diversion waned in the 1980s, in part resulting from a series of negative evaluation findings. Contrary to the expected benefits, early evaluations consistently detected a lack of positive effects on conviction rates, recidivism, or cost savings (e.g., Baker and Sadd 1979; Freed et al. 1983; Salzberg and Klingberg 1983). A particularly common finding was that early diversion programs tended to target extremely low-level cases, where the charges were so minor that the defendants would not have otherwise been exposed to adverse legal outcomes (Baker and Sadd 1979; Feeley 1983). In other words, the early diversion programs tended to engage in what is commonly known as "net widening," or imposing new treatment or service requirements on a group of defendants that, in totality, constitute more onerous conditions than the same defendants would previously have been faced. Net widening represents the *opposite* effect of that which is intended by the creators of most diversion programs, which is to provide a *less* onerous, and a more proportionate, just, and meaningful, alternative to a traditional approach to case processing that would have involved court adjudication and, potentially, conviction and incarceration.

With renewed interest in diversion currently spiking, variously reflecting the influence of ballooning court caseloads (e.g., Greenberg and Cherney 2015; Schauffler et al. 2016), concern over the collateral consequences of a conviction (e.g., NAPSA 2010), and the rise of new funding streams, such as the annual Smart Prosecution Program of U.S. Bureau of Justice Assistance, updated research is urgently needed. Yet, recent studies of recidivism impacts or cost savings are extremely few in number (e.g., for exceptions, see Broner, Mayrl, and Landsberg 2005; Cowell, Broner, and Dupont 2004; Mire, Forsyth, and Hanser 2007; and George et al. 2016).

About the Current Study

To improve upon the limited state of research knowledge, the Center for Court Innovation, the RAND Corporation, and the Association of Prosecuting Attorneys conducted a multisite evaluation of 16 carefully selected diversion programs that were expressly created or led by prosecutors in 11 jurisdictions across the country. Through our multisite study, we sought to answer the following six research questions:

1. **Program Goals:** Which overarching goals were more or less prominent for the prosecutors who created diversion programs?

2. **Diversion Policies:** What eligible target populations and diversion policies are now in place across the country? To what extent do existing programs incorporate evidence-based practices?

3. **Impact on Case Outcomes:** Do prosecutor-led diversion programs reduce conviction and incarceration rates for participating defendants?

4. **Impact on Recidivism:** Do prosecutor-led diversion programs reduce recidivism?

5. **Impact on Cost:** Do prosecutor-led diversion programs produce efficiencies for prosecutor's offices or other criminal justice agencies by routing defendants away from traditional court adjudication and, thereby, avoiding traditional court costs?

6. **Lessons for Prosecutors:** What are the strengths of existing diversion approaches, and what are some of the identifiable challenges or shortcomings?

Overview of the Study Design

In-depth case studies were conducted of the 16 diversion programs listed in Table 1.1. Ten of the 11 prosecutor's offices were situated in large urban settings whose populations exceed 800,000. Some sites were predominantly African-American (Philadelphia), others were largely Hispanic/Latino (e.g., Dallas and Phoenix), and one site served a relatively homogenous white population (Chittenden County, Vermont).

Fifteen programs in ten of the 11 prosecutor's offices were examined utilizing a standardized process evaluation methodology. The methodology for the sixteenth program, run by the Los Angeles City Attorney's Office, differed due to a change of leadership during the study period, leading to a significant reorganization and expansion of diversion programming. These circumstances enabled Los Angeles to be profiled as a case-in-point of how diversion programs can be created or reconstituted in a time of change in a prosecutor's office.

In addition, five programs were selected for rigorous, quasi-experimental impact evaluations, and an overlapping four programs participated in quasi-experimental cost evaluations (see Table 1.2, right-most column).

About This Report

The current publication provides a broad overview of all major study findings. A companion publication provides comprehensive findings from the case studies (Labriola et al. 2017). Additional planned publications will detail full results from the impact and cost evaluations.

Table 1.1. Study Sites

Prosecutor's Jurisdiction	Program Name	Program Start	Jurisdiction Population	Annual Cases (Est.)	Type of Study
Northeast					
Chittenden County (VT)	• Rapid Intervention Community Court Project	2010	161,000	5,000	Process, Impact, Cost
Philadelphia (PA)	• Small Amount of Marijuana Program (SAM) • Accelerated Misdemeanor Program (AMP) • Accelerated Rehabilitative Disposition (ARD)	2010 2010 1972	1,567,000	51,000	Process Process Process
Midwest					
Cook County State's Attorney's Office (IL)	• Cook County Drug School • Cook County Misdemeanor Diversion Program • Cook County Felony Diversion Program	1972 2012 2011	5,238,000	250,000	Process, Impact, Cost Process, Impact, Cost Process
Hennepin County (MN)	• Operation De Novo (Property and Drug Diversion)	1971	1,223,000	6,500	Process
Milwaukee County (WI)	• Diversion Program • Deferred Prosecution Program	2007 2007	957,735	12,800	Process, Impact Process, Impact
South					
Dallas County Attorney's Office (TX)	• Memo Agreement Program	2007	2,553,000	81,000	Process
West					
City of Los Angeles (CA)	• Community Justice Initiative	2013-15	3,949,000	50,000	Process (Special)
Maricopa County (AZ)	• Maricopa TASC Adult Prosecution Program	1989	4,168,000	30,288	Process
Phoenix City (AZ)	• Project ROSE	2011	1,583,000	45,000	Process
San Diego City (CA)	• Beach Area Community Court	2005	1,391,000	20,000	Process
San Francisco (CA)	• Neighborhood Courts	2011	864,816	8,600	Process, Cost

Source for Population Figures: 2015 U.S. Census update. Population figures rounded to nearest thousand.

Chapter 2

Design and Methodology

This chapter summarizes the study design and methodology, respectively for the case studies, impact evaluations, and cost evaluations.

Case Studies of 16 Diversion Programs

The aim of the case studies of 16 programs in 11 jurisdictions was to provide a portrait of prosecutor-led diversion as it exists today.

Site Selection

We intentionally sought well-established, high-volume programs, as we wanted to investigate how prosecutor-led diversion works when it "goes to scale." The focus was not "boutique" programs that serve few actual defendants. While we believe our findings can be generalized to smaller jurisdictions as well, by emphasizing larger prosecutor's offices in our site selection, we both gained the capacity to reach the greatest possible sample sizes for the impact and cost studies, while also maximizing external validity with precisely the types of jurisdictions that can reach the largest numbers of defendants nationwide.

Regarding the individual diversion programs selected for study, we sought variability in: (1) *timing of pretrial diversion*: pre-filing, or prior to the filing of a court case, and post-filing, or after court appearances have begun; (2) *eligible charges*: misdemeanor and felony programs; and both programs targeting a specific type of charge (e.g., drug cases) and programs open to multiple charges; and (3) *geographic region*: our final sites included a geographically diverse sample consisting of two prosecutor's offices in the Northeast, one in the South, three in the Midwest, and five in the West.

Core Process Evaluation Methods

We utilized a standard set of evaluation methods to examine 15 purposefully selected diversion programs operating out of ten of our eleven selected prosecutor's offices. (The eleventh office is discussed below.) These methods included document review, email and

phone question-and-answer sessions, and in-depth, multi-day site visits, each conducted by two members of the research team. The site visits included observations of each programs' participants and procedures as well as in-depth interviews with both high-level stakeholders and supervisors and relevant line staff—including prosecutors at both supervisory and line staff levels and individuals from partner agencies: defense attorneys, judges, probation officers, pretrial services staff, and community-based service providers.

To structure our interviews and observations, we utilized a 31-page, 103-question interview protocol (available in Labriola et al. 2017), comprehensively covering program history, all aspects of the current model, program strengths and challenges, and available data.

Focus Groups

The aforementioned methods were supplemented with focus groups (protocol available in Labriola et al. 2017) with diversion participants enrolled in the following six programs from five of the study jurisdictions:

1. **Chittenden County, Vermont:** Rapid Intervention Community Court;
2. **Cook County, Illinois:** Felony Diversion Program;
3. **Milwaukee County, Wisconsin:** Early Interventions Project participants, encompassing both the Diversion and Deferred Prosecution programs;
4. **San Francisco, California:** Neighborhood Courts program; and
5. **Hennepin County, Minnesota:** Operation DeNovo program.

Los Angeles

The current Los Angeles City Attorney's Office, Mike Feuer, took office July 2013, when the current study was just underway. Our initial plan was to include Los Angeles as an eleventh study site, treated identically to the others. We instead implemented a different set of protocols designed to elicit information specifically about the ramifications of the 2013 change of leadership. Exploring the policies of this new initiative and how it served, in effect, to reconstitute and expand on prior diversion programming provided a unique case study opportunity. Results from our special study of the reconstitution of diversion programs in Los Angeles are the subject of an entire chapter in our companion report that provides a more in-depth set of findings from our case studies in all 11 selected jurisdictions.

Impact Evaluations of Five Diversion Programs

Three sites (Cook County, Chittenden County, and Milwaukee) were selected for quasi-experimental impact evaluations on the basis of our evaluability assessments from the case study site visits, which queried staff interest and willingness to participate; data content and quality; and overall logistical feasibility of conducting such an analysis. We also sought higher volume programs with a comparatively robust and well-established model (pointing to Cook County and Milwaukee), while also favoring the inclusion of Chittenden County, which was the only relatively small jurisdiction in our original sample of 11 sites.

Five programs were included at the selected sites: two in Milwaukee (both Diversion and Deferred Prosecution); the sole program in Chittenden County (Rapid Intervention Community Court); and two programs in Cook County (Misdemeanor Deferred Prosecution Program and Drug School). The Cook County Drug School sample was split into misdemeanor and felony sub-samples, which were analyzed separately. (This split enabled creating better matched samples between diversion participants and comparison defendants for each charge severity, but, ultimately, Drug School is still a singular program model.)

For each program, we obtained a de-identified dataset including demographics, criminal histories, and instant case outcomes for a sample of participants and comparison defendants that fell within the confines of a pre-specified sampling frame (for more, see the Technical Appendix on Impact Methodology). After assembling and cleaning the data from each sample, we identified each individual's instant case as either the arrest that triggered entry into the diversion program or, for comparison defendants, the first arrest within the specified timeframe. The final disposition was then recorded for this case, and prior arrests and re-arrests (and their associated charges and severity) were then identified and summed.[1]

The next step was to perform a propensity score match for each sample to statistically equalize treatment and comparison groups on an array of demographic, criminal history, and

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[1] Substantial proportions of case dispositions were unavailable for the Cook County programs: 40% for misdemeanor Drug School cases, 30% for felony Drug School cases, and 58% for Cook County's Misdemeanor Deferred Prosecution program. No correlation was found between missing data and any background variable (e.g., date of arrest, age), so we assumed that case outcome data was missing at random. Nonetheless, the sizable quantity of missing disposition data in this site is a notable study limitation.

instant case variables (see, e.g., Rosenbaum and Rubin 1983; Rubin 1973). This procedure is described in the Technical Appendix. The results, presented and described in more detail in the Technical Appendix, indicate that propensity score matching was successful in balancing the samples of observable background variables. Having established the equivalence of the treatment and comparison groups, we were in a good position to perform an impact analysis of diversion programs on case dispositions, sentences, and re-arrest outcomes.

Cost Evaluations of Four Programs

Three of the same programs selected for the impact evaluation were also included in the cost study: Cook County's Drug School and Misdemeanor Deferred Prosecution programs and Chittenden's Rapid Intervention Community Court. For data availability reasons, the two Milwaukee programs were omitted. In their place, we added the San Francisco Neighborhood Courts program. Data were obtained using administrative records and interviews with key staff. For those agencies from which we could not collect this information, we relied on available estimates in the literature specific to the jurisdictions studied. (A separate Technical Appendix on Cost Methodology provides further details.)

For each cost evaluation, we included: (1) costs that go into a case (*investment costs*) for the Prosecutor's Office, Public Defender's Office, and Court; and (2) costs that result from the disposition/judgment of a case (*output costs*) for the prosecutor's office, service providers, and corrections. For this purpose, diversion is considered a type of judgment and associated costs are, therefore, treated as output costs.

Figure 2.1 shows the main stages of a case that are included in the cost analysis—intake and charging to arraignment, pretrial, trial, and judgment and lastly post-judgment. Not all cases go through every stage (e.g. trial). Therefore, for each program under study, we used data on the probability that a case will continue through each stage. In each stage, there are relevant actors (prosecution, court, public defender) for whom we collected data through interviews. In all cases, we used literature for corrections and interview service providers for their costs per person, and data on sentence length to calculate output costs (e.g., cost of jail).

Investment Costs

We refer to activities involved in adjudicating a case as "investment costs" (Byrne et al. 2005). Using a list of potential activities to process similar cases that do and do not go

through each diversion program, relevant individuals (e.g. assistant prosecutors) identified the time they spend on each type of activity for each case. Given the uncertainty and range in reporting case processing times, individuals provided the typical time they spend on a case, as well as the minimum time (more straightforward cases) and maximum time (more complex cases). We then applied a relevant monetary value (hourly pay by job type and indirect cost rate) and aggregated to generate the average investment cost per case, which is weighted by the proportion of cases that go through three distinct pathways: (1) early plea, (2) later plea, and (3) trial. Successfully diverted cases are also treated as a distinct category.[2]

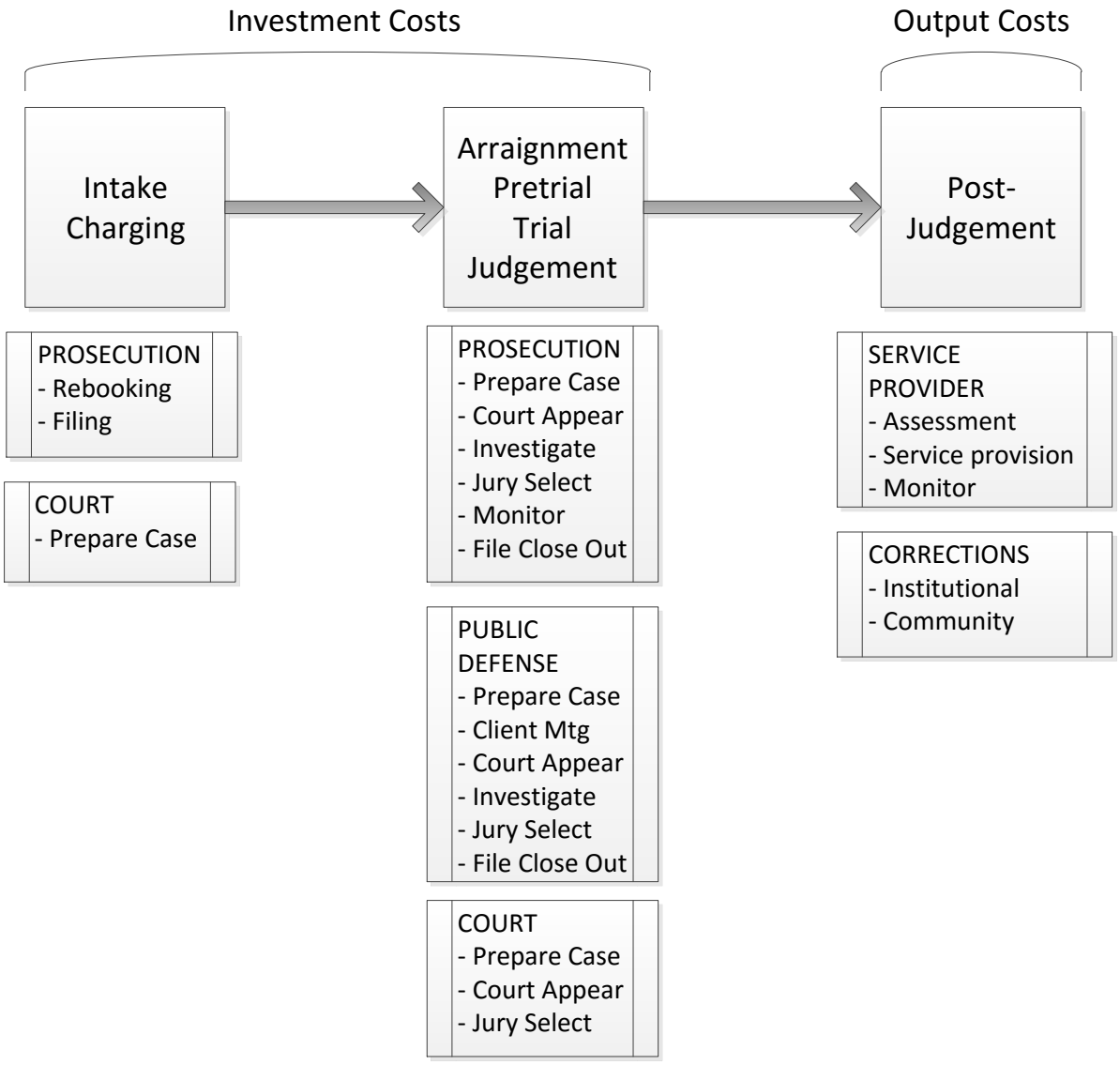
Output Costs

We also calculated the resources spent on the disposition of cases, or output costs. For this purpose, we used the proportion of cases resulting in each disposition and average sentence and the relevant cost. Specifically, for cases that go through the pretrial diversion program, every provider (e.g., community-based service provider) had contracts with the prosecutor's office. For those providers that did not provide the cost per participant, we generated the average cost per person, dividing the annual contract amounts into the number of people in the program. For similar cases that go through the traditional route, we generated the cost by using the proportion receiving each main sentence type (jail, probation, split sentence, other diversion) for each eligible crime types, along with average sentence length and cost per unit.

For more details on how costs were calculated for each program, and how the cost-effectiveness analysis was conducted, see the Technical Appendix on Cost Methodology.

[2] The exact activities depend on the program, actor, and stage. For example, preparing a case can include activities (and related costs) such as: review arrest report, review criminal record, review evidence (e.g. video), paperwork, prepare and issue subpoenas, legal research, write decision, discovery-related work, order supplements, discuss case with witnesses. And court appearances can include judge instructions, case discussion (e.g. testimonies, physical evidence), sentence discussion, plea, waiting, pre-sentencing investigation, judge comments, and victim statements.

Figure 2.1: General Cost Methodology



Chapter 3

The Goals of Prosecutor-Led Diversion

We expected that prosecutors might have varying rationales for diverting cases. Faced with crushing caseloads and increasingly limited resources, diversion might be appealing for reasons of resource efficiency and cost savings—i.e., routing some cases away from traditional prosecution and, as a result, saving resources for the prosecution of more serious cases. In addition, consistent with the rationale for other alternative-to-incarceration programs, prosecutors might seek to divert cases in order to link defendants to rehabilitative services that could potentially address the underlying causes of their criminal behavior and, thereby, reduce recidivism. We also assumed that some prosecutors might intend to help defendants by reducing the collateral consequences of a conviction. By requiring strict compliance with required diversion services, some prosecutors might see diversion as an effective means of promoting defendant accountability.

During semi-structured interviews, we asked program staff and stakeholders to assess the importance of the following 12 goals as well as to add other goals they considered important.

1. Hold defendants accountable for their illegal behavior;
2. Rehabilitate defendants by treating their underlying problems;
3. Reduce defendant recidivism;
4. Use prosecutorial resources more efficiently;
5. Use court resources more efficiently;
6. Provide line prosecutors with more plea bargaining options;
7. Reduce the collateral consequences of conviction for defendants;
8. Have the defendants gain insight into the harm their behavior caused;
9. Involve victims in prosecutorial decisions and outcomes;
10. Involve community members in prosecutorial decisions and outcomes;
11. Provide more discriminating responses to different types of defendants (e.g., high-risk and low-risk); and
12. Increase public confidence in the prosecutor's office.

In order to simplify the resulting information, we then collapsed the goals into seven overarching categories: (1) Administrative Efficiency/Cost Savings; (2) Reduced Collateral Consequences; (3) Community Engagement; (4) Defendant Accountability; (5) Recidivism Reduction; (6) Rehabilitation; and (7) Restorative Justice.

Results are available for all programs except the Community Justice Initiative in Los Angeles. As shown in Table 3.1, the most widely and strongly embraced goals (based on an assessment that they are "extremely important"[3] to program staff) were: administrative efficiency/cost savings (cited at 10 programs) and reduced collateral consequences for defendants (cited at 10 programs). These goals were followed by recidivism reduction (7 of 15), rehabilitation (7 of 15), and restorative justice (7 of 15). Detailed staff and stakeholder interview data collected during case study site visits also generally yielded themes and findings that track this order of importance across sites.[4]

Staff at most prosecutor-led diversion programs embraced, not one, but multiple, diverse goals; in fact, staff at nine of the 15 programs (60%) cited "extremely important" goals in at least three of the seven categories. As presented in the rightmost column in Table 3.1, we identified four *broad scope* programs with extremely important goals in five or more categories, six *moderate scope* programs with goals in three or four categories; and five *narrow scope* programs with goals in one or two of the categories.

[3] Limiting the table to goals selected as "extremely important" allowed us to display and learn from variation; staff at most programs listed nearly all goals as important to at least some degree.

[4] During our interview protocol, staff were asked specifically to rate each goal's importance (beginning with the initial list of 12 goals) on a Likert scale. For the most part, the Likert scale responses inform how programs are classified in Table 3.1, although in a small few instances, researchers adjusted the coding for specific sites based on more in-depth, open-ended question and answer sections of the protocol, where such interactions ultimately drew primary attention to a goal that had not initially been placed in the "extremely important" category.

Table 3.1. Goals of Prosecutor-Led Diversion Programs

Program Name	Goal Categories							Program Scope
	Administrative Efficiency/Cost Savings	Reduced Collateral Consequences	Community Engagement	Defendant Accountability	Recidivism Reduction	Rehabilitation	Restorative Justice	
Chittenden County (VT) Rapid Intervention Community Court (RICC)	✓	✓		✓			✓	moderate
Cook County (IL) Drug School		✓			✓			narrow
Cook County (IL) Felony Deferred Prosecution Program		✓			✓		✓	moderate
Cook County (IL) Misdemeanor Deferred Prosecution					✓			narrow
Dallas Memo Agreement Program	✓	✓						narrow
Hennepin County, MN: Operation De Novo (Property and Drug)	✓	✓					✓	moderate
Maricopa County (AZ) Treatment Assessment Screening Centers	✓	✓		✓	✓	✓		broad
Milwaukee County (WI) Diversion Program						✓		narrow
Milwaukee County (WI) Deferred Prosecution Program						✓		narrow
Philadelphia Accelerated Misdemeanor Program (AMP 1 and AMP 2)	✓	✓	✓	✓	✓	✓	✓	broad
Philadelphia Accelerated Rehabilitation Disposition	✓	✓		✓		✓	✓	broad
Philadelphia Small Amount of Marijuana (SAM)	✓	✓	✓	✓	✓	✓		broad
Phoenix Project ROSE	✓	✓			✓	✓		moderate
San Diego Beach Area Community Court (BACC)	✓		✓				✓	moderate
San Francisco Neighborhood Court (NC)	✓		✓				✓	moderate
Number of programs represented in goal category	***10***	***10***	***4***	***5***	***7***	***7***	***7***	

Chapter 4

Target Population, Program Policies, and Local Perspectives

This chapter provides an overview of the major policies put into place across the 15 programs that we profiled through our standard case study methodology. A separate section towards the end of this chapter briefly summarizes the major components of the sixteenth featured program, the newly established Community Justice Initiative in Los Angeles. Finally, we summarize the major themes and findings from staff and stakeholder interviews at all 15 programs and from focus groups held with participants at six of the programs.

Target Population

In general, identifying the target population requires program developers to make four fundamental decisions: (1) determining whether to establish a *pre-filing* or *post-filing* program; (2) identifying the eligible *charge severity*—felony, misdemeanor, citation, or lesser charge; and (3) targeting only select *charge types* (e.g., drugs, property, or prostitution) or many or all types; and (4) setting *criminal history restrictions* (e.g., first-time only or priors allowed). Table 4.1 indicates how these decisions played out across the 15 programs.

Timing of Diversion: Pre-Filing or Post-Filing

Of the 15 programs in question, eight were *post-filing*, meaning that pretrial diversion takes place after a court case is officially filed; three programs were *pre-filing*, meaning that they enroll participants prior to—and in lieu of—the filing of the court case; and four programs enroll participants either pre- or post-filing depending on case specifics (*mixed model*).

In theory, pre-filing programs offer a greater opportunity to save time and resources for prosecutors and other court players—since diversion occurs prior to any court appearance. Pre-filing programs also minimize collateral consequences for defendants. For example, in pre-filing programs, defendants avoid lost time or wages while attending court dates and avoid the potentially stigmatizing psychological effects of court attendance and involvement.

Post-filing programs, on the other hand, are the only logistically or legally feasible option in some jurisdictions where cases are rapidly transferred from law enforcement to their first court appearance (e.g., in Cook County, Illinois). Where prosecutors can avail themselves of either option, post-filing programs also afford greater legal leverage, since a judge is assigned to the case and can monitor compliance and swiftly sanction noncompliance. For example, the Maricopa County TASC Program explicitly diverts some cases pre-filing and others post-filing based on the amount of legal leverage deemed appropriate in the individual case; specifically, defendants with a prior criminal history and/or prior failures to appear for scheduled court appearances are more likely to be diverted post-filing.

Charge and Criminal History Restrictions

Shown in Table 4.1,[5] six of the programs accept only misdemeanors (or citations), three accept only felonies, and six programs take a mix of misdemeanor and felony cases.

Nine of the 15 programs (60%) do not narrowly specialize in a specific charge type. Among the remaining programs, diverting drug or marijuana possession cases is especially common: The Cook County Drug School and Maricopa TASC programs are for drug or marijuana cases; the Philadelphia Small Amount of Marijuana program is for low-level marijuana cases; the Hennepin County program has separate tracks that are respectively for felony level drug possession and property cases; and the Dallas Memo Agreement program primarily targets retail theft and marijuana possession misdemeanors. Differing from these models, Phoenix's Project ROSE targets misdemeanor prostitution cases (see pull-out box below).

As shown in Table 4.1, most programs have at least some eligibility restrictions tied to criminal history (e.g., excluding cases with prior violent convictions or excluding cases with certain numbers of prior convictions, regardless of the charge).[6]

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[5] Several programs have additional eligibility restrictions beyond what is listed. In particular, some programs target or exclude long lists of specific charges or limit eligibility based on further case specifics (e.g., whether underlying drug sales is involved or whether the victim consents to participation). Table 4.1 provides eligibility essentials, not an exhaustive list of criteria.

[6] Several programs have additional eligibility restrictions beyond what is reflected in Table 4.1. For instance, some programs either target or exclude long lists of specific charges, limit eligibility based on probation status, or limit eligibility based on other specifics (e.g., whether

Eligibility for Project Rose in Phoenix

Phoenix's Project ROSE specializes exclusively in misdemeanor prostitution cases. Since local prostitution defendants with three prior convictions are charged with a felony, they are ineligible. In arguably the most demanding program model we observed relative to charge type and severity, Project ROSE requires participants to complete 66 hours of educational, life skills, support group, and/or trauma-informed treatment classes over six months, presenting the diversion option to participants as an explicit alternative to certain jail time.

Screening and Enrolling Cases

Having established formal eligibility criteria, each program designates a unit or individual, in almost all cases from the prosecutor's office, to screen and enroll cases. In general, the entity that screens cases may use discretion to rule out some cases that ostensibly meet formal legal criteria, as defined above. However, indicated by annual volume numbers provided in Table 4.1, the screening process in most of our profiled programs is not so restrictive as to prevent sizable numbers of individuals from participating. Annual volume in six of the 15 profiled programs exceeds 1,000 and, at the other end of the spectrum, only Phoenix's Project ROSE enrolled less than 100 individuals in the year for which data was collected.

Risk and Needs Assessment

Only four programs use a formal, validated risk assessment tool. Both Chittenden and Maricopa Counties use the Ohio Risk Assessment System (ORAS) to inform the specific choice of service mandates. Milwaukee uses the LSI-R for both of its diversion programs as part of systematic, universal screening and assessment process (see pull-out box below).

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underlying drug trafficking is involved or whether the victim consents to participation). Table 4.1 provides each program's target population essentials, not an exhaustive list of all criteria.

Table 4.1. Target Population

Program Name	Filing Stage	Charge Severity	Charge Type	Major Criminal History Restrictions or Other Key Criteria	Annual Volume (2012 or 2013)
Chittenden County (VT) Rapid Intervention Community Court Project	Mixed	Misd, Fel, or Citations	Not specialized	No history of sex offenses, offenses involving bodily harm, gang offenses, or commercial drug dealing. No gun charge or domestic violence charge. Cannot currently live in a residential treatment facility.	327
Cook County (IL) Drug School	Post	Misd/Fel	Drug charge (possess. drug paraphernalia, ≤100 gm cannabis, ≤2.5 gm. other drugs)	No prior violent conviction (typically within a 10-year window) or prior drug conviction. No current open case. Current case does not involve an underlying drug dealing/manufacturing charge.	3,384
Cook County (IL) Felony Diversion Program	Post	Fel	Not specialized (limited to select nonviolent felonies)	No prior violent conviction (typically within a 10-year window), felony conviction, arrest for delivery of controlled substance. No current open case.	734
Cook County (IL) Misdemeanor Diversion Program	Post	Misd	Not specialized (but limited to nonviolent misdemeanors)	No prior violent conviction (typically within a 10-year window) or prior conviction for child-related offense. No current open case.	1,154
Dallas Memo Agreement Program	Post	Misd	Mainly retail theft or marijuana possession	No prior arrest. Select charge exclusions (e.g., no public lewdness, indecent exposure, family violence, DWI, or prostitution).	1,600
Hennepin County (MN) Operation De Novo, Property and Drug Diversion	Mixed	Fel	Drug- or property-related felonies	No prior felony conviction, no more than 3 misdemeanor convictions. No drug sales. Cannot owe more than $5,000 to a citizen or $10,000 to the government. Select other charge exclusions (e.g., burglary, identity theft, theft of public funds, or underlying domestic violence in the current case).	663 (drug & property diversion)
Maricopa County (AZ) TASC Adult Prosecution Program	Mixed	Fel	Drug- or marijuana-related	No prior drug offense or dangerous offense; not more than two prior convictions (any charge); no known gang membership; not on felony probation; not involved with TASC within the past year.	2,901
Milwaukee County (WI) Diversion Program	Pre	Misd/Fel	Not specialized	Risk assessment criteria: LSI-R:SV classification of low risk. Excludes select charges (e.g., violent, firearms, sex offense, drug sales).	277
Milwaukee County (WI) Deferred Prosecution Program	Post	Misd/Fel	Not specialized	Risk assessment criteria: LSI-R:SV above low risk and LSI-R of medium risk. Excludes select charges (e.g., violent, firearms, sex offense).	478
Philadelphia Accelerated Misdemeanor Program (AMP)	Post	Misd	Not specialized (but only nonviolent misd.)	No prior violent conviction (typically within a 10-year window)	5,474
Philadelphia Accelerated Rehabilitative Disposition (ARD)	Post	Misd/Fel	Not specialized	No prior conviction; not more than one prior arrest. No violent crimes with weapons, no possession cases with intent to deliver; no domestic violence cases; no DUI with injury, no for most weapons cases.	1,291
Philadelphia Small Amount of Marijuana Program (SAM)	Post	Misd	Marijuana possession <30 gm.	No violent felony convictions in past three years or within two years of parole for such crime; not in possession of a gun at time of arrest.	3,194
Phoenix Project ROSE	Pre	Misd	Prostitution	No more than 3 prior prostitution convictions, no prior ROSE completion.	86
San Diego Beach Area Community Court (BACC)	Pre	Misd/Citations	Not specialized	First time in BACC. No violent charges, sex offenses, or gang members. “Chronic” offenders or homeless persons are referred elsewhere.	150
San Francisco Neighborhood Courts (NC)	Mixed	Misd/Fel	Not specialized	Active probation or parole cases are referred on case-by-case basis. No current open case. No violent charges. Prior convictions allowed on prosecutor’s individual discretion.	376

Universal Screening and Risk-Informed Decision-Making in Milwaukee

In a unique model amongst all programs examined, Milwaukee County adopted a universal screening and assessment protocol that is operated by the courts and used by the District Attorney's Office to aid in producing diversion eligibility determinations as well as producing determinations of which of the two diversion programs—Diversion or Deferred Prosecution—are most suitable in each case.

The process works as follows: First, every defendant who is arrested and booked into the County's Central Criminal Justice Facility are administered the short-form LSI-R:SV assessment, a brief risk-need screener that classifies defendants as low, medium, or high risk of re-offense. Among defendants who are legally eligible for diversion, those in the low risk category are routed to the less intensive pre-filing Diversion program, which typically involves community service, restitution, and possibly a restorative justice conference. The Diversion program does *not* involve intensive treatment for underlying criminogenic needs, but then since the defendants are low-risk, such treatment is counter-indicated.

Those defendants whose risk level is medium or high on the LSI-R:SV are then administered the full-length LSI-R assessment, a comprehensive, well-validated risk-needs assessment tool that covers all of the "Central Eight" factors that have repeatedly been shown to predict re-offending, including criminal history, antisocial attitudes, antisocial peer associations, and substance abuse (Andrews and Bonta 2010; Bonta and Andews 2007). Legally eligible defendants who are classified as medium risk on the full-length LSI-R are routed to the more intensive post-filing Deferred Prosecution program, which involves an intensive, individualized treatment plan, possibly including alcohol or drug treatment, drug testing, community service, restitution, employment counseling, or other needs-based services.

Finally, high risk defendants on the LSI-R are ineligible for both diversion programs.

As of when case study data was collected, no other program outside of Milwaukee's had adopted a similarly rigorous protocol for risk-informed decision-making. However, evaluated separately in conjunction with the Smart Prosecution Program of the Bureau of Justice Assistance, the Cook County State's Attorney's Office adopted an analogous protocol for its Misdemeanor Deferred Prosecution Program in 2015 (see Labriola, Ramdath, and Kerodal 2017).

Regardless of whether the programs assess for risk, nine of the 15 (60%) administer at least some form of needs assessment. Results are primarily used to determine appropriate services (e.g., alcohol or drug treatment, employment or educational services, need for Spanish-language programming, cognitive or behavioral treatment needs, and other service needs).

Program Mandates

Table 4.2 provides a snapshot of the basic types of program mandates utilized by each program. Five programs have adopted a straightforward approach, linking participants to a standard set of educational classes, community service hours, or other requirements. While a "one size fits all" philosophy may seem antithetical to well-crafted treatment and rehabilitation aims, it bears reiterating that not all programs prioritized these aims (see previous chapter). Instead, many programs prioritized the benefits of greater resource efficiency for the system or a variety of other goals—most importantly, helping defendants to avoid the collateral consequences of a conviction.

Six other programs, including Milwaukee's (see pull-out box above), use individualized mandates, tailored to the needs of each defendant. Finally, two of Cook County's programs use a mix of standardized and individualized mandates; and Philadelphia's Accelerated Misdemeanor Program (AMP) divides participants into one of two tracks (AMP 1 and AMP 2), the latter of which includes more intensive, individualized mandates.

Other mandate components include the following:

- **Education about the Defendant's Problems:** Thirteen of the 15 programs link at least some participants to educational classes about the relevant problem behavior, including classes about drugs, driving, theft, prostitution, weapons, health, and/or parenting.

- **Community Service:** Ten of the 15 programs order at least some participants to perform community service.

- **Cognitive-Behavioral Therapy:** Staff at only one program (Maricopa's TASC) explicitly cited the use of evidence-based cognitive-behavioral therapy (CBT), which seeks to change maladaptive or antisocial thoughts as well as impulsive decision-making tendencies that contribute to drug use and/or other criminal behavior. Subsequent to the timing of research interviews, we learned that some participants in San Francisco's Neighborhood Courts program receive CBT, and at least some participants in Milwaukee's Deferred Prosecution Program receive the same; at the time of our case

study was conducted, Milwaukee was just then seeking to add a new CBT option specifically to address criminal thinking patterns.

- **Restorative Justice:** Only four programs use restorative justice groups with at least some participants. For San Francisco's Neighborhood Courts program (see pull-out box below) as well as Los Angeles' newly created Neighborhood Justice Initiative, described below in a separate section, restorative justice represents the guiding philosophy of the model.

San Francisco's Neighborhood Courts Program

San Francisco had adopted a particularly unique diversion model due both to the neighborhood focus and to the use of *restorative justice* as a central organizing principle. As background, San Francisco is divided into ten neighborhood-based police districts. By the spring of 2012, each district established a local "Neighborhood Court," working in partnership with a dedicated neighborhood prosecutor. Although called a "court," the neighborhood-based sites are not technically criminal courts—the program in fact predominantly uses a pre-filing diversion model.

Individuals arrested on eligible misdemeanors or felonies are offered the opportunity to participate in Neighborhood Court. If they choose to do so, they report to their neighborhood site where they meet with trained Neighborhood Court Adjudicators—volunteer community members trained in restorative principles. During their "hearing" they accept responsibility for their behavior and discuss the harm they have caused. Volunteer adjudicators then issue individualized "directives" that participants then typically complete over the next 30-60 days. According to staff, directives can vary significantly based on the seriousness of the offense, the defendant's needs, and the extent to which the defendant appears apologetic and conveys responsibility. Victims may also meet with the adjudicators to discuss the incident and their restorative needs. Potential mandates are letters of apology, reflective essays, community service, needs-based classes, cognitive behavior therapy groups and other programming. Any restitution owed to victim must be paid. Staff indicated that there are "hundreds" of individualized options for services or classes. Ultimately, the main goals of the program are restorative: involve community members in prosecutorial decision, have the defendants gain insight into the harm they caused, and treat the defendants as individuals. Sessions are offered during both daytime and evening hours to facilitate participation. Like many pre-filing programs, this one also aims to save prosecutorial resources for more serious cases.

Table 4.2. Diversion Program Mandates

	"One Size Fits All" (Universal Mandate)	Some Universal & Individ-ualized Elements	Individ-ualized Mandates Only	Education About Presenting Needs	Cognitive-Behavioral Therapy	Commun-ity Service	Group Coun-seling	Restor-ative Justice	Average Duration	Average Dosage
Chittenden County (VT) Rapid Intervention Community Court			X	Some		Some	Some	Some	Usually 90 days	Varies
Cook County (IL) Drug School	X			All					3 months	4 classes: 2.5 hours/class
Cook County (IL) Felony Deferred Prosecution Program		X		Some		Some	Some		9-12 months	Varies
Cook County (IL) Misdemeanor Deferred Prosecution Program		X		Some			Some		1 week to 3 months	2 appointments
Dallas Memo Agreement Program	X			Some		All	Some		60 days	24-36 hrs. community service + classes
Hennepin County, MN: Operation De Novo			X	Some		Some	Some		Varies	Varies
Maricopa County (AZ) TASC Adult Prosecution Program	X			All	All		All		24 days	1 hour/day
Milwaukee County (WI) Diversion Program		X				Some		Some	6 months	Varies (but limited: mainly community svc.)
Milwaukee County (WI) Deferred Prosecution Program		X				Some	Some		6 months	Varies (see pull-out box)
Philadelphia Accelerated Misdemeanor Program (AMP 1 and AMP 2)	AMP I		AMP 2	Some		All AMP 1/ Some AMP 2	Some	Some	AMP 1: 5-10 weeks/ AMP 2: 15-20 weeks	AMP 1: 12-18 hrs/ AMP 2: Varies
Philadelphia Accelerated Rehabilitation Disposition		X		Some		Some			6 months-2 years	Varies
Philadelphia Small Amount of Marijuana (SAM)	X			All					1 day	3-4 hours
Phoenix Project ROSE	X			All			All	All	6 months	66 hours
San Diego Beach Area Community Court (BACC)	X			All		All			2 days	3 hours/day
San Francisco Neighborhood Court (NC)		X		Some	Some	Some	Some	All	Varies	Varies (see pull-out box)

Legal Leverage

Diversion participants who do not successfully complete program requirements risk court filing (pre-filing) or resumption of their court case (post-filing) in all 15 programs examined. Staff in every diversion program except Project ROSE in Phoenix reported giving noncompliant participants "second chances." Participants in the Cook County's Drug School program, for example, could miss multiple classes—but they would often have to restart the program from the beginning. Staff indicated that participants in Milwaukee's programs receive "numerous opportunities" to make up for failed drug tests, and time was frequently extended for participants to pay restitution costs.

Local Perspectives: Themes and Findings from Staff, Stakeholders, and Program Participants

This section provides a snapshot of the major themes and findings emerging in staff and stakeholder interviews at all 11 sites and 16 programs and in focus groups with participants in six programs: Cook County's Felony Diversion Program; Hennepin's Operation De Novo program; Milwaukee's two programs; San Francisco's Neighborhood Courts; and Chittenden's Rapid Intervention Community Court. Complete findings may be found in Labriola et al. (2017).

Staff and Stakeholders

Benefits of Diversion: When asked to summarize the strengths of their diversion programs, staff and stakeholders most often underscored: (1) speedier case processing and related cost savings; (2) reduced collateral consequences of a conviction—with respondents especially emphasizing the implications for defendants' future employability; and (3) strong interagency collaboration, both among different justice agencies and community-based providers. In addition, staff at the San Francisco and Chittenden sites, both of which employ restorative justice approaches, emphasized the benefits of having defendants, victims, and/or community members each be able to tell their stories and have a voice in the process.

Program Challenges: Respondents from each site named distinct challenges, although several cross-site themes were also apparent. They included: (1) a lack of resources (e.g., lack of funding to serve more defendants, lack of space for community-based programming, and reliance on old/outdated technology; (2) need for administrative improvements—

especially a better system for service providers to report compliance information efficiently to the justice players; and (3) need for enhanced programming (e.g., more individualized programming or expanded drug and alcohol treatment slots).

Program Participants

Motivation to Participate: Focus group participants across all sites described the decision to participate as an easy one to make, variously citing diversion as better than jail, wanting to have their court cases end more quickly, and reducing the chance of missing work or getting fired than would have been more likely to happen in the traditional process (e.g., due to a conviction or to missing work to attend court).

Individualized Accommodations: Focus group participants across most sites responded positively to program elements that were individualized. These elements variously included: tailoring specific services and requirements to participants' needs; allowing classes or appointments to be rescheduled based on personal circumstances or scheduling conflicts; and providing extra time to complete the program if they ran into problems. However, participants in two sites expressed the opposite view on the specific issue of scheduling, lamenting a lack of flexibility with appointment times.

Fairness: Focus group participants largely believed they were treated fairly by program staff. In Milwaukee, several participants agreed that they were treated "more than fairly," and one Chittenden County participant agreed that this program was "… more than fair. Fair, fair, fair, across the board." Some participants explicitly compared the fairness of diversion to the opposite experience in traditional courts. Expressing a commonly heard sentiment, one San Francisco participant stated, "[In the traditional court] they kind of forget about our rights … It's totally different with Neighborhood Courts, they actually care."

Chapter 5

Impact Findings at Five Programs

The five programs selected for the impact study, while incorporating a diverse range of specific program policies, were all relatively well-established, high-volume models.

- **Cook County Felony Drug School:** In operation since 1972, Drug School is a post-filing program for either misdemeanor or felony defendants facing drug or marijuana possession charges. Participants must attend four standardized drug education classes of two and half hours per class, with one curriculum for younger defendants ages 17-25 and another curriculum for older defendants ages 26 and up.

- **Cook County Misdemeanor Deferred Prosecution Program:** Established in 2013, this post-filing program is open to a wide range of nonviolent misdemeanor cases. Based on a short assessment conducted before enrollment, participants are assigned to two community-based appointments involving a more in-depth needs assessment and voluntary referrals for further services. Veterans are placed on a special "veterans" track.

- **Milwaukee Diversion Program:** Established in 2007, pre-filing enrollment targets a wide range of misdemeanors and felonies, as long as the LSI-R:SV risk assessment classifies the defendant as "low risk." Participants receive a relatively low service dosage (responsive to their low risk), consisting mainly of community service, required restitution, and, possibly, attendance at a restorative justice conference.

- **Milwaukee Deferred Prosecution Program:** Also established in 2007, the post-filing Deferred Prosecution program has generally the same exclusions as those for the Diversion program, except that the target population is classified as medium risk on the full-length LSI-R. Participants can receive a range of individualized treatment and social services.

- **Chittenden County Rapid Intervention Community Court:** Since 2010, this program is open to felony, misdemeanor, and citation defendants—but mainly targets low-level charges. Based on a risk-needs assessment using the ORAS tool, participants are assigned to individualized treatment, services, or restorative justice components.

Staff from all five programs cited recidivism reduction and/or rehabilitation as an extremely important goal, and staff from the Cook Drug School and Chittenden program also cited reducing collateral consequences for the defendants (e.g., conviction or incarceration).

Analytic Plan

Having successfully matched the program participants to comparison defendants (see Chapter 2 and the Technical Appendix on Impact Methodology), the next step was to examine program effects on: (1) instant case outcome (convicted or not); (2) use of jail; and (3) two-year re-arrest. To facilitate cross-site comparisons, we also computed odds ratios for each outcome as an estimate of effect size. Essentially, an odds ratio less than 1.00 indicates a positive effect—i.e., diversion participants were *less* likely than comparisons to have the given undesired outcome (conviction, jail, or re-arrest), whereas an odds ratio greater than 1.00 indicates a negative effect (diversion participants were more likely to have an undesired outcome). In addition, survival analyses were conducted to provide a richer comparison of re-arrest outcomes than a simple dichotomous measure of re-arrest at the two-year mark.

Although the general consistency of the results across sites (see below) is promising from the standpoint of study generalizability, it remains a limitation that only three jurisdictions and five programs were included in the evaluation. Other diversion programs may not necessarily produce similar results. Additional limitations tied to data quality and comparison group sample size, especially for Cook County, are discussed in the Technical Appendix.

Results

Conviction Rates

As shown in Table 5.1, the pretrial diversion programs produced a considerable decrease in the percentage of cases ending in conviction (and, therefore, in exposure to the collateral consequences of conviction). All statistical tests were significant in the expected (positive) direction. Results pointed to an especially large magnitude of impact in the Milwaukee Diversion program (9% of diversion compared to 74% of comparison group convicted), the Chittenden County Rapid Intervention Community Court (16% compared to 64% convicted), and among felony defendants who participated in the Cook County Drug School (3% compared to 63% convicted).[7]

[7] Estimates for the Cook County Drug School programs were weighted to adjust for differential rates of missing case disposition data in the diversion and comparison samples.

Although all five programs reduced the conviction rate on balance, it remains notable that more than half of the *comparison group* in the Cook County Misdemeanor Deferred Prosecution Program and among misdemeanor defendants in the Cook County Drug School program had their cases dismissed. It is likely that some of these dismissals followed few court appearances and, ultimately, required of the defendants less time, and less onerous obligations, than diversion participation. Our impact evaluation was not explicitly designed nor was data available to make possible pinpointing the precise experience of defendants in the comparison group who had their cases dismissed. Nonetheless, it is conceivable that, in relative terms and especially in the aforementioned Cook County sites, diversion led to a degree of net widening for some defendants who might otherwise have received a dismissal without having to complete any diversion requirements.

Use of Jail

Pretrial diversion programs were also effective in reducing the use of a jail sentence. This was largely driven by their larger percentage of dismissed cases (none of which received jail time). Overall, Milwaukee's Diversion program (4% vs. 50%) and felony defendants participating in Cook County's Felony Drug School (1% vs. 37%) produced the greatest decrease in the use of jail. On the other end of the spectrum, jail was rare among eligible misdemeanor defendants for the Cook County Drug School, either among diversion participants (zero) or matched comparisons (5%).

Recidivism

The lower section of Table 5.1 shows that four of five programs examined—both Milwaukee programs and both Cook County programs—reduced the prevalence of two-year re-arrest and, for those re-arrested, delayed the time to re-arrest, when comparing diversion and comparison group defendants.[89] The fifth program, Chittenden County's, did not produce

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[8] The sole caveat and exception to this general conclusion is that while the Cook County Misdemeanor Deferred Prosecution program significantly reduced the two-year re-arrest rate, those program participants who were re-arrested were re-arrested after less time.

[9] Although not all findings were statistically significant, at least one two-year re-arrest finding reached statistical significance ($p < .05$) for at least one outcome measure in the analysis of three programs, while a fourth program achieved a two-year re-arrest impact that approached significance ($p < .10$).

significant differences in the occurrence of two-year re-arrest, but did significantly lengthen the time to first re-arrest.

Summary

Taken together, the results indicate that although there is clearly variation between programs in all outcomes, the general trend appears to be towards far fewer convictions, less use of jail (mainly as a byproduct of fewer convictions and, hence, less exposure to any sentence), and reduced re-arrest for the diversion programs.

Table 5.1. Impacts on Case Dispositions, Sentences, and Recidivism

	Milwaukee Diversion		Milwaukee Deferred		Chittenden County RICC	
	Diversion	Comparison	Deferred	Comparison	RICC	Comparison
	N = 139	N = 139	N = 290	N = 290	N = 268	N = 536
Case Disposition						
Pled Guilty/Convicted	9%	74%[d]	52%	70%[e]	16%[f]	64%
Dismissed/Not Convicted	91%	26%***	48%[g]	30%***	84%	36%***
Odds Ratio for Conviction	.03		.47		.10	
Sentence						
Of all defendants						
Jail	1%	14%	27%	18%	0%	0%
Probation	0%	3%	1%	3%	3%	9%
Jail and Probation	3%	36%	12%	28%	8%	29%
Other (fine, restitution, etc.)	5%	22%	12%	21%	4%	26%
No sentence	91%	26%	48%	31%	84%	36%
Chi-square test for significance	***		***		***	
Total with jail sentence	4%	50%***	39%	46%+	8%	29%***
Odds Ratio for Jail	.04		.72		.54	
Of those with a guilty disposition						
Jail Only	8%	19%	51%	26%	0%	0%
Probation Only	0%	4%	3%	4%	20%	14%
Jail and Probation	33%	48%	23%	40%	51%	46%
Other (fine, restitution, etc.)	58%	29%	23%	30%	29%	40%
Chi-square test for significance	*ns*		***		*ns*	
Total with jail sentence	41%	67%	74%	66%***	51%	45%
Recidivism						
Two-year Re-arrest						
Any Re-arrest	17%	28%*	31%	38%+	49%	44%
Any Felony Re-arrest	7%	15%*	15%	20%	9%	8%
Any Misdemeanor Re-arrest	13%	18%	20%	25%	53%	47%[h]
Any Drug Re-arrest	7%	9%	7%	11%	6%	5%
Days to First Re-arrest (Cox regression)	538.72	346.05[i]	389.06	341.31	623.39	534.51*
Odds Ratio for Two-Year Re-Arrest	.56		.73		1.21	

Table 5.1. Impacts on Case Dispositions, Sentences, and Recidivism *(Cont.)*

	Cook County Felony Drug School		Cook County Misdemeanor Drug School		Cook County Misdemeanor Deferred Prosecution	
	Felony Drug School[a]	Comparison	Misdemeanor Drug School[b]	Comparison	MDPP[c]	Comparison
	N = 1000	N = 1000	N = 689	N = 689	N = 132	N = 132
Case Disposition						
Pled Guilty/Convicted	3%	63%	<1%	15%	0%	7%
Dismissed/Not Convicted	97%	37%***	99%	85%***	100%	93%
Odds Ratio for Conviction	.02		.02			
Sentence						
Of all defendants						
Jail	1%	26%	0%	3%		
Probation	1%	23%	<1%	10%		
Jail and Probation	<1%	11%	0%	2%		
Other (fine, restitution, etc.)	0%	<1%	<1%	1%		
No sentence	97%	39%	99%	85%		
Chi-square test for significance	***		***			
Total with jail sentence	1%	37%***	0%	5%***		
Odds Ratio for Jail	.02					
Of those with a guilty disposition						
Jail Only	50%	45%	0%	20%		
Probation Only	35%	36%	50%	65%		
Jail and Probation	15%	18%	0%	10%		
Other (fine, restitution, etc.)	0%	0%	50%	5%		
Chi-square test for significance	*ns*		*ns*			
Total with jail sentence	65%	63%	0%	30%		
Recidivism						
Two-year Re-arrest						
Any Re-arrest	48%	54%**	38%	43%+	29%	41%*
Any Felony Re-arrest	26%	32%**	10%	14%*	8%	6%
Any Misdemeanor Re-arrest	36%	41%*	32%	37%+	24%	40%**
Any Drug Re-arrest	27%	30%+	18%	23%*	8%	8%
Days to First Re-arrest (Cox regr.)	448.94	320.98***	478.82	404.56**	278.20	539.94***
Odds Ratio for Two-Year Re-Arrest	.68		.79		.59	

***p < .001. **p < .01. *p < .05. +p < .10.

Note: It was not possible to compute sentence percentages from Cook County MDPP due to high proportions of missing data.

[a] For felony Drug School instant case disposition DS N = 993 and comparison N = 416; sentence DS N = 20 and comparison N = 261.

[b] For misdemeanor Drug School instant case disposition DS N = 661 and comparison N = 166; sentence DS N = 2 and comparison N = 20.

[c] For Cook Co. MDPP instant case disposition MDPP N = 79 and comparison N = 31; sentence MDPP N = 0 and comparison = <10.

[d] Milwaukee Diversion comparison case outcome N = 138 (1 unknown).

[e] Milwaukee Deferred comparison case outcome N = 288 (2 cases not resolved).

[f] For RICC case outcome N = 259, as 9 were coded "other" (e.g., referral to drug court).

[g] For Milwaukee Deferred Program 3 participant and 3 control cases were still open.

[h] For the Chittenden County RICC program, misdemeanor re-arrest results in fact encompass both misdemeanor and citation re-arrests.

[i] For Milwaukee Diversion days to re-arrest missing data from 6 participants and 6 comparisons.

Chapter 6

Cost Findings at Four Programs

As described in Chapter 2, programs in the cost evaluation included three from the impact study (the two Cook County programs and Chittenden County's) as well as San Francisco's Neighborhood Courts program (whose model is summarized in a pull-out box in Chapter 4). Notably, Cook County's Drug School enrolls both felony and misdemeanor defendants, but the cost evaluation focused solely on the felony cases.

Analytic Plan

As shown in Table 6.1, costs for diversion and comparison cases are each presented as a range, with separate results for "low," "typical," and "high" cost cases—and with results also distinguished for the prosecutor, public defender, and court. The criteria for low, typical, and high depend on the program because the eligible case types differ. Generally speaking, low costs refer to less complex cases that resolve quickly (e.g. no conflicting information, no continuances); typical cases tend to take a relatively limited amount of time (e.g. limited conflicting information, no video evidence); and high cost cases refer to those that take more time to resolve (e.g. some conflicting information, more witnesses). Details of the criteria for each program are described in the technical appendix.

The low, typical, and high estimates for program and control cases include nearly all phases of a case (e.g. initial appearance through sentencing), and we take into account the proportion of cases that go through key cost phases, including early plea or dismissal, later plea or dismissal, bench trial, or jury trial. (We do not include post-sentencing.) We also account for some diversion cases that are unsuccessful in completing their mandate and returned to traditional adjudication. Based on program data, our estimates assume that 9% of Cook Misdemeanor Deferred Prosecution, 3% of Cook Drug School, 17% of Chittenden Rapid Intervention Community Court (RICC, and 14% of San Francisco Neighborhood Courts diversion cases fail to complete their mandate and, thus, incur added costs associated with traditional prosecution. In addition, our output cost estimates for comparison cases take into account that not all comparisons are convicted; some are dismissed or found not guilty.

Several study limitations are worth underlining. First, we used self-reported time spent data. While observational data would have been ideal, it was not feasible within this study. Second, for programs that cost less than the alternative, we have not taken into account the additional benefit to society of shifting their tax revenue to other cases.[10] Third, the diversion programs potentially produce non-tangible benefits (e.g., psychological benefits for the defendants or symbolic benefits for the system) or other tangible benefits (e.g., restitution payments to victims or socioeconomic benefits to participants) that could not be measured.

Results

Investment Costs

At all four sites, diversion produced significant investment cost savings. Specifically, focusing on the "typical" case and as contrasted with each program's comparison group, diversion produced a relative investment cost reduction of a magnitude of: 82% for San Francisco's Neighborhood Courts (from $4,277 to $758 for a cost differential of $3,519 per typical case);[11] 59% for Chittenden County's Rapid Intervention Community Court (from $893 to $366 for a cost differential of $556 per typical case); 46% for Cook County's Misdemeanor Deferred Prosecution Program (from $2,132 to $1,154 for a differential of $978 per typical case); and, also, 38% for felony Drug School cases (from $1,749 to $1,081 for a differential of $668 per case). Diversion led prosecutors, public defenders, and courts all expend fewer resources for program than control cases.

Output Costs

For case outputs (cost estimates available for three of the four programs), results were similarly favorable for diversion (see Table 6.1 for separate low, typical, and high estimates):

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[10] This is formally known as "deadweight loss of taxes." For more on how this is calculated and applied to benefit-cost analyses of government-funded programs, see Boardman 2011; and Boardman, Greenberg, Vining, and Weimar 1997.

[11] Our estimates of comparison cases in San Francisco had to include non-traffic misdemeanor cases that are not eligible for Neighborhood Courts and that are known to take more time of judges, staff, and attorneys (e.g. DUI). Therefore, we overestimate the benefits of the Neighborhood Courts. We cannot be certain by how much, however.

- **Chittenden County's RICC:** Case outcomes (dispositions and sentences) cost $519 on average (when taking into account the program failure rate and costs of returning to docket to go be processed as a comparison case), almost 15% less than similar comparison cases ($594).

- **Cook County's Misdemeanor Deferred Prosecution Program:** Case outcomes cost $130 on average, representing a 27% relative reduction from the average cost of $168 for similar comparison cases; and:

- **Cook County's Felony Drug School:** Case outcomes cost $296 on average, representing an 84% relative reduction from the average cost of $1,888 for similar comparison cases.

Costs and Program Effectiveness

The "bottom-line" summary results of the cost analysis for the three sites where the analysis extended beyond investment costs alone are shown towards the bottom of Table 6.1. The following provides a brief summary for each program:

Chittenden County's RICC: Considering both investment and output costs, the total average cost differential was $602 per case. Over the period investigated (September 2012 through December 2013), in which there were 464 diversion participants, the RICC program freed up approximately $279,489 (or $223,590 per year on average) in criminal justice resources that could be used for other cases. Recidivism results for the RICC indicate no differences. However, the impact analysis indicates that RICC defendants were significantly less likely than comparisons to have a conviction or jail sentence (see previous chapter), a finding that is also supported in this cost analysis. The resources made available—i.e., resulting from the differences in case dispositions and sentencing—and the time devoted to each case type by judges, attorneys, and staff are the source of the benefit to society.

Cook County's Misdemeanor Deferred Prosecution Program: The average cost differential, including both investment into cases and output, indicates that diversion costs an average of $1,026 less per person than the alternative. Further, results in the previous chapter show that diversion resulted in a reduction in the re-arrest rate. Specifically, the re-arrest rate for any new charge (within two years) for diversion cases was 29% lower than comparison cases. Therefore, the program not only costs less in terms of investment and disposition resources used, but also costs the criminal justice system less as the result of fewer re-arrests.

Cook County's Felony Drug School: The average cost differential, including both investment into cases and the output, indicates that diversion cost $2,259 less per person for a typical case than the alternative. Results in the previous chapter show that diversion resulted in a statistically significant (at the 1% level) reduction in the re-arrest rate within two-years. The any re-arrest rate (within two years) of the diversion group was 11% less than the comparison group. Given the costs of arrests and subsequent charging and adjudication, the program led to further resource gains in the criminal justice system.

Summary

Among other goals, pretrial diversion programs are designed to keep cases out of (or minimize their involvement in) the formal criminal justice system, thereby shifting more resources to cases with higher social and victim costs (e.g. murder, rape and sexual assault, and aggravated assault), and yet still holding defendants accountable for their role in criminal behavior and protecting public safety. Our results indicate that, on balance, all four programs were beneficial in at least some ways (see Table 6.1). Chittenden County's RICC program appears to free up sizable resources for the system, particularly in the judicial/legal system and corrections, though with no clear impact (positive or negative) on participant recidivism. Given the number of participants in the diversion program, $233,590 annually were made available to the judicial/legal and corrections systems. We analyzed two programs in Cook County, and they appeared to provide both cost and recidivism reduction benefits. In total, the Misdemeanor Deferred Prosecution and Felony Drug School programs freed up approximately $1,082,040 and $674,830 of resources per year in the judicial/legal and corrections systems, respectively. Finally, the average San Francisco Neighborhood Court case cost about $2,200 to $5,200 less than comparison cases, based strictly on investment costs.[12]

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[12] Although not in the scope of this study, we did inquire about output costs of Neighborhood Court cases—specifically, the cost of participation in assigned services. Interviews indicate an average cost of $436 for diversion services (including classes and case monitoring). The cost can vary widely across individuals because some cases result in the defendant writing a letter and thus have case monitoring costs but no service expenses, whereas other defendants may have to take classes and require more intensive monitoring. There is a sliding scale administration fee and classes are also paid for by defendants based on a sliding scale. For example, shop lifting classes range from $0 to $120 and the prostitution procurement class can range from $0 to $1,000. Our estimate does not take into account that some defendants pay for their directives.

Table 6.1. Summary Cost Findings, Typical Case (in dollars)

	Chittenden County RICC	Cook County Misdemeanor Deferred Prosecution	Cook County Felony Drug School	San Francisco Neighborhood Court
Cost Estimate Per Case				
Investment Costs for Diversion Cases*	**366 (271-483)**	**1,154 (661-1,784)**	**1,081 (765-1,563)**	**758 (493-1,136)**
Prosecutor's Office	325 (236-439)	283 (158-472)	523 (370-705)	460 (281-685)
Public Defender's Office	22 (15-24)	268 (178-418)	236 (177-431)	152 (70-298)
Court	20	603 (324-893)	322 (218-427)	146 (142-153)
Investment Costs for Comparison Cases	**893 (648-1,057)**	**2,132 (1,449-3,327)**	**1,749 (1,341-2,376)**	**4,277 (2,718-6,291)**
Prosecutor's Office	651 (443-803)	377 (221-633)	847 (698-1,112)	2,378 (1,397-3,359)
Public Defender's Office	127 (90-139)	525 (353-980)	342 (259-528)	1,039 (461-2,072)
Court	115	1,230 (875-1,714)	560 (384-736)	860
Output Costs				
For Diversion Cases*	**519 (282-1,213)**	**130**	**296**	**.**
For Comparison Cases	**594 (393-735)**	**168 (55-365)**	**1,888 (212-3,563)**	**.**
Estimated Cost Differential Per Case				
Investment cost differential	**527 (377-574)**	**978 (788-1,543)**	**668 (576-813)**	**3,519 (2,225-5,155)**
Output cost differential	**75 (111-479)**	**38**	**1,591**	**.**
Total cost differential	**602 (488-95)**	**1,016**	**2,259**	**.**
Estimated Cost Differential Per Year	**223,590**	**1,082,040**	**674,830**	.

Notes: Positive value indicates the program costs less than the alternative. Low and high estimates in parentheses. Where missing, no low or high estimates available. Red text indicates negative value.
N/A- not applicable because cannot divide into zero.
* Takes into account failure rate and cost of case returning to docket (i.e. cost of comparison case).

Chapter 7

Conclusions and Lessons

This chapter summarizes ten key conclusions for the field and, specifically, for prosecutors interested in replicating diversion programs in their jurisdiction.

Diverse Goals and Target Populations

1. Today's prosecutor-led diversion programs can and do pursue a wide range of goals, not limited to rehabilitation and recidivism reduction. The primary aforementioned motivation for programs established in the 1970s was to rehabilitate defendants and reduce recidivism (Baker and Sadd 1979; Feeley 1983; U.S. Department of Labor 1974). By contrast, contemporary programs are pursuing a much more variable and diverse array of goals. Specifically, we identified seven overarching goal types, each one of which was endorsed as "extremely important" by staff in at least six of 15 programs examined. The two most frequently endorsed goals were:

- **Administrative and Cost Efficiencies:** Saving time, resources, and money by diverting appropriate cases early in the criminal justice process and, thereby, redeploying prosecutorial and other resources towards the most serious and complex cases; and

- **Reduced Collateral Consequences:** Aiding defendants' life chances by reducing the likelihood of a conviction and, thereby, reducing exposure to collateral consequences.

2. Several programs are explicitly designed to pursue goals related to restorative justice. A surprising number of programs made restorative justice an important, or even central, priority. Five programs employed variations of restorative justice conferences, in which defendants: (a) attend a session with victims and/or community members, (b) are invited to take responsibility for the harm they caused, and (c) are intentionally treated with respect and in a way that is intended to promote reintegration. Restorative justice arguably served as the preeminent organizing principle of San Francisco's Neighborhood Courts program and Los Angeles' Neighborhood Justice Initiative. The use of restorative justice strategies represents another key area in which the programs we studied deviated in substantial ways from the earlier models of the 1970s.

3. Several programs are also designed to pursue recidivism reduction and/or offender rehabilitation. Staff from seven of 15 programs identified recidivism reduction as an extremely important goal, and rehabilitation was similarly singled out by staff at six of the programs. Thus, even if prosecutor-led diversion is driven by a diverse array of goals not limited to recidivism reduction, reducing recidivism remains a common consideration.

4. Prosecutor-led diversion is one of several increasingly popular "front-end" interventions targeting cases early in case processing, often before a case reaches the courts. Our study confirmed a broader trend towards diverting cases to treatment or services at an extremely early juncture in criminal case processing. Whereas, by counter-example, most adult drug courts require participating defendants to plead guilty to an offense in advance of participation (see Rossman et al. 2011), virtually all of the programs in the present study divert prior to a plea or other case disposition. Indeed, seven of the 15 programs we examined enroll participants before the prosecutor even files charges with the court, enabling program completers to avoid any and all court involvement. The rise of "pre-filing" prosecutor-led diversion dovetails with a coinciding rise of in police-led diversion one step earlier still in the process. In police-led diversion, defendants are routed away from the formal justice system after initial contact with law enforcement but before a case is forwarded to the prosecutor's office in the first place. Recent research points to growing interest in police-led diversion, coupled with positive evaluation results of Project Lead, an increasingly popular model first developed in Seattle, Washington (see, e.g., Collins, Lonczak, and Clifasefi 2016 on Project Lead; and, see, Tallon et al. 2016 for data describing the national trend towards early police-led diversion).

5. Today's prosecutor-led diversion models extend both to misdemeanors and felonies. Diversion programs of the 1970s focused almost exclusively on extremely low level misdemeanor or lesser charges (Baker and Sadd 1979; Feeley 1983; Salzberg and Klingberg 1983). By contrast, nine of the 15 programs we examined are either felony-only programs or mixed programs that admit both misdemeanors and felony defendants. Moreover, our impact evaluation included two misdemeanor-only programs but also three that admit felonies—and we found that all three produced positive effects, including reduced recidivism—indicating that diversion can be an effective public safety strategy with a wide array of target charges.

Promising Impacts

6. Prosecutor-led diversion appears highly successful in reducing exposure to a conviction. All five programs in the impact evaluation reduced the conviction rate, and some of the effect sizes were quite large. Conviction rates among diversion and comparison cases were 9% vs. 74% in Milwaukee's Diversion program, 16% vs. 64% in Chittenden County's Rapid Intervention Community Court (RICC), and 3% vs. 61% among felony defendants in Cook County's Drug School. All five programs also achieved at least some reduction in the use of jail sentences, although these effects were not statistically significant at all sites.

7. Diversion also appears highly successful in freeing up resources for criminal justice agencies—especially pre-filing programs. All four programs in the cost evaluation produced sizable investment savings. The greatest relative savings were achieved by the two programs that accept cases pre-filing: San Francisco's Neighborhood Courts and Chittenden's RICC program. This confirms expectations, since pre-filing programs interrupt the prosecution process at a particularly early stage. Regarding specific criminal justice agencies, public defenders and courts came out ahead in all sites. In one site, Cook County's Misdemeanor Deferred Prosecution Program (MDPP), prosecutors invested more time and cost into diversion than comparison cases—but because MDPP ultimately reduced recidivism, prosecutors recouped their investment later on. Of final interest, all three programs included in an analysis of output costs (e.g., from reduced use of probation or jail at sentencing) reduced cost on net.

8. Diversion reduces recidivism more often than not, although positive effects appear more modest and less consistently achieved than the aforementioned effects on conviction, jail, and cost. Four programs, two in Milwaukee and two in Cook County, produced meaningful recidivism reductions (statistically significant or approaching significance on at least one outcome measure for all four programs). However, Chittenden County's RICC program did not reduce recidivism. Also, for the four programs seeing positive effects, the magnitudes were not as great as the magnitudes of the aforementioned large effects seen on conviction, jail, and cost outcomes. The "bottom line" is that four of five programs reduced recidivism, a clear positive finding. We merely caution that diversion programs do not appear *always* appear to reduce recidivism and, when they do, effects are often modest in magnitude relative to the achievement of other goals.

9. Programs seeking to rehabilitate defendants might benefit from looking to Milwaukee as a model. The Milwaukee District Attorney's Office is unique among the prosecutor's offices we examined for implementing a universal risk-informed decision-making protocol, including a system for matching defendants of different risk levels to diversion programming of appropriate intensity—either the brief Diversion model or more intensive Deferred Prosecution model. In addition, for those in Deferred Prosecution, treatment is individualized to assessed needs. Both Milwaukee programs reduced recidivism. Programs prioritizing rehabilitation and recidivism reduction would do well to start with Milwaukee's system as a promising model for the implementation of successful, evidence-based practices.

Unanswered Questions and Future Directions

10. Where diversion reduces recidivism, future research is needed to rigorously isolate why and how. Whereas it is unproblematic to make sense of Milwaukee's positive recidivism impacts (see above), Cook County's Drug School and MDPP programs also reduced recidivism—but without the benefit of a rigorous risk-needs assessment and treatment matching strategy.[13] Cook County's programs likely exerted positive effects through mechanisms other than the use of evidence-based assessment and rehabilitation strategies. Our process research points to several candidate mechanisms, including:

- **Procedural Fairness:** Focus group participants in multiple sites emphasized that they were treated fairly and that program staff appeared to "care" about them.

- **Substantive Justice:** Many program staff (inclusive of Cook County, specifically) emphasized their sincere desire to aid participants by reducing their exposure to a conviction. In turn, in focus groups, participants' comments suggested that they had gained a more positive view of the law and the system through the substantive outcome of having the chance to avoid traditional prosecution and having their case dismissed.

- **Restorative Justice:** Discussed above, several diversion models incorporated a restorative approach that sought to hold participants accountable for misconduct in ways that reintegrate rather than stigmatize. This approach too may be a promising mechanism to change defendants' behavior.

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[13] Cook County implemented risk-informed decision-making in its Misdemeanor Deferred Prosecution Program in 2015, after our samples were drawn for this study's impact evaluation.

Future research is necessary to provide more rigorous answers regarding the extent to which positive impacts can be attributed these (or other) candidate elements.

11. The 15 programs examined through in-depth process research made little use of evidence-based cognitive-behavioral therapy; instead, educational classes predominated. Only a few of the 15 programs studied appeared to order diversion participants to cognitive-behavioral therapy (CBT), despite its proven positive effects (e.g., see Lipsey, Landenberger, and Wilson 2007). Conversely, 13 of 15 programs ordered at least some, if not all, program participants to non-therapeutic educational classes about the nature of defendants' problems (e.g., educational about drugs, marijuana, DUI, or prostitution). Prosecutors establishing diversion programs in the future—and especially prosecutors seeking to maximize rehabilitative or recidivism reduction benefits—may wish to consider a more CBT-based, therapeutic focus.

12. Especially with misdemeanor programs, the potential for legally disproportionate requirements is an area of concern. In the course of seeking to help defendants, we detected some potential for diversion programs to apply onerous requirements relative to the legal outcomes and sentences defendants would otherwise have received (i.e., "net widening"). For example, Project ROSE in Phoenix imposed a demanding set of requirements on misdemeanor prostitution defendants. Several programs do not have a standardized dosage of required services, a strategy that offers the clear benefit of individualization and flexibility, yet a strategy that can result in excessive program length if care is not taken. Obviously, this cautionary note (echoing a major theme in research on early diversion programs from the 1970s, see, e.g., Feeley 1983) applies especially to programs serving defendants facing low-level charges with little legal exposure in the preexisting status quo. As diversion programs continue to spread, prosecutors will have to diligently navigate the competing demands of robust, evidence-based programming and legal proportionality.

13. Pretrial diversion is a ripe area for future research. The present study sets the stage for a number of potentially valuable future research inquiries. First, the field could benefit from research seeking to replicate our basic process and impact findings with diversion programs run out of smaller prosecutors' offices. Second, as introduced above, now that we have found that diversion can reduce recidivism, additional research is needed to pinpoint the mechanisms through which recidivism reductions are possible (e.g., therapeutic programming, procedural fairness, avoidance of stigma and psychological harm resulting from traditional court processing, or other processes). Third, a potentially more profound

area for future inquiry could be the extent to which the rise of prosecutor-led diversion is contributing to (or dovetailing with) broader changes in the culture, embodied within individual line prosecutor and prosecutors' offices nationwide—potentially leading prosecutors to emphasize a newly broad array of goals and performance measures (e.g., avoidance of collateral consequences, holding defendants accountable for misconduct in ways other than convictions and jail time, reducing recidivism, or more efficiently deploying prosecutorial resources even if it means dismissing or declining to prosecute some cases).

A final fruitful avenue for future research could involve comparing the decision to divert a case with the competing option of declining to prosecute a case altogether. In this regard, it bears emphasizing that diversion is but one means that prosecutors have at their disposal to re-routing cases away from full prosecution. Prosecutors can also decline to file certain types of cases, usually ones involving first-time minor misconduct, *without* first requiring participation in diversion. In this regard, future research on front-end criminal justice reforms could include examinations of prosecutorial decision-making along a full continuum of options, including: (1) straight decline-to-prosecute; (2) pre-filing diversion; (3) post-filing diversion (subsequent to court involvement but prior to a disposition); (4) alternative-to-incarceration at the dispositional stage (i.e., guilty plea required to participate); and, finally, (5) traditional prosecution, disposition, and sentencing. Whereas the current study involved an in-depth examination of two of these possibilities—pre-filing and post-filing prosecutor-diversion—future research assessing when and why today's prosecutors make the choices they make among all of these aforementioned options could help to illuminate the full gamut of today's reform horizon.

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Appendix A.

Technical Appendix on Impact Methodology

Data on pretrial diversion participants was obtained from the five programs, and de-identified demographic, criminal history, and recidivism data was obtained for both diversion and potential comparison defendants from the state Statistical Analysis Centers in Illinois[14] and Vermont, and from the Milwaukee District Attorney's Office. The Milwaukee District Attorney's Office also provided LSI-R:SV risk assessment data for both diversion and comparison defendants. This appendix describes our propensity score matching process in greater detail, whereby the samples obtained from these data sources were refined and balanced on observable background characteristics.

Propensity score matching (PSM) is a commonly used procedure (actually, family of procedures) for approximating true random assignment to treatment and comparison groups, where randomization is not feasible. A properly matched sample provides an unbiased estimate of the impact of a treatment and eliminates the need to statistically control for potentially confounding background variables. Our PSM procedure included the following steps, performed separately for each of six data sets. (Felony and misdemeanor defendants participating in the Cook County Drug School were analyzed separately.)

[14] Several formal caveats and qualifications apply to data obtained from the Illinois Criminal Justice Information Authority (ICJIA), the state's Statistical Analysis Center: Only arrests occurring in Illinois are recorded. Further, only arrest information that has been submitted successfully to the CHRI System (meaning has passed through all edit checks) is available. ICJIA does not have a view of any sealed or expunged records, so the data is valid as of the date it was pulled; data pulled at a later date may produce slightly different results. The smaller the geographic unit analyzed, the more missing data and data reporting practices affect the results. Biometric-based (fingerprints) matches are the most likely to be correct. Matches based on names and dates of birth will have more false positive and negative results. Biometric matching is not possible outside of an actual CHRI System. ICJIA uses exact name matching supplemented by manual review of near matches.

1. Merge and clean the de-identified data from diversion program participants and potential comparison defendants.

2. Identify an instant case—for diversion defendants, the arrest leading to program participation; for comparisons, the first arrest in a pre-specified time window, such that all earlier arrests are priors and all subsequent arrests are re-arrests.

3. For all instant cases and priors, identify the charge type, charge severity, and final case disposition (if available). Regarding data availability, the Cook County site, extending to both the Drug School and Misdemeanor Deferred Prosecution Program (MDPP), had substantial proportions of missing disposition information, stemming from limitations in data obtained from the Illinois Criminal Justice Authority.

4. Calculate group differences in the means or frequencies on the entire array of demographic, prior arrest, and instant case variables. Where available, include other background information as well (e.g., in Milwaukee, all participants had LSI-R-SV risk scores on file).

5. Identify all background variables on which the treatment and comparison groups differ at $p < .50$. If the impact analyses were to be performed on the entire sample, these variables would potentially bias the estimate of the impact of treatment on study outcomes.

6. Perform a logistic regression in which group membership (treatment vs. comparison) is the binary dependent variable, and all variables identified in (5) are the predictors. Specifically, run a backward stepwise procedure that begins with all predictors in the model, then iteratively removes predictors until all remaining predictors are associated with group membership. Save the predicted probability of group membership such that values closer to 1 reflect greater likelihood of membership in (i.e., greater similarity to other members of) the treatment group.

7. Sort all participants by ascending propensity score. For each treatment group participant select one comparison with an identical (or nearly identical) score. (For each Chittenden County RICC participant we selected two comparisons from the very large comparison sample we received). Treatment cases were removed from the analysis if their propensity score fell outside the range of those from the comparison group. The tables below show that most treatment participants were selected into the impact analyses, but in Cook County Misdemeanor Drug School and Misdemeanor Deferred Prosecution, a larger proportion of treatment participants were removed by this criterion.

8. Re-compute differences between selected treatment and comparison groups on all background variables. All (or nearly all) differences should be well below the $p < .05$ criterion.

9. If significant differences remain, repeat this procedure as necessary until this criterion is achieved.

10. Retain selected participants and comparisons for impact analyses on case outcome, use of jail, and re-arrest.

We were confident that the PSM was successful, as can be seen in the following tables that show the pre- and post-matched samples for each site. The rightmost columns show no differences at $p < .05$ between groups on any background variable, and only three that were significant at $p < .10$, well within the range of random sampling error.

It should be noted that PSM can only ensure statistical equivalence between groups on variables that were actually measured. That is, it is possible that treatment and comparison groups differ on relevant background characteristics that were not measured (e.g., personal or contextual information that is statistically related to our study outcome variables). This would not be a problem had the groups been truly randomly assigned. True random assignment in field studies, however, is notoriously difficult to achieve.

Three other data quality limitations should also be noted. First, as can be seen in the footnotes to Table 5.1, there were a substantial proportion of missing case disposition and sentence data from the three Cook County data sets. For Misdemeanor and Felony Drug School, case dispositions and sentences for the entire sample (lower portion of the "sentence" section) were weighted estimates. For the MDPP sample there were too few case outcomes to make a reliable estimate (we had only 23% of case dispositions for the comparison group and had sentence information for only two participants). Second, MDPP comparison data were available from only one of the three district courts originally requested. (Cook County is divided into multiple branch and district courts, defined based on the location of the arrest.) Third, comparison cases for the two Milwaukee data sets were drawn from a larger pool of potential comparisons; specifically, we used the score from their assessment tool (LSI-R: SV) to select potential comparisons for, respectively, the Diversion and Deferred Prosecution programs before proceeding to the propensity score calculation. (The pull-out box on Milwaukee's universal screening and assessment model in Chapter 4 explains how this site uses LSI-R risk classifications to inform diversion eligibility.)

Milwaukee County Diversion Program Matching: Treatment and Control Groups

	Pre or Post Match			
	Pre-Matching		Post-Matching	
	Diversion	Comparison	Diversion	Comparison
Demographics	**N = 196**	**N = 233**	**N = 139**	**N = 139**
Agea	29.39	27.88	29.57	27.03+
Male	71%	75%	71%	71%
Black	49%	55%	53%	53%
White	41%	37%	40%	40%
Criminal history				
Arrests				
Any	.48	1.80***	.50	.60
Felony	.08	.50***	.08	.06
Misdemeanor	.27	1.05***	.29	.31
Drug	.06	.28***	.07	.07
Convictions				
Any	.32	1.26***	.35	.44
Felony	.06	.35***	.06	.06
Misdemeanor	.13	.69***	.17	.18
Drug	.07	.27***	.06	.06
Assessment				
LSIR total score	1.63	1.74	1.65	1.58
LSIR: 2 or more priors	10%	12%	10%	5%
LSIR: arrested before age 16	8%	7%	8%	7%
LSIR: unemployedb	58%	58%	53%	56%
LSIR: criminal friends	33%	38%	37%	38%
LSIR: alcohol/drugsc	13%	16%	11%	12%
LSIR: psych assessment	17%	18%	19%	15%
Charge category				
Drug possession	27%	29%	26%	26%
Other drug	14%	18%	14%	18%
Burglary	1%	1%	1%	1%
Theft	20%	20%	21%	25%
Violent	2%	0%	1%	1%
Disorderly conduct	4%	3%	4%	4%
Resisting an officer	4%	3%	3%	4%
Other charge	29%	25%	29%	22%

***p < .001. +p < .10.
a Comparison group pre-matching N = 232.
b Diversion group pre-matching N = 154, post-matching N = 107. Comparison group pre-matching N = 187, post-matching N = 115.
c Diversion group pre-matching N = 187 post-matching N = 131. Comparison group pre-matching N = 226, post-matching N = 139.

Milwaukee County Deferred Prosecution Matching

	Pre or Post Match			
	Pre-Matching		Post-Matching	
	Deferred Prosecution	Comparison	Deferred Prosecution	Comparison
Demographics	**N = 375**	**N = 387**	**N = 290**	**N = 290**
Age[a]	28.68	28.49	27.96	29.56+
Male	68%	70%	68%	67%
Black	38%	40%	39%	37%
White	57%	56%	56%	59%
Criminal history				
Number of Arrests				
Any	1.65	2.52***	1.77	1.73
Felony	.31	.60***	.33	.39
Misdemeanor	1.13	1.67**	1.19	1.16
Drug	.21	.49***	.23	.24
Number of Convictions				
Any	1.34	2.03***	1.45	1.36
Felony	.23	.46***	.25	.30
Misdemeanor	.77	1.11*	.81	.78
Drug	.18	.38***	.20	.19
Assessment				
LSIR total score	3.47	3.47	3.51	3.39
LSIR: 2 or more priors[b]	28%	29%	30%	25%[g]
LSIR: arrested before age 16	29%	30%	30%	30%[g]
LSIR: unemployed[c]	77%	80%	76%	80%
LSIR: criminal friends[d]	61%	60%	60%	59%
LSIR: alcohol/drugs[e]	48%	53%	46%	51%
LSIR: psych assessment[f]	41%	36%	42%	35%+
Charge category				
Drug possession	30%	30%	31%	30%
Other drug	8%	7%	8%	6%
Burglary	6%	6%	5%	7%
Theft	24%	26%	23%	27%
Vehicle	5%	4%	5%	3%
Violent	5%	6%	4%	7%
Disorderly conduct	8%	6%	7%	7%
Resisting an officer	2%	2%	2%	2%
Other charge	14%	13%	14%	13%

***p < .001. **p < .01. +p < .10.
a Deferred group pre-matching N = 372, post-matching N = 287.
b Comparison group pre-matching N = 386.
c Deferred group pre-matching N = 320, post-matching N = 250. Comparison group pre-matching N = 327, post-matching N = 248.
d Deferred group pre-matching N = 374. Comparison group pre-matching N = 386, post-matching N = 28
e Deferred group pre-matching N = 363, post-matching N = 275. Comparison group pre-matching N = 363, post-matching N = 282.
f Deferred group pre-matching N = 385.
g Comparison group post-matching N = 289.

Chittenden County, VT: Propensity Score Matching

	Pre or Post Match			
	Pre-Matching		Post-Matching	
	Rapid Intervention Community Court	Comparison	Rapid Intervention Community Court	Comparison
Demographics	**N = 268**	**N =2510**	**N = 268**	**N = 536**
Agea	37.42	36.63	37.42	37.12
Age at first CJ system contacta	25.32	25.09	25.32	25.31
Male	58%	59%	58%	63%
Black	5%	4%	5%	6%
White	91%	94%	91%	92%
Criminal history				
Total prior arrests				
Any	6.52	6.48	6.52	6.52
Felony	.84	.76	.84	.71
Total prior charges				
Violation of conditions/court orders	.58	.65	.58	.78
Assault	.72	.71	.72	.76
Drug possession	.42	.42	.42	.38
Other drug	.13	.10	.13	.09
DUI/motor vehicle	1.21	1.42	1.21	1.31
Burglarly/theft	1.41	1.35	1.41	1.31
Disorderly conduct	.97	.99	.97	1.01
Other	1.08	.10	1.08	.87
Total prior convictions				
Any	3.96	4.32	3.96	4.37
Felony	.75	.68	.75	.65

[a] Pre- and post-matching RICC N = 265.

Cook County Felony Drug School: Propensity Score Matching

	Pre or Post Match			
	Pre-Matching		Post-Matching	
	Felony Drug School	Comparison	Felony Drug School	Comparison
Demographics	**N = 1195**	**N = 12406**	**N = 1000**	**N = 1000**
Age	27.64	34.75***	28.24	27.82
Male	80%	80%	80%	83%+
Black	50%	54%**	47%	47%
White	49%	43%***	52%	50%
Criminal history				
Prior arrests				
Any	4.34	6.45***	3.93	4.35
Misdemeanor	2.32	2.74***	2.14	2.19
Felony	.82	1.63***	.79	.73
Property	1.07	1.69***	.98	.90
Drug	1.22	1.90***	1.63	1.63
Violent	.64	.94***	.59	.57

***p < .001. **p < .01.
Note. Only those with felony drug instant case charges are included.

Cook County Misdemeanor Drug School

	Pre or Post Match			
	Pre-Matching		Post-Matching	
	Misdemeanor Drug School	Comparison	Misdemeanor Drug School	Comparison
Demographics	**N = 1416**	**N = 1485**	**N = 689**	**N = 689**
Age	22.55	23.16*	22.37	22.27
Male	87%	80%***	82%	81%
Black	48%	49%	41%	45%
White	50%	49%	57%	53%
Criminal history				
Prior arrests				
Any	2.70	.59***	.65	.62
Misdemeanor	1.81	.39***	.45	.42
Felony	.32	.33	.07	.08
Property	.61	.14***	.17	.14
Drug	.81	.17***	.18	.19
Violent	.50	.09***	.11	.10

***p < .001. +p < .10.
Note. Only those with misdemeanor drug instant case charges are included.
Note. Hipanic/Latino/a ethnicity was not listed in official records.

Cook County Misdemeanor Deferred Prosecution Program: Propensity Score Matching

	Pre or Post Match			
	Pre-Matching		Post-Matching	
	MDPP	Comparison	MDPP	Comparison
Demographics	**N = 1775**	**N = 3014**	**N = 713**	**N = 713**
Age	27.89	30.33***	25.46	27.34
Male	58%	87%***	48%	54%
Black	39%	65%***	54%	49%
White	46%	34%***	22%	21%
Charge category				
Drug	15%	28%***	7%	7%
Property	75%	31%***	77%	77%
Violent	3%	20%***	0%	0%
Disorderly conduct	2%	2%	6%	6%
Resisting an officer	2%	4%*	0%	0%
Driving while intoxicated	0%	6%***	0%	0%
Warrant	3%	3%	10%	10%
Criminal history				
Prior arrests				
Misdemeanor	1.18	8.34***	1.43	1.30
Felony	.22	3.61***	.38	.38
Drug	.31	4.45***	.29	.30
Property	.71	5.06***	1.29	.73
Violent	.29	2.44***	.36	.42
Disorderly conduct	.07	.50***	.09	.03
Resisting an officer	.05	.40***	.08	.09
Driving while intoxicated	.05	.30***	.05	.03
Traffic charge	.03	.11***	.05	.01
Warrant	.08	1.04***	.15	.11

Note. No one was coded as Hispanic in the control group files.

Appendix B.

Technical Appendix on Cost Methodology

This study applied a bottom-up approach to calculate costs for each program.[15] Not all programs could provide the exact same data, nor do the programs all work the exact same way, as some programs had activities (and thus costs) that did not occur in other programs. Below we provide details of the activities included for each program evaluation.

Rapid Intervention Community Court (RICC), Chittenden County, Vermont

In the RICC pre-filing program, the community coordinator in the prosecutor's office screens cases for charges and risk factors (using the ORAS risk-needs assessment), and defendants meeting program eligibility criteria are offered the program; defendants refusing the offer continue with the traditional route. Upon acceptance, individuals are assigned obligations that can include an accountability component, victim restitution, service to the community, substance abuse treatment, mental health counseling, writing a letter to a family member or victim, or other services or counseling where relevant. Typically, defendants are assigned two requirements and have 90 days to complete in order to be compliant. Some services or dispositions may take longer to complete. Defendants who are compliant never have to go to court. When a defendant is not compliant, their case is returned to docket and it goes through the traditional process.

[15] There are two general approaches to processing information, a top-down and a bottom-up approach, that are used in a variety of fields including examining policy implementation (Sabatier 1986). In estimating the cost of a program, a top-down approach breaks down total expenditures into a relevant unit (e.g. total labor and equipment costs) using shares that could be attributed to costs of the program. A bottom-up approach to estimating the cost of a program identifies each of the resources expended to produce the output of the program (e.g. number of hours spent sending letters), applies a relevant monetary value (e.g. hourly pay by job type), and aggregates them to generate the additional cost of providing services of the program.

The costs we estimate are “low” (lowest cost per case over the period 2011 to 2015), “typical” (mean between 2011 and 2015), and “high” (greatest cost per case over the period 2011 to 2015). We include labor and indirect expenditures per participant between 2011 and 2015. We use an average over this longer period because the program started in 2011 and expenditures were still changing, so we use a more stable average cost as the typical case cost.

Data Collection

For the “investment costs” of the RICC cases, we obtained administrative records of the budget and number of participants. Administrative records included de-identified data on intake date, main charge code, dispositions assigned (and to which organization), end result (completed or returned to docket), and end result date. This also allowed us to determine the proportion of successful cases since our calculation of the cost of RICC cases includes costs associated with unsuccessful cases going through the traditional process.

For the investment costs of comparison cases, we used previous literature of costs to Courts, State’s Attorney’s Office, and Office of the Defender General (Schlueter et al. 2014). We use the literature estimates because an in-depth study was already conducted on the time spent for cases relevant to this study that were worked on during the time period of this study. Specifically, these costs are based on median hourly salary/benefits for judges, court clerical staff, state’s attorneys, victim advocates, and public defenders multiplied by the average processing time by crime type (property crime, drug crime, and public order/major motor vehicle crimes) for each of these job types. These costs consider different case pathways (e.g. dismissed or plea before trial, trial).

RICC Results: Investment Resources Used by Stakeholder Group, by Case Type

	SAO	PD	Court
RICC Cases			
Successful Cases	$219 ($155-$326)	$0 ($0-$0)	$0 ($0-$0)
Unsuccessful Cases	$838 ($630-$990)	$127 ($90-$139)	$115 ($115-$115)
*Weighted Average***	$325 ($236-$439)	$22 ($15-$24)	$20 ($20-$20)
Traditional Cases			
	$651 ($443-$803)	$127 ($90-$139)	$115 ($115-$115)

Regarding RICC case output costs, the cost to taxpayers comprises labor, equipment, and indirect costs. Specifically, labor costs include time spent on intake, case hearing, check-ins

(if needed), resource navigation meetings, completion of paperwork, communication and monitoring, and travel. Indirect expenses and minor supply and equipment costs include utilities, telephone, and lab costs (e.g. UA tests). In order to consider the range of participants and differences in costs of services, service providers responded to questions regarding the time spent and equipment costs for three groups: those who rarely attend the program, the average-intensity successful participant, and the highly-intensive successful participant (e.g. more victims, more encouragement needed to complete). We generate costs separately for those who do and do not complete the program.

Regarding output costs of non-RICC cases, we use previous detailed research (Schlueter et al. 2014). Given the crime types eligible for RICC (drug possession, retail theft, disorder), we consider the proportion of cases that are not convicted (e.g. dismissed, not guilty) that result in a sentencing cost of zero and the proportion convicted that result in costs identified in the study. We also take into account that only a proportion of felony and misdemeanor cases were defended by public defender: property (62%), drug (40%), public order/major MV (59%).

RICC Results: Output Costs by Stakeholder Group, by Case Type

RICC Cases	
Weighted Average Service Provider Cost per Case*	$519 ($282-$1,030)
Service Provider Type A	$26 ($6-$86)
Service Provider Type B	$9 ($5-$19)
Service Provider Type C	$101 ($38-$281)
Classes (retail theft, cannabis)	$11 ($0-$11)
Treatment, Counselor	$37 ($21-$105)
Contract Cost per Case	$335 ($211-$529)

Traditional Cases	
Not Convicted	$0 ($0-$0)
Convicted	$1,074 ($711-$1,327)
Weighted Average Output Cost per Case, Total	$594 ($393-$735)

Note: Accounts for assignment to more than one service provider, class, and/or treatment. Includes labor cost (salary and benefits) and indirect expenses. Based on proportion of successful (0.829) and unsuccessful (0.171) cases. †Based on proportion of RICC cases where main charge is property (0.420), drug (0.206), or public order (0.374).

Misdemeanor Deferred Prosecution Program (MDPP), Cook County, Illinois

Working with the State's Attorney Office (SAO), we started by developing a process map of activities and decisions from intake to closing the case. The main cost pathways of cases that go through MDPP and comparable misdemeanors that go through the traditional process. The MDPP intervention occurs after an initial court appearance. An Assistant State Attorney (ASA) reviews a defendant's file for eligibility, and for those eligible, makes an offer to the defense attorney.[16] A defendant can accept or refuse the offer. If a defendant accepts, the preliminary hearing is waived for a 90-day adjournment to complete supervision and services. If participants are compliant, the case is dismissed by the court.[17] If participants do not comply, they return to the traditional court process. In the traditional process, after an individual is arrested, the defendant has an initial appearance where a bail decision is made. Then the defendant enters a plea, after which there are three, mutually exclusive paths of the traditional process as shown on the left side of the figure: 1) enter plea of guilty or no contest, or the case is dismissed; or the defendant enters a plea of not guilty and has a trial by 2) bench or 3) jury.

Data Collection

Within these pathways, there are number of activities performed by each stakeholder group that are included in this study. Using the overview of case pathways shown in the figure above, we interviewed stakeholders (e.g. assistant prosecutors, assistant public defenders) about the type of activities they perform for cases that do and do not go through the program. We refer to activities involved in adjudicating a case as "Investment costs" since these are the resource inputs to cases (Byrne, Carey, Crumpton, Finigan, & Waller, 2005). The table below presents the activities included in the cost estimation for each stakeholder by case type. While the general activities are the same for the SAO and PDO, the tasks differ for each group. For example, both groups conduct initial case preparation, but the tasks differ such that assistant public defenders discuss the case with their client, whereas assistant prosecutors obviously do not perform such tasks. Noted in the table are details of tasks included in determining the time spent on cases for all stakeholders.

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[16] Sometimes, the defense attorney may approach the ASA about a deal first.

[17] If at first participants are not compliant, they may be offered a second chance to attend appointments.

Activities Included in the Investment Cost Estimation[18]

Case Type		Activities by Stakeholder	
		Prosecutor's and Public Defender's Offices	Court
Program cases	Successful	• Initial case preparation • Court appearances	• Court appearances
	Unsuccessful	• Successful case + Traditional case activities	• Court appearances + Traditional case activities
Traditional cases	Guilty plea / Dismiss	• Initial case preparation • Court appearances	• Court appearances
	Bench trial	• Initial case preparation • Court appearances • Witness interview & Trial Prep • Trial • Sentencing	• Court appearances • Trial • Sentencing
	Jury trial	• Initial case preparation • Court appearances • Witness interview & Trial prep • Jury selection • Trial • Sentencing	• Court appearances • Jury Selection • Trial • Sentencing

Given recall bias and the resulting uncertainty in reporting case processing times, individuals reported the typical amount of time they spend on a case, as well as the minimum and maximum amount of time they could recall spending on each task. Specifically, each main activity has a set of criteria that ranges from a straightforward case with no conflicting information or continuances or non-police witnesses (minimum) to cases with some conflicting information and many appearances or continuances (maximum). The same criteria were used for interviews with the Prosecutor's and Public Defender's office.

[18] Tasks included in the cost estimation, by activity listed in the table include: **Case preparation**- review arrest report, review RAP sheet, work up file, paperwork; **Court Appearance**- review case, make/receive/review MDPP offer, time in court (e.g. judge instructions, etc.), discuss case, paperwork; **Witness & Trial Prep**- review evidence, discovery, determine what to show, order supplements, discuss case with witnesses, client discussion, subpoenas; **Jury Selection**- jury instruction, discussion, selection; **Trial**- continuances, judge's instructions, trial (e.g. statements, testimonies, physical evidence); and **Sentencing**- pre-sentencing investigation, judge's instructions, judge's comments, victims' comments.

Criteria for Low, Typical, and High Cases

	Low	Typical	High
Initial case preparation	No conflicting information	Limited conflicting information	Some conflicting information
Court appearance	1 appearance Quick appearance, no conflicting information	2 appearances Typical appearance, limited conflicting information	3 appearances Longer appearances, some conflicting information
Witness interview & Trial prep	Only police witness, no video evidence	Police and 1-2 witnesses, no video evidence	Police and 2-3 witnesses, video evidence
Jury Selection	Quick selection	Average selection	Long jury selection
Trial	No continuance, no video evidence, experienced judge and attorneys	1 continuance, no video evidence, experienced judge and attorneys	2 continuances, video evidence, longer discussions with attorneys
Sentencing	No continuance, relatively quick	No continuance, typical case	1 continuance, complex

Method

To generate the investment costs of each stakeholder group for each case type, we start by separately calculating the investments costs for misdemeanor cases that go through the traditional process by each stakeholder group *j* (ϵ SAO, PDO, Court) as a function of the minutes *c* spent by individuals *i* (ϵ assistant state attorney, 1st chair state attorney, assistant public defender II, assistant public defender IV, public defense investigator, judge, court clerk, court reporter, pretrial officer, police officer, and bailiff) working directly on guilty plea/dismissed cases (*c*), minutes *d* worked on bench trial cases, and minutes *f* worked on jury trial cases. The minutes spent are weighted by the proportion of guilty plea/dismissed cases (*a*), bench trial cases (*b*), and jury trial cases (1-*a*-*b*). The minutes spent by job type *i* is multiplied by their pay rate per minute y_i, which generates the direct labor investment cost per traditional cost.

Last, this is multiplied by the indirect or overhead rate *r* for stakeholder group *j* to include the indirect labor and supplies and equipment used to adjudicate the traditional case. Our cost estimates include the indirect resources of administrative staff (e.g. accountants, administrative assistants, secretaries, paralegals) and capital and equipment needed to deliver prosecution services. The indirect rate of the Cook County SA's Office is 7.5% of direct labor (Cook County State Attorney's Office, 2016). We multiply the total cost estimate of attorneys' time on cases by this indirect rate and sum to get the costs of inputs through the SA's Office. Similarly, we add indirect costs for the Public Defender's Office using the rate

provided, 7.35%. For the Cook County Circuit Court, we add the costs of the Office of the Chief Justice that provides interpreters, law clerks and support staff, as the average indirect of the SA's Office and the Public Defender's Office.

We also calculate the resources spent on the disposition of cases, or "Output costs", and include criminal justice resources to monitor and deliver services associated with the sentence. This is calculated by using the proportion of cases resulting in each disposition and average sentence and the relevant cost. Specifically, for cases that go through the pre-trial diversion program, every program had contracts with the prosecutor office (with pre-trial services organizations). Specifically, the participant is assessed by Treatment Assessment Screening Center (TASC[19]) and administered the SBIRT, CAS, and the PHQ-2. Defendants are assigned to a community partner, and required to attend two appointments with the community partner. The SAO is kept apprised of whether the participant complied with the program. For the diversion cases, the State Attorney's Office provided costs per participant for MDPP (TASC and Presence Behavioral Health).

For similar cases that go through the traditional route, we generate the cost by using the proportion convicted, average length of sentence, and cost per unit of sentence. Misdemeanor statistics for Cook County indicate 87.5% of misdemeanor cases result in conviction by plea or trial (George et al., 2015), and data shows the most likely sentence is community supervision (Illinois State Commission on Criminal Justice and Sentencing reform, 2016). We use data on probation length for misdemeanors served by offense type of 513 days in 2006 (Adams, Bostwick, & Campbell, 2011), and use two standard deviations (SD=237) below the mean to generate the minimum and two standard deviations above the mean to generate the maximum. The SAO provided Cook County costs per day in 2013 for Adult Probation Department services of $4.67 per probationer per day, which we assume is approximately the cost for Social Service Department costs per supervised individual.

[19] http://www.tascsolutions.org/

Direct Time Spent by Case Type, by Stakeholder Group (in Minutes)

State Attorney's Office	
MDPP Cases	
Successful Cases	
Misdemeanor ASA	45 (25-75)
Unsuccessful Cases	
Misdemeanor ASA	47.2 (27.1-77.9)
1st chair ASA	10.5 (6.4-18.3)

State Attorney's Office	
Traditional Cases	
Guilty Plea/Dismissal	
Misdemeanor ASA	35 (20-55)
Bench Trial	
Misdemeanor ASA	120 (100-240)
1st chair ASA	120 (60-240)
Jury Trial	
Misdemeanor ASA	845 (560-1425)
1st chair ASA	780 (520-1260)

Public Defender's Office	
MDPP Cases	
Successful Cases	
APD II	30 (20-45)
Unsuccessful Cases	
APD II	45.4 (36.8-73.2)
APD IV	8.9 (5.9-26.5)
PD Investigator	17.14 (3.4-28.6)

Public Defender's Office	
Traditional Cases	
Guilty Plea/Dismissal	
APD II	35 (30-45)
Bench Trial	
APD II	195 (145-390)
APD IV	120 (90-300)
PD Investigator	450 (90-750)
Jury Trial	
APD II	680 (415-2070)
APD IV	600 (360-1980)
PD Investigator	450 (90-750)

Output Costs

Cases that do not go through MDPP cost between an estimated $55 and $365 ($168 on average). Cases that successfully go through MDPP cost on average $130. Taking into account that 9% of cases are unsuccessful and return to the traditional pathway, the weighted average output cost of a MDPP case is $144. Therefore, program case outputs are typically an estimated $23 less than cases that go through the traditional route.

Court				
MDPP Cases			**Traditional Cases**	
Successful Cases			*Guilty Plea/Dismissal*	
Judge	10 (5-15)		Judge	20 (15-25)
Court clerks, court reporter, and pretrial officer	30 (15-45)		Court clerks, court reporter, and pretrial officer	120 (90-150)
Police officer and bailiff	4 (2-6)		Police officer and bailiff	4 (3-5)
Unsuccessful Cases			*Bench Trial*	
Judge	28.7 (19.6-41.7)		Judge	150 (80-335)
Court clerks, court reporter, and pretrial officer	96.7 (68.9-132.72)		Court clerks, court reporter, and pretrial officer	340 (180-729)
Police officer and bailiff	12.3 (7.7-21.3)		Police officer and bailiff	124 (63-305)
			Jury Trial	
			Judge	570 (345-885)
			Court clerks, court reporter, and pretrial officer	1180 (710-1830)
			Police officer and bailiff	544 (333-845)

Felony Drug School, Cook County, Illinois

The Drug School Program is a post-filing program targeting eligible drug charges (see Chapter 4). Analogous to the MDPP, we started by working with the State's Attorney Office (SAO) to develop a process map of activities and decisions from intake to closing the case. The main cost pathways of cases that go through Felony Drug School (FDS) and comparable felony drug cases that go through the traditional process. Defendants attend bond court and then, subsequently, enrollment typically happens at/just prior to the next court appearance in the preliminary hearing court. If the defendant enrolls, s/he signs a contract and receive a three-month court date. The participant then attends an appointment with the TASC office within 72 hours of accepting. They receive a program orientation and pick the program location where they will attend classes. The participant must attend all four classes to complete the program (see further details in Chapter 4). Activities included in the cost analysis over a 16-month intake window between September 5, 2012 and December 30, 2013 were broadly similar to the MDPP program.

Data Collection

Within these pathways, there are number of activities performed by each stakeholder group that are included in this study. Using the overview of case pathways, we interviewed

stakeholders (e.g. assistant prosecutors, assistant public defenders) about the type of activities they perform for cases that do and do not go through the program. We refer to activities involved in adjudicating a case as Investment costs. The table below presents the activities included in the cost estimation for each stakeholder by case type. While the general activities are the same for the SAO and PDO, the tasks differ for each group. Noted in the table are details of tasks included in determining the time spent on cases for all stakeholders.

Activities Included in the Investment Cost Estimation[20]

	Prosecutor's and Public Defender's Offices	Court
Successful	• Bond court • Preliminary Hearing • Arraignment • Monitor participation	• Bond court • Preliminary Hearing • Arraignment
Unsuccessful	• Successful case + Traditional case activities	• Successful case + Traditional case activities
Guilty plea / Dismiss	• Bond court preparation & appearance • Preliminary Hearing • Arraignment	• Bond court appearance • Preliminary Hearing • Arraignment
Bench trial	• Bond court preparation & appearance • Preliminary Hearing • Arraignment • Court appearances • Witness interview & Trial Prep • Trial • Sentencing	• Bond court appearance • Preliminary Hearing • Arraignment • Court appearances • Trial • Sentencing
Jury trial	• Bond court preparation & appearance • Preliminary Hearing • Arraignment • Court appearances • Witness interview & Trial prep • Jury selection • Trial • Sentencing	• Bond court appearance • Preliminary Hearing • Arraignment • Court appearances • Jury Selection • Trial • Sentencing

[20] Tasks included in the cost estimation, by activity listed in the table include: **Bond Court:** Review police report, interview client (discuss plea), time in court (e.g. judge instructions, etc.), paperwork; **Client Conference:** Read through discovery (police report, maybe photos), talk to client, decide what subpoenas to issue; **Preliminary Hearing:** Review police report, review criminal history, prepare offer, talk to attorney, judge's instructions, plea entered, discussion, paperwork; **Arraignment:** Open file, motion for discovery, judge's instructions, enter plea, paperwork; **Monitor Participation:** Communicate with pretrial services, run background check, dismiss for successful cases, discuss and arrange appearance for incomplete cases; **Trial Preparation:** Prep/review case for court, issue subpoenas; **Trial:** jury selection, judge's instructions, trial, paperwork; and **Sentencing:** Pre-sentencing investigation, judge's instructions, judge's comments, victims' comments.

Given recall bias and the resulting uncertainty in reporting case processing times, individuals reported the typical amount of time they spend on a case, as well as the minimum and maximum amount of time they could recall spending on each task. Specifically, as shown in the table below, each main activity has a set of criteria that ranges from a straightforward case with no conflicting information or continuances or non-police witnesses (minimum) to cases with some conflicting information and many appearances or continuances (maximum). The same criteria were used for interviews with the Prosecutor's and Public Defender's office.

Criteria for Low, Typical, and High Cases

	Low	Typical	High
Bond Court	No conflicting information	Limited conflicting information	Some conflicting information
Preliminary Hearing	Quick appearance	Typical appearance	Longer appearance
Arraignment	Quick appearance, no conflicting information	Typical appearance, limited conflicting information	Longer appearances, some conflicting information
Witness interview & Trial prep	Only police witness, no video evidence	Police and 1-2 witnesses, no video evidence	Police and 2-3 witnesses, video evidence
Jury Selection	Quick selection	Average selection	Long jury selection
Trial	No continuance, no video evidence, experienced judge and attorneys	1 continuance, no video evidence, experienced judge and attorneys	2 continuances, video evidence, longer discussions with attorneys
Sentencing	No continuance, relatively quick	No continuance, typical case	1 continuance, complex

Method

To generate the investment costs of each stakeholder group for each case type, we start by separately calculating the investments costs for misdemeanor cases that go through the traditional process by each stakeholder group j (ϵ SAO, PDO, Court) as a function of the minutes c spent by individuals i (ϵ assistant state attorney, 1st chair state attorney, assistant public defender II, assistant public defender IV, public defense investigator, judge, court clerk, court reporter, pretrial officer, police officer, and bailiff) working directly on guilty plea/dismissed cases (c), minutes d worked on bench trial cases, and minutes f worked on jury trial cases. The minutes spent are weighted by the proportion of guilty plea/dismissed cases (a), bench trial cases (b), and jury trial cases (1-a-b). The minutes spent by job type i is

multiplied by their pay rate per minute y_i, which generates the direct labor investment cost per traditional cost.

Direct Time Spent by Case Type, by Stakeholder Group

State's Attorney's Office				
FDS Cases			*Traditional Cases*	
Successful Cases			Guilty Plea/Dismissal	
Misdemeanor ASA	40 (25-55)		Misdemeanor ASA	90 (75-120)
Unsuccessful Cases			Bench Trial	
Misdemeanor ASA	101.0 (84.3-133.0)		Misdemeanor ASA	245 (205-305)
1st chair ASA	6.9 (5.0-8.9)		1st chair ASA	90 (60-120)
			Jury Trial	
			Misdemeanor ASA	815 (685-965)
			1st chair ASA	480 (360-600)

Public Defender's Office				
FDS Cases			*Traditional Cases*	
Successful Cases			Guilty Plea/Dismissal	
APD II	20 (15-40)		APD II	23 (20-25)
Unsuccessful Cases			Bench Trial	
APD II	33.4 (27.3-53.7)		APD II	183 (140-385)
APD IV	6.9 (5.0-8.9)		APD IV	90 (60-120)
PD Investigator	17.14 (3.4-28.6)		PD Investigator	450 (90-750)
			Jury Trial	
			APD II	658 (440-2050)
			APD IV	480 (360-600)
			PD Investigator	450 (90-750)

Court				
FDS Cases			**Traditional Cases**	
Successful Cases			*Guilty Plea/Dismissal*	
Judge	3 (2-4)		Judge	6 (4-8) (4-8)
Court clerks, court reporter, and pretrial officer	18 (12-24)		Court clerks, court reporter, and pretrial officer	36 (24-48)
Police officer and bailiff	6 (4-8)		Police officer and bailiff	12 (8-16)

Court	
Unsuccessful Cases	
Judge	28.7 (19.9-41.7)
Court clerks, court reporter, and pretrial officer	50.3 (34.2-66.5)
Police officer and bailiff	23.4 (16.3-30.5)

Bench Trial	
Judge	150 (80-335)
Court clerks, court reporter, and pretrial officer	228 (150-306)
Police officer and bailiff	106 (70-142)
Jury Trial	
Judge	570 (345-885)
Court clerks, court reporter, and pretrial officer	1008 (750-1266)
Police officer and bailiff	976 (730-1222)

Last, this is multiplied by the indirect or overhead rate *r* for stakeholder group *j* to include the indirect labor and supplies and equipment used to adjudicate the traditional case. Our cost estimates include the indirect resources of administrative staff (e.g. accountants, administrative assistants, secretaries, paralegals) and capital and equipment needed to deliver prosecution services. The indirect rate of the Cook County SA's Office is 7.5% of direct labor (Cook County State Attorney's Office, 2016). We multiply the total cost estimate of attorneys' time on cases by this indirect rate and sum to get the costs of inputs through the SA's Office. Similarly, we add indirect costs for the Public Defender's Office using the rate provided, 7.35%. For the Cook County Circuit Court, we add the costs of the Office of the Chief Justice that provides interpreters, law clerks and support staff, as the average indirect of the SA's Office and the Public Defender's Office.

We also calculate the resources spent on the disposition of cases, or "Output costs," and include criminal justice resources to monitor and deliver services associated with the sentence. For similar cases that go through the traditional route, we generate the cost by using the proportion convicted, average length of sentence, and cost per unit of sentence. Misdemeanor statistics for Cook County indicate 87.5% of misdemeanor cases result in conviction by plea or trial (George et al., 2015), and data shows the most likely sentence is community supervision (Illinois State Commission on Criminal Justice and Sentencing reform, 2016). We use data on probation length for misdemeanors served by offense type of 513 days in 2006 (Adams, Bostwick, & Campbell, 2011), and use two standard deviations (SD=237) below the mean to generate the minimum and two standard deviations above the mean to generate the maximum. The SAO provided Cook County costs per day in 2013 for Adult Probation Department services of $4.67 per probationer per day, which we assume is approximately the cost for Social Service Department costs per supervised individual.

For felony drug case outputs cost, we use felony statistics for Cook County because data shows the greatest proportion of cases are drug cases (e.g. possession of controlled substance, manufacture or delivery of narcotic) (Kunichoff, Hing, & Peterson, n.d.), which are eligible offenses for felony drug school. This latter point is important- while individuals convicted of felony drug possession can get jail time (Saltmarsh, 2016), those eligible for felony drug school do not have prior convictions in the last 10 years and are therefore are more likely to receive probation, rather than jail. Data shown in Chapter 3 indicates 63.0% of felony cases result in conviction, and data shows the most likely sentence for eligible cases is probation. We use data on probation length for felony drug cases served by offense type of 21.4 months (standard deviation=9.5) in 2006 (Adams et al. 2011). We use the State Attorney's Office provided costs per day in 2013 for Adult Probation Department services of $4.67 per probationer per day.

Output Costs

Cases that do not go through FDS cost between an estimated $211 and $3,563 ($1,888 on average). Cases that successfully go through MDPP cost on average $240. Using that 3% of cases are unsuccessful and return to the traditional pathway, the weighted average output cost of a FDS case is $297. Therefore, program case outputs are typically an estimated $1,591 less than cases that go through the traditional route.

Neighborhood Court, San Francisco City and County, California

The Neighborhood Court Program offered by the San Francisco City District Attorney's Office (SF DAO) involves predominantly misdemeanor cases with some felony property offenses permitted (based on the value of the theft). The most common offenses are theft, vandalism, graffiti, and prostitution. The program involves Assistant State Attorneys making eligibility decisions and offering the program.

As with all other programs for which we estimated costs, we started by working with the SF DAO to identify key cost pathways. As shown in the figure below, after a rebooker identifies a case as eligible and offers neighborhood court (NC), there is a period of time in which defendants need to accept NC. Those who accept the program go to a Community Board with a local trained panel who review the case and identify "directives" to be completed in a particular timeframe. Pretrial Services deliver services, assign offenders to sites, and monitor compliance. An individual may not accept the program in time (7 days), but there is another opportunity during the first court appearance. Similar cases that do not go through NC go through arraignment and several court appearances, including trial if they plead not guilty.

Data Collection

To collect the relevant cost data, in coordination with the SF DAO, we identified the key pathways that Neighborhood Court and similar cases take in the city of San Francisco jurisdiction. Using these pathways, we discussed the list of activities performed by attorneys separately in the District Attorney's Office and Public Defender's (SF PD's) Office. The attorneys in these offices discussed among themselves the time spent on the activities.

Activities included from the DAO and PD's Office in this cost analysis are listed below. The analysis uses non-traffic misdemeanors for the comparison group, with time spent for judges and clerks and staff based on results from a workload study in 2010 (see SB 56 Working Group 2011). We compare the costs of cases that go through Neighborhood Court to similar cases that did not, over the calendar year of 2016 (for SAO and PD's office) and 2010 (for Court).

Given recall bias and the resulting uncertainty in reporting case processing times, individuals reported the typical amount of time they spend on a case, as well as the minimum and maximum amount of time they could recall spending on each task. Specifically, each main activity has a set of criteria that ranges from a straightforward case with no conflicting information or continuances or non-police witnesses (minimum) to cases with some conflicting information and many appearances, conflicting information, and many witnesses (maximum). The same criteria were used for interviews with the Prosecutor's and Public Defender's office.

Method

To estimate the time spent on cases that go through the "Traditional Route," we adjusted for the proportion of cases that are disposed of before trial (at arraignment and at pre-trial settlement) and after trial. The cost of labor, salary and benefits, by job type for the DA's Office and PD's Office was provided by the DA's office. Our cost estimates also include the indirect resources of administrative staff (e.g. Accountants, Administrative Assistants, Secretaries, Librarians) and supplies and equipment needed to deliver prosecution services. The indirect rate of the San Francisco DA's and PD's Offices is 33.13% of direct labor (obtained through communication with the District Attorney's Office).

We multiplied the total cost estimate of attorneys' time on cases by this indirect rate and sum to get the costs of inputs through the DA's and PD's Office. For the San Francisco Court, we added the costs of the judges based on time spent for non-traffic misdemeanor cases in the 2010 workload study (SB 56 Working Group, 2011). Time spent by law clerks and support

staff for misdemeanors was not collected separately for traffic and non-traffic cases. However, 2016 unpublished data (at the time of this study) was available to the DA's office and preliminary findings indicate that non-traffic misdemeanor cases are 153.7% more time-consuming than the average misdemeanor (which includes traffic cases). We applied reported salaries (SF Superior Court 2016) and use the same indirect rate of the San Francisco DA's and PD's office.

Activities Included in the Investment Cost Estimation[21]

Case Type	Activities by Stakeholder	
	DAO	PDO
Successful	• Rebooking • Prepare case, offer NC • Setup NC case • Monitor completion • File close-out	• Court appearance (for late acceptance cases)
Unsuccessful	• Successful case + Traditional case activities	• Successful case + Traditional case activities
Guilty plea / Dismiss	• Case prep • Arraignment	• Case prep • Arraignment
Settle at pretrial	• Rebooking • Prep for & Arraignment • Prep for & Pretrial conference • Pre-trial settlement & conference • File close-out	• Prep for & Arraignment • Prep for & Pretrial conference • Pre-trial settlement & conference • File close-out
Settle at pretrial	• Rebooking • Prep for & Arraignment • Prep for & Pretrial conference • Pre-trial settlement & conference • Prep for trial & motions • Jury selection & Trial • Prep for & sentencing • File close-out	• Prep for & Arraignment • Prep for & Pretrial conference • Pre-trial settlement & conference • Prep for trial & motions • Jury selection & Trial • Prep for & sentencing • File close-out

[21] Tasks included in the cost estimation, by activity listed in the table include: **Rebooking:** Review cases for charging and eligibility, send referral packets; **Prepare Case:** Enter case into database, review and organize file, generate letter and new citation, order evidence, contact witnesses/victims/officers, review jury instructions, investigations, communication, subpoenas, research, draft motions, prepare scripts/statements/display of evidence/etc., paperwork (e.g. facts of case, key information checks, stay away orders, memos, etc.); **Set Up Case:** Schedule hearing, serve new citation, paperwork; **Charge Case:** Notifications, provide information; **Court Appearance:** Judge instructions, time on record waived, discussion, calendaring; **Monitor:** Monitor case in computer, provide updates to court; and **File Close-out:** Paperwork.

Direct Time Spent by Case Type, by Stakeholder Group (in Minutes)

State's Attorney's Office	
NC Cases	
Successful Cases	
Rebooker	7 (5-10)
Misdemeanor ADA	47 (31-82)
Unsuccessful Cases	
Rebooker	7 (5-10)
Misdemeanor ADA	1115.4 (658.0-1591.8)
NC Director	5.4 (2.7-8.1)
Traditional Cases	
Early Plea/Dismissal	
Misdemeanor ADA	40 (5-75)
Later Plea/Dismissal	
Misdemeanor ADA	468 (240-695)
NC Director	10 (5-15)
Jury Trial	
Misdemeanor ADA	5688 (3480-7895)
NC Director	10 (5-15)

Public Defender's Office	
NC Cases	
Successful Cases	
APD II	3 (2.5-3.7)
Unsuccessful Cases	
APD II	311.2 (146.1-619.3)
APD IV	5.4 (2.7-8.1)
Traditional Cases	
Early Plea/Dismissal	
APD II	10 (5-20)
Later Plea/Dismissal	
APD II	155 (65-240)
APD IV	10 (5-15)
Jury Trial	
APD II	1595 (760-3360)
APD IV	10 (5-15)

Note. Low and High in parentheses.

Court	
NC Cases	
Successful Cases	
Judge	3 (2-4)
Clerk	10 (8-13)
Unsuccessful Cases	
Judge	149
Clerk	472

Traditional Cases	
Judge	146
Clerk	462

INDIANAPOLIS CRIMINAL JUSTICE REFORM TASKFORCE

RECOMMENDATIONS

MAYOR JOSEPH H. HOGSETT
DECEMBER 2016

INDIANAPOLIS CRIMINAL JUSTICE REFORM TASKFORCE

RECOMMENDATIONS

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EXECUTIVE SUMMARY

The criminal justice system in Marion County is over-burdened and beset by underlying challenges that run back generations. Despite that, every single day, those working in the criminal justice system wake up and work tirelessly to make Marion County's streets safer. Over the last six months, leaders from across the criminal justice system came together to address challenges decades in the making and forge a new way forward. Every agency, despite the barriers that face all who seek to change the status quo, came forward ready to work collaboratively. The fundamental objective of these recommendations is to, in the long-term, work together to change the culture of the Marion County criminal justice system:

- from process driven to people driven;
- from processors to problem-solvers;
- from outdated policies and procedures to modern, cutting-edge evidence-based best practices;
- from inefficient and costly to outcome-driven and lean;
- from the ten-year cycle of "emergency, reform, stagnation, deterioration, emergency" to constant and continual innovation; and
- from an opaque and confusing system to one that is internally accountable and externally transparent.

How do we do that? By forging an identifiable, systemic approach to address the root causes of individuals' interactions with the criminal justice system.

The approach we recommend is threefold:

(1) create the prerequisites for constant, data-driven innovation;

(2) embrace and implement policies that promote accountability and transparency; and

(3) divert, when appropriate, residents suffering from mental illness and/or addiction from the criminal justice system and into evidence-based treatment.

CHAPTER 1

INTRODUCTION

On May 11, 2016, in his inaugural State of the City Address, Mayor Joe Hogsett set Indianapolis on a path of holistic, data-driven criminal justice reform[1]. Consistent with that commitment, Mayor Hogsett signed Executive Order No. 4, 2016 the very same day, which launched the Indianapolis Criminal Justice Reform Task Force (the "Task Force") as the vehicle for such change in Indianapolis[2].

Executive Order No. 4 set forth three specific directives[3]:

(1) The Mayor hereby creates and orders his staff to support the Criminal Justice Reform Task Force whose mission shall be to assess, research, examine, and ultimately report recommendations for the systemic reform and optimization of the current county criminal justice system, and – based on those recommendations – identify requirements for the location, construction, and/or renovation of county criminal justice facilities.

(2) The Mayor shall appoint members of the Criminal Justice Reform Task Force from the three branches of City-County government and pertinent City-County agencies represented in the Criminal Justice Planning Council, as well as subject matter experts and members of the community at his discretion.

(3) The Criminal Justice Reform Task Force shall finalize its work and report its findings and recommendations to the Criminal Justice Planning Council at the CJPC's regularly scheduled meeting in December of 2016.

This report represents the culmination of the work set out by Mayor Hogsett for the Criminal Justice Reform Task Force and marks the fulfillment of the three directives set forth in Executive Order No. 4, 2016.

[1] See Appendix A – Mayor Joseph. H Hogsett, State of the City Address, May 11 2016.
[2] See Appendix B – Mayor Joseph H. Hogsett, Executive Order No. 4, 2016.
[3] See Appendix B – Mayor Joseph H. Hogsett, Executive Order No. 4, 2016.

CHAPTER 2

TASK FORCE ORGANIZATION

At the direction of Mayor Hogsett, the Task Force was put together with transparency at the very heart of its organizational design. The Task Force consists of four key groups:

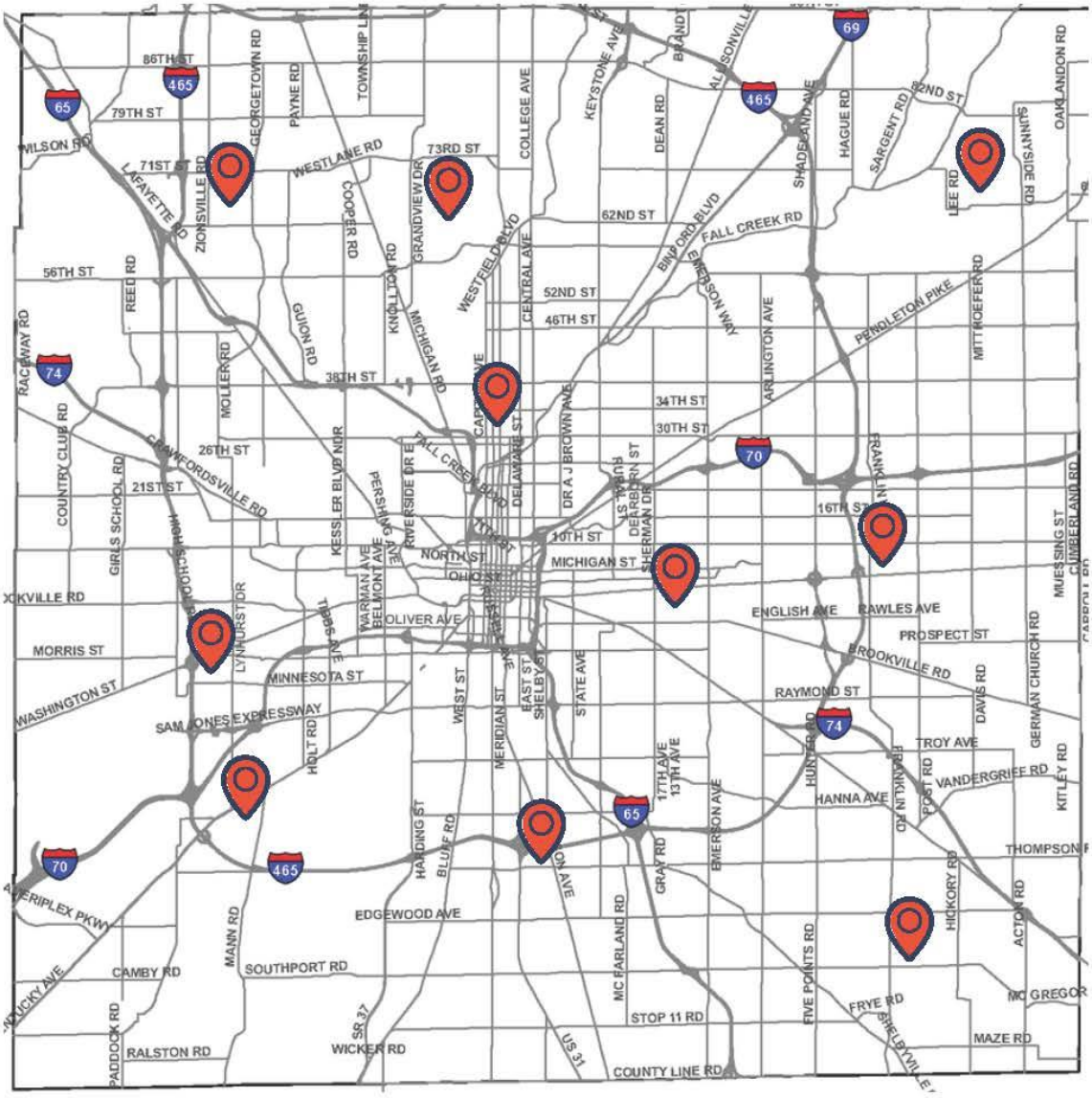
(1) **Community and Issue Stakeholders**: The Marion County criminal justice system impacts every part of Indianapolis and transcends the traditional lines drawn between government, non-profits, and neighborhoods. As a result, from the very beginning, the Task Force included non-governmental members of the community with a particular perspective, interest, or role in the Marion County criminal justice system. For example, the Task Force gained invaluable advice and cutting edge ideas from the following:

ACLU of Indiana
Central Indiana Community Foundation
EmployIndy
Greater Indianapolis NAACP
Greater Indianapolis Progress Committee
Health Foundation
Indiana Department of Corrections
Indiana University Health
Indianapolis Bar Association
Indy Chamber
Indy Chamber Workforce Policy Council
IndyCAN
Marion County Reentry Coalition
Mental Health America of Indiana
Recycle Force
The Richard M. Fairbanks Foundation

In addition to collaboration and discussions with these and other community and non-profit based organizations, the Task Force convened ten neighborhood-based forums throughout Indianapolis. Receiving ideas and feedback in all parts of the city, these forums and the conversations that they fostered underlie the recommendations set forth in this report.

Clockwise top left: **South District Meeting** (MNA Allie Kast); **Lawrence Township Meeting** (MNA Rosie Stockdale**); Wayne Township Meeting** (MNA Jordan Rodríguez); **NE and NW Center Township Meeting** (MNA Betty Smith and MNA Greg Garrett)

COMMUNITY FORUMS ON CRIMINAL JUSTICE REFORM



- 5401 W Washington St
- 501 N Post Rd
- 3935 W Mooresville Rd
- 6501 Sunnyside Rd
- 9010 E Southport Rd
- 4107 E Washington St
- 4925 Shelby St
- 5353 W 71st St
- 6701 Hoover Rd
- 3243 N Meridian St

(2) **Indianapolis-Marion County City-County Council:** The Task Force includes all twenty-five members of the City-County Council and the Chief Financial Officer of the Council. A bipartisan group of councilors from across the city engaged in various parts of the Task Force's work, including internal discussions with government stakeholders, community conversations at ten different neighborhood-based forums, and various meetings with community and issue stakeholders.

(3) **Enterprise Stakeholders:** The Task Force includes internal government stakeholders who work every day in the Marion County criminal justice system. The following offices and agencies are represented on the Task Force:

Health & Hospital Corporation of Marion County
Indianapolis Metropolitan Police Department
Indianapolis Office of Public Health & Safety
Indy EMS
Marion County Circuit Court
Marion County Clerk's Office
Marion County Community Corrections
Marion County Coroner's Office
Marion County Forensic Service Agency
Marion County Prosecutor's Office
Marion County Public Defender Agency
Marion County Sheriff's Department
Marion County Superior Court

(4) **Hogsett Administration:** The Task Force includes various members of the Hogsett Administration. This group was sub-divided into five lines of inquiry that drove the Criminal Justice Reform Task Force's analysis.

Community Outreach and Engagement Team

- **Dr. David Hampton**, *Deputy Mayor of Neighborhood Engagement;*
- **Lena Hackett**, *Executive Director - Marion County Re-Entry Coalition*

Finance Team

- **Bart Brown**, *Chief Financial Officer - City-County Council*
- **Fady Qaddoura**, *City Controller*
- **Sarah Riordan**, *Executive Director and General Counsel, Indianapolis Local Public Improvement Bond Bank*

Operational Team

- **Camille Blunt**, *Legislative Director* | Inter-Governmental Relations
- **A. Scott Chinn**, *Partner - Faegre Baker Daniels LLP* | General Counsel
- **Krystal Hill**, *National Urban Fellow* | Education and Workforce Training
- **Andrew J. Mallon**, *Corporation Counsel* | Facilities Team
- **Timothy J. Moriarty**, *Special Counsel to the Mayor* | Chair
- **André Zhang Sonera**, *Peterson Fellow* | Operations Director

Process Mapping Team

- **Paul Babcock**, *Director – Office of Public Health & Safety*
- **Scott Hohl**, *Project Manager – Information Services Agency*

System Design Team

- **Former Lt. Governor Kathy Davis**, *City Systems Engineer*
- **Hope Tribble**, *Director, Office of Audit and Performance*

CHAPTER 3

TASK FORCE TIMELINE AND ENGAGEMENT

The Criminal Justice Reform Task Force's work was divided into three distinct phases.

(1) <u>Phase One – Discovery</u>

- June – August 2016
  - One-on-one sessions
  - Data-gathering
  - Current criminal justice system process map
  - Exemplary systems ("best practices") review

(2) <u>Phase Two – Analysis</u>

- September – October 2016
  - Departmental review
  - New criminal justice system process map
  - Determine new facility needs
  - Rank scenarios

(3) <u>Phase Three – Master Plan</u>

- November – December 2016
  - Determine top 2-3 scenarios
  - Neighborhood-based, community forums
  - Vet scenarios
  - Complete final recommendations

CHAPTER 4

THE STATUS QUO IN OUR CRIMINAL JUSTICE SYSTEM

The Marion County criminal justice system is exhausted and without an identifiable, systemic approach to many of the underlying causes of crime in Indianapolis. This impairs the system's ability to promote both safety and justice. Understanding the way forward requires a clear-eyed assessment of the past.

A. The Apparent Problem: An Overcrowded and Antiquated Jail System

Every morning, city and county leaders receive a report from the Marion County Sheriff's Office providing the county's current Jail population. Every morning, the report shows a population approaching or exceeding 2507 (the capacity of Marion County's jails). As of December 2, 2016, Marion County's jail population was three over its limit. Every morning, the Marion County criminal justice system teeters on the edge of its capacity.

Indianapolis is not unique in the fact that it is facing an overcrowded local jail. For decades, United States jail and prison populations grew as arrest rates climbed.[4] In recent years, the trend has gone in the opposite direction, as the number of individuals ending up in prison or jail after the disposition of their case has started to decline.[5] However, such a decline has not been true of those who are detained in local jails *pre-disposition*.[6] In fact, the percentage of pre-disposition detainees

[4] Revicki, Jesse et al. *Local Justice Reinvestment: Targeting Reforms at The Front End of the Criminal Justice System.* The Crime and Justice Institute, October 2015.
[5] Ibid.
[6] Ibid.

"has increased from 52 percent of the US jail population in 1990 to 63 percent in 2014."[7] Since 2000, the pre-disposition population in the United States "has accounted for 95 percent of the nation's jail population growth."[8] Consistent with this growth, a 2014 study found that 84% of detainees in Marion County's jails were pre-disposition.[9] Grappling with exploding jail populations, jurisdictions all over the country are in search of answers.

Though part of what is a national trend, jail overcrowding is not something new to Indianapolis. As recently as 2006 and 2007, criminal justice leaders were grappling with many of the same issues as today, including a jail overcrowding crisis. At the time, Mayor Bart Peterson, Sheriff Frank Anderson, and judicial leaders came together to address the issue in the short term. And they were successful in abating the crisis. However, over the succeeding ten years, the momentum created by that period of consensus was lost, as contentious debates increasingly focused on new facilities took hold, and any discussion of holistic reform died.

In 2013, with the passage of House Enrolled Act 1006 ("HEA 1006"), the State of Indiana made clear its intent to push a significant number of inmates out of the Indiana Department of Corrections and into local jails. As of January 1, 2016, with those changes in effect, the Marion County criminal justice system has accumulated more and more inmates that, in the past, would have gone to state prison. On April 26th, 2016, with Marion County Jail I and Jail II straining at full capacity, Sheriff John Layton declared a jail emergency. To abate the crisis, Sheriff Layton was forced to move so-called "1006" inmates to other jails throughout Indiana at great expense. Given its only recent implementation, the full effect of HEA 1006 on Marion County jails remains to be

[7] Revicki, Jesse et al. *Local Justice Reinvestment: Targeting Reforms at The Front End of the Criminal Justice System.* The Crime and Justice Institute, October 2015.
[8] Ibid.
[9] See Appendix C, BKD Jail Capacity Data Analytics Strategic Plan for the City of Indianapolis – Marion County, October 20, 2016.

seen. In fact, an analysis conducted by an outside consultant (Huron) estimated that HEA 1006's full impact could bring an additional 109 to 468 detainees to Marion County's jails. Yet again, the system confronts a jail overcrowding crisis.

In looking back at Marion County's various struggles with its jail population, a pattern or cycle has clearly developed. It starts with some sort of emergency (typically an overcrowded jail). The emergency drives a series of patchwork reforms and temporary fixes. The resulting changes keep the system operational and semi-functional (for a time). Ultimately, stagnation and then decline prevail. Another emergency or crisis ensues and overcrowding comes back into public light.

This cycle is inherently self-defeating and it continues for three reasons. First, the cycle is reinforced by the fact that success or failure in the criminal justice system has been too closely tied to the jail population's proximity to its capacity. If there are beds open, things are going "well." If the population is at capacity, things are not going "well." Second, with this focus on the jail population, many critical aspects of the criminal justice system have been oriented (from organizational structure to policies and procedures) around the overcrowding issue. And third, as a result, given this profound focus on capacity and remediating the issue that is front and center (overcrowding), the system has been unable to adequately analyze, identify, and remediate the issues actually driving the crisis. Jail overcrowding itself is *not* the fundamental problem the Marion County criminal justice system must address. The fact that many vital parts of the Marion County criminal justice system have, over the last two decades, been oriented completely around the overcrowding issue is the fundamental problem that must be addressed. And to look forward, city and county leaders must look back.

B. The Beginning: A "War on Drugs"

On June 17, 1971, at a press conference announcing the formation of the Special Action Office for Drug Abuse Prevention, President Richard M. Nixon told the American people that "public enemy number one in the United States is drug abuse. In order to fight and defeat this enemy, it is necessary to wage a new, all-out offensive" – and so began America's "War on Drugs."[10] In the years that followed President Nixon's pronouncement, federal, state, and local governments initiated a series of new policies and spent over $1 trillion attempting to win the "war."[11] Taken as a whole, their strategies have not achieved their stated goals. A report by the *British Medical Journal* concluded that in the United States "the average inflation-adjusted and purity-adjusted prices of heroin, cocaine and cannabis decreased by 81%, 80% and 86%, respectively, between 1990 and 2007, whereas average purity increased by 60%, 11% and 161%, respectively."[12] In addition, between 1980 and 2009, the number of those incarcerated in the United States climbed from 500,000 to 2.3 million.[13] A large part of that exponential rise came in the form of drug arrests, as "[s]ince the 1980s, the number of drug offenders in state and federal prisons has increased more than 10-fold."[14]

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[10] See Appendix D – President Richard M. Nixon, Remarks About an Intensified Program for Drug Abuse Prevention and Control, June 17, 1971. It is worth noting that, in his accompanying message to Congress, President Nixon said the following (See http://www.presidency.ucsb.edu/ws/?pid=3048):

> While experience thus far indicates that the enforcement provisions of the Comprehensive Drug Abuse Prevention and Control Act of 1970 are effective, they are not sufficient in themselves to eliminate drug abuse. Enforcement must be coupled with a rational approach to the reclamation of the drug user himself. The laws of supply and demand function in the illegal drug business as in any other. We are taking steps under the Comprehensive Drug Act to deal with the supply side of the equation and I am recommending additional steps to be taken now. But we must also deal with demand. We must rehabilitate the drug user if we are to eliminate drug abuse and all the antisocial activities that flow from drug abuse.

[11] Associated Press, "AP IMPACT: After 40 years, $1 trillion, US War on Drugs has failed to meet any of its goals," *Fox News*, May 13, 2010. (See also http://www.foxnews.com/world/2010/05/13/ap-impact-years-trillion-war-drugs-failed-meet-goals.html).

[12] Werb, Dan et. Al. "The Temporal Relationship Between Drug Supply Indicators: An Audit Of International Government Surveillance Systems". *BMJ Open,* vol 3, no. 9, 2013, p. e003077. *BMJ,* doi:10.1136/bmjopen-2013-003077

[13] Li, Hao, "The War on Drugs a 'Total Failure' and Statistics Prove It". *International Business Times*, June 6, 2011.

[14] Ray, B. et al. "Access to Recovery and Recidivism Among Former Prison Inmates". International Journal of Offender Therapy and Comparative Criminology, 2015, SAGE Publications, doi:10.1177/0306624x15606688.

C. <u>The Underlying Issue, Part I:</u> The Crack Cocaine Epidemic

In the 1980s, crack cocaine proliferated in American cities – including Indianapolis. Crack's invention "represented a technological innovation that dramatically widened the availability and use of cocaine in inner cities."[15] Things moved fast, "[v]irtually unheard of prior to the mid-1980s, crack spread quickly across the country, particularly within Black and Hispanic communities."[16] Distributed in small amounts, "in relatively anonymous street markets, crack provided a lucrative market for drug sellers and street gangs."[17] And related violence followed, "[b]etween 1984 and 1994, the homicide rate for Black males aged 14-17 more than doubled and homicide rates for Black males aged 18-24 increased almost as much."[18] As the nation moved through the 1990s, the crack cocaine epidemic subsided and homicides declined across American cities – except in Indianapolis.[19] Indianapolis stayed among a very small group of cities "where crack use and homicide rates . . . [rose] sharply in the 1990's, an exception to the national declines."[20] And then, seemingly without pause, one drug crisis was succeeded by another.

D. <u>The Underlying Issue, Part II</u>: The Opioid Epidemic

Over the course of the past ten years, an opioid epidemic has invaded and seized control of the streets of American cities, and suburbs, and small towns, and rural communities. In 1995, the United States Food and Drug Administration "approved a controlled-release pain pill called *OxyContin* in response to complaints that patients with cancer and other chronic diseases were not getting the pain relief they needed."[21] And its use exploded, as "OxyContin . . . [became] the most

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[15] Fryer, Roland et al. "Measuring Crack Cocaine and Its Impact". 2006.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Butterfield, Fox, "Drop in Homicide Rate Linked to Crack's Decline," *The New York Times*, Oct. 27, 1997.
[20] Ibid.
[21] Disis, Jill, "Indy's Heroin Epidemic: It's Cheap, Easy to Get, Deadly," *The Indianapolis Star*, Mar. 12, 2014.

prescribed brand-name narcotic medication for treating moderate-to-severe pain in the country."[22] By 2005, "prescription pain medication had become a $329.2 billion industry, with a record 4.02 billion drug prescriptions filled in 2011."[23] For many, pill by pill, the treatment of pain turned into the feeding of an addiction. Indeed, in the United States, "overdose deaths from prescription painkillers quadrupled between 1999 and 2011."[24] As a result, government at all levels cracked down on pharmaceutical companies and how they marketed painkillers, on many doctors who over (or illegally) prescribed, and on street dealers.[25] Pills became harder to get (and therefore cost more).[26] But opioid addiction is an all-consuming affair – for those afflicted "'their whole lives are organized around them getting opioids.'"[27] Strung out and desperate, they went in search of something cheaper and easier to come by.[28]

Heroin is prolific in America as Mexican cartels are flooding the United States illegal drug market with it.[29] In fact , "the sticky brown and black 'tar' heroin they produce is [being] channeled by traffickers into the U.S. communities hit hardest by prescription painkiller abuse, offering addicts a $10 alternative to $80-a-pill oxycodone."[30] And the collateral effects of the transition are evident: "In 2012, the most recent year for which data are available, nationwide deaths from prescription painkillers dropped 5 percent from 2011, but heroin overdose deaths surged by 35 percent."[31] But

[22] Ibid.
[23] Ibid.
[24] Khazan, Olga, "The New Heroin Epidemic," *The Atlantic Monthly*, Oct. 30, 2014.
[25] Ibid.
[26] Ibid.
[27] Ibid.
[28] Volkow, Nora, M.D., "America's Addiction to Opioids: Heroin and Prescription Drug Abuse," *National Institute on Drug Abuse: Presentation to Senate Caucus on International Narcotics Control*, May 14, 2014.
("The emergence of chemical tolerance toward prescribed opioids, perhaps combined in a smaller number of cases with an increasing difficulty in obtaining these medications illegally . . . may in some instances explain the transition to abuse of heroin, which is cheaper and in some communities easier to obtain than prescription opioids.)
[29] Miroff, Nick, "Losing Marijuana Business, Mexican Cartels Push Heroin and Meth," *The Washington Post*, Jan. 11, 2015.
[30] Ibid.
[31] Khazan, Olga, "The New Heroin Epidemic," *The Atlantic Monthly*, Oct. 30, 2014.

this transition isn't "apples to apples," it's far more treacherous than that. What makes heroin different, and in many respects profoundly more dangerous, than prescription pain-killers is not only its availability (it's easy to come by in most cities) and its price (it's very cheap) but is its unpredictability: "With heroin, impurities and contamination can make an already dangerous drug even more deadly."[32] In addition, "[h]eroin is one of the most addictive drugs, more habit-forming than cocaine, alcohol, and other common substances."[33] All over the country, heroin's grip has so altered the American public health landscape that law enforcement officials indicate that opioid addiction kills more individuals than violent crime and vehicle accidents.[34] In fact, "[a]mong persons aged 25 to 64 years old in the United States, unintentional drug overdose is now the leading cause of death with prescription and illicit opioids as the most common cause of these fatal overdoses."[35] Indiana, and Indianapolis, are no exception.

Over the past four years, Indiana has been at the epicenter of the nation's heroin epidemic. As the state's largest city, Indianapolis has seen an exponential rise in heroin usage.[36] And the collateral effects have taken hold. This year Indianapolis is on pace to set a record for opioid overdose 911 calls.[37] What's more, while in the past paramedics administered roughly 500-600

[32] Ibid.
Haberman, Clyde, "Heroin, Survivor of War on Drugs, Returns with New Face," *The New York Times*, Nov. 22, 2015. ("Nearly 44,000 Americans a year — 120 a day — now die of drug overdoses. Neither traffic accidents nor gun violence, each claiming 30,000-plus lives a year, causes so much ruination.")
[33] Khazan, Olga, "The New Heroin Epidemic," *The Atlantic Monthly*, Oct. 30, 2014.
[34] Daniels, Deborah, "Heroin Abuse is a True Public Health Crisis," *Indianapolis Business Journal*, June 11, 2016. ("When I was a prosecutor, I thought the spread of addictive drugs was primarily a law enforcement problem. We had little authority to impact demand, and generally saw that as someone else's problem. Maybe when all you have is a hammer, the world looks like a nail. I now recognize that, while enforcement is critical in getting major dealers off the street, this is in fact a major public health problem.")
[35] Fisher, Rian et al. "Police Officers Can Safely and Effectively Administer Intranasal Naloxone". 2016
[36] Disis, Jill, "Indy's Heroin Epidemic: It's Cheap, Easy to Get, Deadly," *The Indianapolis Star*, Mar. 12, 2014.
[37] Denoon, Leigh, "Illicit Fentanyl is Amplifying Indy's Overdose Epidemic," *WFYI*, Aug. 1, 2016.

dosages of Naloxone[38] a year, 2015 saw that number rise to 1220.[39] In 2016, first responders are on pace to administer over 1,500 dosages in Indianapolis.[40] However, heroin's impact transcends the user.

In case after case, heroin invades and destroys more than a person, it destroys families. From a public health standpoint, overdoses represent only the immediate aspect of heroin's toll, as its "use increases the risk of being exposed to HIV, viral hepatitis, and other infectious agents."[41] For pregnant women, heroin use "during pregnancy can result in neonatal abstinence syndrome (NAS)"[42] – transmitting addiction from mother to fetus.[43] Indeed, the impact of heroin upon children is nothing short of tragic. Since the onset of the epidemic, Indiana has seen a marked rise in the number of CHINS (Child in Need of Services) cases statewide – from over 16,000 in 2014 to over 20,000 in 2015.[44] In Marion County the issue is particularly acute, as it saw a 65% rise in the number of CHINS cases in only five years (from 2,300 in 2010 to 3,800 in 2015).[45]

[38] See Substance Abuse and Mental Health Services Administration (SAMHSA), http://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone. ("Naloxone is a medication approved by the Food and Drug Administration (FDA) to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of the overdose. Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection.")

[39] Denoon, Leigh, "Illicit Fentanyl is Amplifying Indy's Overdose Epidemic," *WFYI*, Aug. 1, 2016.

[40] Ibid.

[41] National Institute on Drug Abuse, "Research Report Series: Heroin," U.S. Department of Health and Human Services - National Institutes of Health. See https://www.drugabuse.gov/sites/default/files/rrheroin-14.pdf.

[42] Ibid. ("NAS occurs when heroin passes through the placenta to the fetus during pregnancy, causing the baby to become dependent along with the mother.") See https://www.drugabuse.gov/sites/default/files/rrheroin-14.pdf.

[43] Tully, Matthew, "Tully: Meet Heroin's Tiniest, Youngest Victims," *The Indianapolis Star*, June 1, 2015. ("Morphine raced through the newborn's tiny body. He had been given a dose earlier that morning to fight off his opiate cravings and would soon receive more. Without the drug, nurses told me, the baby's pain would be overwhelming. His body would shake and he would be racked with diarrhea so bad that it could eat at his skin. His loud cries and screams would pierce the halls here at Franciscan St. Francis Health on the city's Southside.")

[44] Haeberle, Bennett, "Child welfare cases soar within Indiana's heroin epidemic," *WISHTV*, Feb. 4, 2016. ("While there is some debate among them about whether there is a single cause linked to these increased caseloads, the consensus remains the same – heroin is part of the equation and the drug's choking grip on Indiana is suffocating a child welfare system already overburdened.")

[45] Ibid.

E. <u>The Underlying Issue, Part III</u>: Mental Illness and the Criminal Justice System

For decades, the fundamental approach to mental illness in the United States centered upon the institutionalization of those afflicted. But, in the 1970s and 1980s, a movement rose in support of deinstitutionalization. Ultimately, the movement won out, and proposals became policies.[46] Since then, the results of deinstitutionalization have been the subject of much debate. At various points, experts and commentators have labeled deinstitutionalization alternatively as a "psychiatric *Titanic*," "one of the great social disasters of recent American history," a "tragedy," and "one of the era's most stunning public policy failures."[47] Meanwhile, its defenders argue those finding a direct causal relationship between deinstitutionalization and a rise in homelessness draw too simple conclusion.[48] Regardless of these disagreements, there have been some indisputable developments as a result:

> *Notwithstanding their broad pronouncements, both supporters and opponents will agree that deinstitutionalization has caused significant positive results for a large number of people who would otherwise have been set apart from their communities and denied the basic interactions of civic life. This includes many people with psychiatric disabilities—as well as people with intellectual and developmental disabilities, whose deinstitutionalization has been far less controversial. But there is also little doubt that, in the wake of deinstitutionalization, a significant number of people with psychiatric disabilities were left to fend for themselves.*[49]

In the end, it is that final point that is particularly relevant. The lack of social service support in conjunction with deinstitutionalization disproportionately failed the poor.

Regardless of the causation question with respect to deinstitutionalization and homelessness, "[e]ven if deinstitutionalization did not cause the problem of homelessness among

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[46] Bagenstos, Samuel R., "The Past and Future of Deinstitutionalization Litigation," Cardozo Law Review, 34:1, at 6-7.
[47] Ibid at 3.
[48] Ibid at 7-11.
[49] Bagenstos, Samuel R., "The Past and Future of Deinstitutionalization Litigation," Cardozo Law Review, 34:1, at 4.

individuals with psychiatric disabilities, it has not provided adequate services and supports to those individuals to enable them to flourish."[50] On the backend of deinstitutionalization, there was never an adequate approach towards "promoting investments in the kind of community service infrastructure that enables people with psychiatric disabilities to thrive in the community."[51] All over the country, and in Indianapolis in particular, many of those who in the past would have been confined to psychiatric hospitals "are now in jails or congregate private institutions like nursing homes and adult-care homes."[52]

The criminal justice system in Indianapolis, and Marion County's jails, have become the default "provider" for many of those suffering from mental illness. Indeed, the mentally ill "are disproportionately represented in jail and prison, both nationally and in Central Indiana."[53] At the national level, the number of mentally ill in jail is ten times higher than those receiving treatment in psychiatric hospitals.[54] And the detention is more expensive, as detaining those with mental illness costs 20%-60% more than other detainees.[55] According to the Marion County Sheriff's Office, over 900 detainees in Marion County's jails at any one time suffer from some form of mental illness and "the additional health care and services required to address the needs of mentally ill prisoners, (including medication, doctors, security, etc.) costs an estimated $8 million per year."[56] And these numbers are growing. The prevalence of those suffering from mental illness in the public health

[50] Ibid at 11.
[51] Ibid at 12.
[52] Bagenstos, Samuel R., "The Past and Future of Deinstitutionalization Litigation," Cardozo Law Review, 34:1, at 12.
See also, E. Fuller Torrey, Editorial, Jails and Prisons—America's New Mental Hospitals, 85 AM. J. PUB. HEALTH 1611 (1995). ("Quietly but steadily, jails and prisons are replacing public mental hospitals as the primary purveyors of public psychiatric services for individuals with serious mental illnesses in the United States.").
[53] Ray, Brad et al. Addressing Mental Illness in The Central Indiana Criminal Justice System. 1st ed., Indiana University Public Policy Institute, 2016, https://policyinstitute.iu.edu/Uploads/PublicationFiles/MentalHealthBrief_Final20031516.pdf.
[54] Wiseman, Jane and Stephen Goldsmith. "Why We Need to Move Away from Jailing the Mentally Ill". Governing Magazine, 2016, http://www.governing.com/blogs/bfc/col-savings-diverting-mentally-ill-jail.html.
[55] Ibid.
[56] Ray, Brad et al. Ibid.

and criminal justice systems increases each year. Between 2010 and 2013, the number of Indianapolis EMS patients/incidents that involved mental illness as a primary factor went from just over 3300 to well over 4800 – a 45% increase in just four years.[57]

F. The Fundamental Challenge: An Exhausted System with No Identifiable Systemic Approach to Underlying Causes

Marion County taxpayers see more of their dollars spent in the criminal justice system than in any other part of local government. Taken together, IMPD, the Marion County Sheriff's Office, the Marion County Prosecutor's Office, the Marion County Public Defender Agency, and the Marion County Superior Courts cost taxpayers over $440,000,000 a year. The question is whether that money is spent appropriately, effectively, and whether overburdened stakeholders have a system that is worthy of their strenuous daily efforts to keep Indianapolis safe. To answer such a question, it is necessary to make a determination of what "success" in the criminal justice system means. If "success" is a jail kept (however tenuously) below its capacity and tens of thousands of arrests and cases adequately processed, then taxpayers are getting a good return on their investment. However, if "success" in the criminal justice system means discernibly safer neighborhoods, then the system is falling short of public expectations. If "success" is preventing those suffering from mental illness and/or addiction from taking the next step on the trajectory of a criminal career by assessing and treating them, then the system is falling short of public expectations. If "success" is preventing offenders from reoffending over and over and over again, then the system is falling short of public expectations.

[57] See Appendix E – Indianapolis EMS, *Mental Health Report 2014*.

In Indianapolis, the opioid epidemic and under-served residents suffering from mental illness are consuming government assets and resources at an ever-increasing rate. From 911 calls, EMS responses, and ER visits to arrests, arrestee processing, plea agreements, jury trials, and jail beds, these two challenges have stressed already overburdened public health and criminal justice systems. However, currently, Marion County's criminal justice systems lack a cohesive strategy for addressing these underlying challenges. For example, while proactive enforcement efforts by the Marion County Prosecutor's Office and IMPD have been successful in targeting the *supply* of heroin in Indianapolis, there is no co-equal (and aligned) approach to addressing the *demand* for heroin in Indianapolis. And while entities like the Marion County Re-Entry Coalition (MCRC) and the Coalition for Homelessness Intervention and Prevention (CHIP) work to bring all the relevant government, non-profit, and community actors together with respect to a particular issue (be it re-entry or homelessness), no such centralized effort exists with respect to mental illness and addiction. As a result, current efforts aimed at treatment and service provision are not systematic, integrated, or appropriately scaled.

Without a cohesive approach, the criminal justice system assets and infrastructure that *are* in place will not adequately and systematically assess individuals to determine what issues are underlying their behavior. And without effective assessment in terms of addiction, mental illness, housing, et cetera, it is impossible to effectively channel individuals to the treatment and services that are available. As a result, so-called "super utilizers" cycle again and again through the public health and criminal justice systems. It is costly, inefficient, inhumane, and unjust.

CHAPTER 5

THE THREE AVENUES OF SYSTEMIC REFORM

Criminal justice reform in Indianapolis, if distilled to its essence, means this: moving from processing to problem-solving. Here's how it can be done.

A. The Pre-Requisites of Constant Innovation

To effectively and meaningfully move from processing to problem-solving, city and county leaders must confront the cycle of "emergency, reform, stagnation, decline, emergency" that has emerged over the past decade. Like any successful organization, new ideas must be considered, implemented, and evaluated constantly. The following recommendations lay the groundwork to make such change possible.

RECOMMENDATION A1

PERPETUAL INNOVATION PARTNERSHIP AND INDIANAPOLIS-MARION COUNTY CRIMINAL JUSTICE EVIDENCE-BASED BEST PRACTICES LIBRARY

To innovate, criminal justice agencies must have access to best practices that have been attempted elsewhere and worked. The Task Force recommends – and has already taken initial steps towards establishing – a partnership between the City of Indianapolis, Office of Public Health & Safety, and Indiana University-Purdue University at Indianapolis - School of Public and Environmental Affairs Professors Dr. Bradley Ray and Dr. Eric Grommon, and Indiana University – Bloomington School of Public and Environmental Affairs Professor Dr. Deanna Malatesta. Under

the terms of a memorandum of understanding, the Task Force recommends that the partnership include:

- Creation of a comprehensive criminal justice evidence-based best practices library rooted in five points of intervention (See Appendix F)[58];
- Consistent updates of the library with emerging, validated best-practices;
- Consultation regarding best practice implementation upon request of a criminal justice agency;
- Study and assessment of the results of best practice implementation upon request of a criminal justice agency;
- Joint application for requisite grants to fund partnership.

RECOMMENDATION A2

CREATION OF "ONE INDY" AND IMPLEMENTATION OF "RWISE" PROGRAM

Traditionally, once an agency selects a new policy or practice it would like to utilize, a pilot project is initiated and after a period of implementation (months, if not years), it is evaluated for effectiveness. A determination is then made as to whether the particular policy or practice should be discarded or expanded. The problem with this approach is it does nothing to address the uncertainty inherent on the front end. Given the plethora of policy options available, it is difficult to determine which may have the greatest impact in a particular city or county. If three different best practices exist with respect to a particular issue, which one does an agency choose? "One Indy" is a City initiative that will utilize a cutting edge tool to provide criminal justice agencies guidance

[58] See Appendix F – Spencer Lawson, Eric Grommon, Bradley Ray, *Review of Evidence-Based Programs and Practices in the Criminal Justice System*, September 2016.

on precisely this question and bring data-driven change to the Marion County criminal justice system.

In an era of shrinking public resources and complex and persistent policy challenges, "One Indy" will enable the City of Indianapolis to develop and utilize actionable intelligence for community leaders to make data-informed decisions and monitor real-time impacts of policy changes. The actionable intelligence results from integration of longitudinal data with evidence-based models to inform collaborative, data-based analysis, discussions and decision making, followed by intentional action planning, measurable goals, and continuous monitoring of outcomes. "One Indy" will integrate resources throughout Central Indiana to create an interactive model of Indianapolis that will provide a testing environment for collaborative design thinking. The building of the environment has begun with the data necessary to understand the environmental factors, individual experiences, and responses related to crime.

Leveraging leading-edge technology, the city will model the impacts of proposed interventions prior to implementation, develop action plans that align, and collectively track results and indicators to adjust and improve. Indianapolis will:

- Integrate longitudinal citizen, property, neighborhood, and economic data;
- Provide interactive access to data elements;
- Visualize and analyze paths with respect to goals;
- Model best practices;
- Build an agent based model and live, forward-looking view of our situation; and
- Design and track actions.

Figure 1 - Actionable Information to Meet System Reform Goals

The opportunity is simple and compelling - police know incidents and responses and crime, service providers know health and basic needs, the city knows property and infrastructure, schools know students and families, universities know communities and economies. The city can bring its information together for a shared view of the landscape, insights into how it can make change, and ongoing accountability for making improvement.

To achieve these objectives, "One Indy" will utilize the Reference World Information System Environment (RWISE). Developed by Purdue University professor Alok Chaturvedi, RWISE is an agent based modeling technology that incorporates Nobel Prize winner Daniel Kahneman's theories of what drives people to action. The agent-based modeling integrates research findings and multiple sources of longitudinal data to create a virtual world, pointed toward a goal. It describes

people's pathways toward that goal, and allows users to test ideas and see how people respond before trying changes in real life.

In RWISE, there is a place for all data. Data is drawn mechanically and located in the virtual world to describe people in their environment over time. The whole person, and every person, is depicted on a path with respect to an objective. Agent based modeling will allow the city to bring its information together and create a historic and live computer environment mirroring the real world. Experiences come from the local geography, infrastructure, organizations, other people, and media with whom de-identified computerized people, or agents, interact.

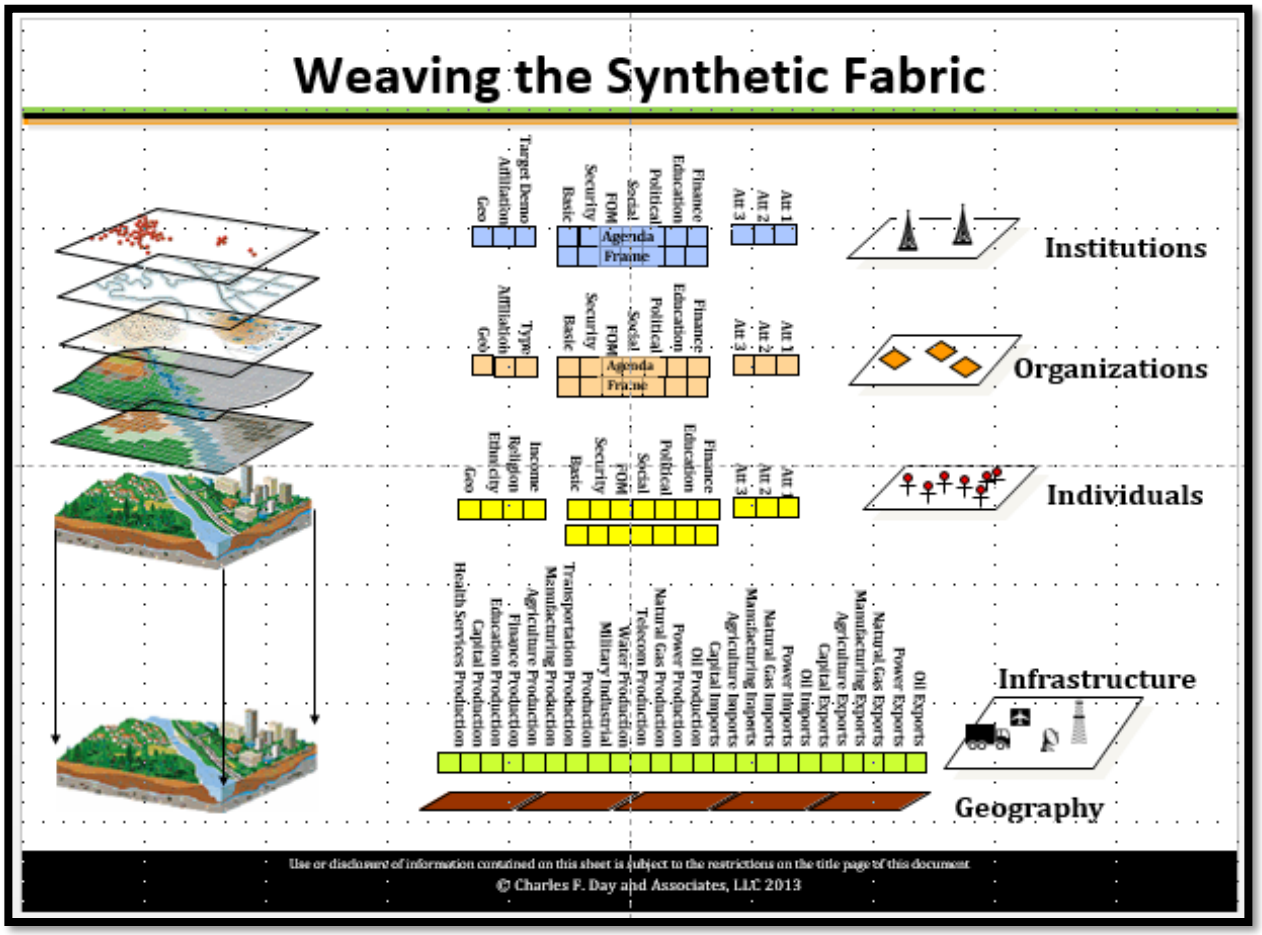

Figure 2 – Building of the Synthetic Environment; Institutions, Organizations, Individuals, Infrastructure, and Geography

People experience wellbeing in several categories. Individuals have common needs for shelter, food, safety, and the ability to get around. Individuals have different priorities for their social, economic, and spiritual well-being. Well-being creates a predictive connection between events in the individual's environment and individual motivation, decisions, and outcomes.

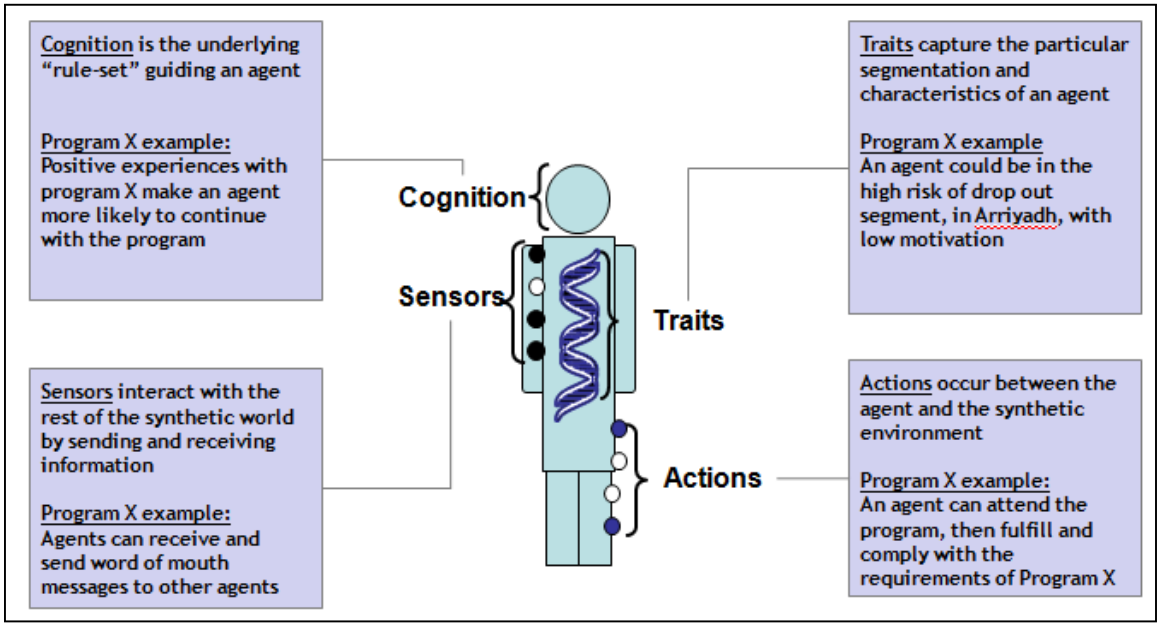

Figure 3 – Fundamental functions within and between agents

The main features of the simulations will be:

- Bringing to life longitudinal data, creating in a computer the pipeline of individual resident demographic representations;
- Modeling the traits, sensors, environment and wellbeing of our citizens;
- Introducing events, real or planned, into the environment. See outcomes through an interactive user interface. Organizations and institutions learn how their contributions are experienced in people's lives.

- Deriving the individual traits, influences, factors, and decision points that most impact results;
- Seeing how strategies are best customized for groups. Write policy and rules that allow for desirable variation;
- Keeping a real time geographic view, a needs analysis and testing environment for collaborative leaders solving complex problems with limited resources.

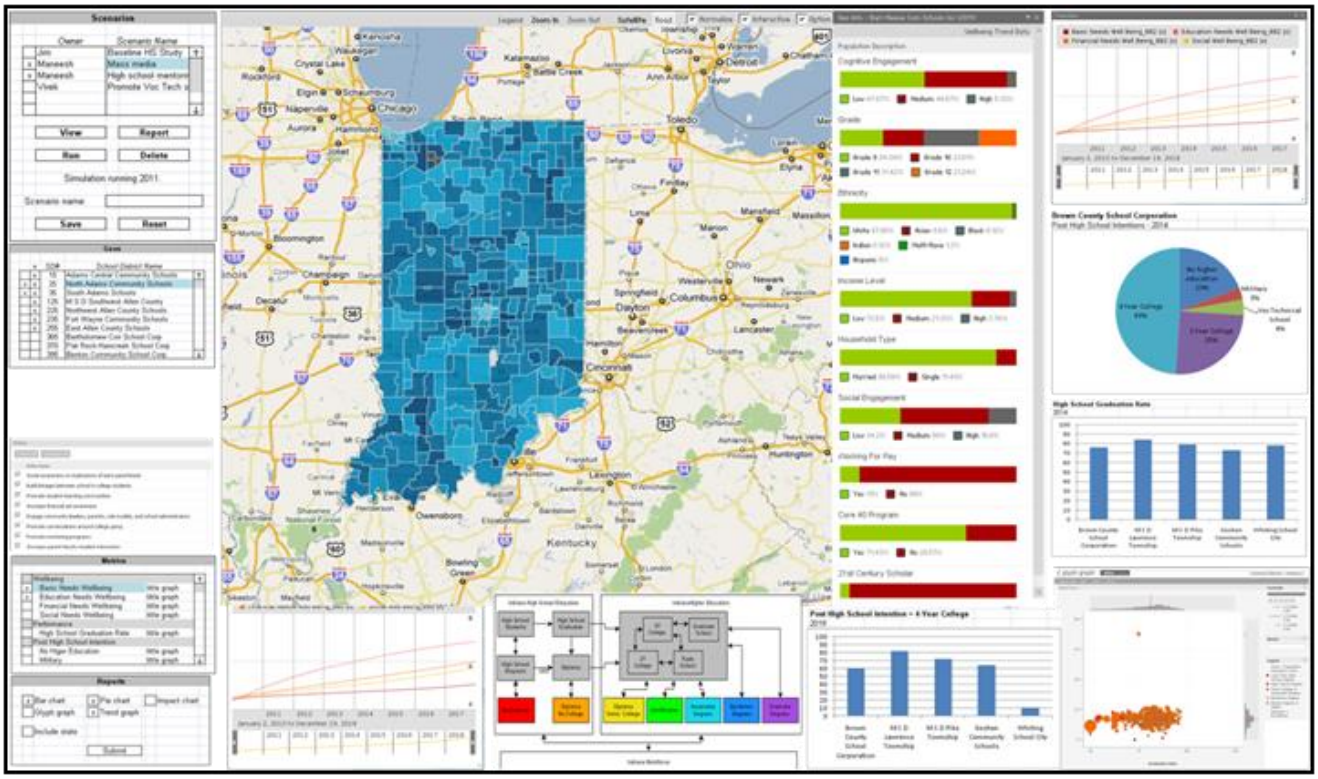

Figure 4 – The environment will have features to run different scenarios, save and compare them, and provide analysis. Users will see how a different mix of policy interventions impact metrics of interest.

Stated simply, One Indy and RWISE will provide the city a picture of its residents and community that is comprehensive enough to target policy interventions to those who need them most, provide what is needed, and measure the results of those efforts.

RECOMMENDATION A3

INDIANAPOLIS SUPER UTILIZERS INITIATIVE

In April of 2016, the Indianapolis-Marion County City-County passed Proposal 112, Mayor Hogsett's proposal to reform the governing structure of Indianapolis' approach to public safety. Fundamentally, Proposal 112 created the Office of Public Health & Safety, which was designed to bring a modern, holistic approach to public safety, crime prevention, and mental health. The office is tasked with coordinating the efforts of local, state, and federal agencies to address the root causes of crime in a comprehensive way across jurisdictional silos. Consistent with that mission, the Office of Public Health & Safety will lead the Indianapolis Super Utilizers Initiative.

A "super utilizer" (or "frequent flyer") is an individual that interacts with a particular public safety or public health agency repeatedly. A report by BKD on the Marion County criminal justice system concluded that "a significant number of individuals with multiple arrests can be identified, and these arrestees take up a disproportionate number of criminal justice resources."[59] Consuming an out-sized portion of agency assets, many cutting-edge best practices are aimed identifying "super utilizers" and then utilizing preventative approaches.

Nationally, various communities are engaged in such inter-agency "super utilizer" approaches. For example, King County, Washington created the "Familiar Faces Initiative." The initiative:

> [consists of] . . . systems mapping, design, and improvement work centered on creating a system of integrated care for complex health populations that can eventually benefit any user of publicly-funded health services. Familiar Faces are a sentinel population defined as individuals who are frequent utilizers of the King County jail (defined as having been booked four or more times in a

[59] See Appendix C, BKD Jail Capacity Data Analytics Strategic Plan for the City of Indianapolis – Marion County, October 20, 2016, at 17.

> twelve-month period) and who also have a mental health and/or substance use condition.[60]

In their initial analysis across jurisdictional lines, King County was able to draw a variety of insightful conclusions. For instance, "94% of all people with 4 or more jail bookings [had] a behavioral health indicator," "93% had at least one acute medical condition (average 8.7 conditions)," "51% had at least one chronic health condition (average 1.8 conditions)," and "[m]ore than 50% were homeless."[61]

All over Indianapolis, hospitals, service providers, first responders, and others are working to identify their respective "super utilizers." However, they are doing so on an intra-agency basis, maintaining jurisdictional silos. Given the fact that "super utilizers" tend to consume not just one entity's resources in an out-sized fashion, the Office of Public Health & Safety will convene all of the relevant public health, criminal justice, and public safety entities in Marion County to share the relevant and necessary data, identify inter-agency "super utilizers," and design a collective, cross-jurisdictional policy of intervention and prevention. A comprehensive, inter-agency approach to "super utilizers" in Marion County will create operational efficiencies for the agencies involved, financial efficiencies for taxpayers, and better outcomes for the target population.

RECOMMENDATION A4

ENHANCED COLLABORATION BETWEEN GOVERNMENT AGENCIES AND OTHER ACTORS WITH RESPECT TO MENTAL ILLNESS AND ADDICTION

Indianapolis has a number of organizations working to address the challenges presented by mental illness and/or addiction. The good work of these non-profit, advocacy, and

[60] See Appendix G, King County Health and Human Services Transformation, The Familiar Faces Initiative, June 2016, at 1.
[61] Ibid at 3-4.

community-based groups has laid the groundwork for much progress. However, a key finding of the Task Force has been the necessity of establishing better connections between such entities and that of government and quasi-governmental actors. There is simply no place where all of the relevant entities consistently can come together to outline what each is doing and seeing, as well as what can be done better collectively. The Task Force recommends that, consistent with Health and Hospital Corporation of Marion County's ("HHC") role as the lead entity with respect to this report's assessment and treatment related system design, HHC also convene the relevant governmental and non-governmental actors to discuss the appropriate steps for enhanced collaboration.

B. Forging Internal Accountability and External Transparency

Across the country, cities and counties are struggling to ensure that all residents and all parts of the community have faith and trust in the criminal justice system. Indeed, Americans' confidence in the criminal justice system has waned as "[s]ixty-seven percent of the public now think [that] government is doing a fair or poor job with our justice system."[62] Meanwhile, almost seventy percent of Americans believe that the justice system is weighted in favor of the rich, and eighty-three prevent believe that "people with money are able to buy their way out of jail, while the poor remain incarcerated."[63] To sustain and build trust, local criminal justice systems must become more transparent about their operations and more open with their data. In addition to enhancing the credibility of the criminal justice system in the broader community, policies aimed at expanding transparency naturally bring with them an enhanced level of internal accountability and, thus, performance. The following recommendations are aimed at bolstering residents' confidence in the

[62] See Appendix C, BKD Jail Capacity Data Analytics Strategic Plan for the City of Indianapolis – Marion County, October 20, 2016, at 22-23.
[63] See Appendix C, BKD Jail Capacity Data Analytics Strategic Plan for the City of Indianapolis – Marion County, October 20, 2016, at 23.

Marion County criminal justice system by making the system more efficient with taxpayer dollars, more effective in its business processes, and more accessible and open in evaluating its own performance.

RECOMMENDATION B1

IMPLEMENTATION OF PERFORMANCE METRICS DASHBOARD

The Marion County criminal justice system currently faces a series of serious challenges when it comes to managing its data. A report by BKD determined that as a result of moving from a "small number of systems (JUSTIS and JIMS) to a greater number of separate software packages for each major stakeholder . . . [,] stakeholders in the state's largest city have lost the ability to look across the entirety of the criminal justice system . . . ."[64] BKD found that much of the historic, pre-existing data had been corrupted or was "otherwise not easily accessible," and ultimately concluded that "the ability to extract and analyze data to provide insight on system challenges is limited."[65] While a core group of stakeholders have made meaningful strides in connecting the relevant software systems, once relevant data does become available it must be utilized in the most effective manner possible. Consistent with the recommendation of BKD, the Task Force recommends implementation of a performance metrics dashboard via utilization of One Indy and RWISE.

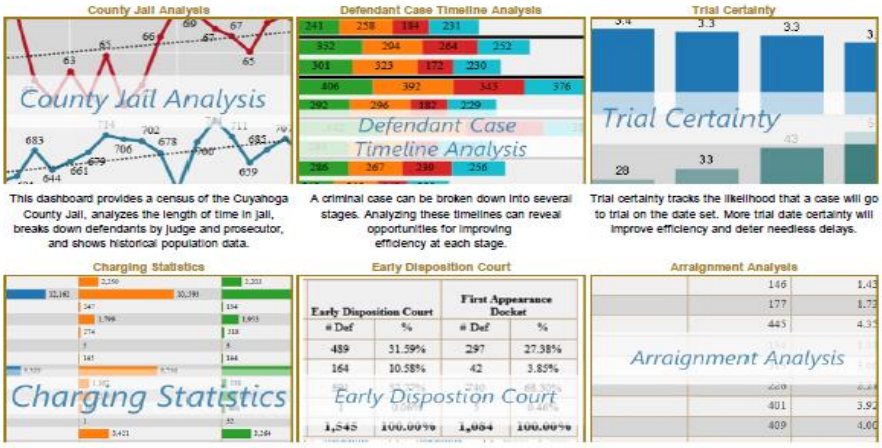

Figure 5 – Cuyahoga County, Ohio Criminal Justice System Performance Metrics Dashboard

[64] Ibid. at 2

[65] See Appendix C, BKD Jail Capacity Data Analytics Strategic Plan for the City of Indianapolis – Marion County, October 20, 2016, at 2.

Performance metrics dashboards have been utilized in other communities to better evaluate justice system performance and to enhance public access. These tools provide a number of metrics that convey the efficiency and timeliness of key processes and make clear vital system outcomes. For example, Cuyahoga County, Ohio provides residents access to metrics such as a jail population analysis, defendant case timeline analysis, trial certainty, charging statistics, early disposition court data, arraignment analysis, diversion breakdown, active case analysis, and adult dispositions. The information is provided online in a user-friendly format.[66] In Marion County, with technical support from One Indy and RWISE, the Task Force recommends that the Criminal Justice Planning Council (CJPC) determine what performance metrics provide the most insight and implement a performance metrics dashboard accordingly. Once designed and implemented, additional data and indicators can be added based on user feedback, stakeholder interest, and community engagement.

RECOMMENDATION B2

Process Mapping and Business Practice Improvements

Marion County criminal justice stakeholders interact with one another in myriad of ways, from communicating sentences, issuing arrest warrants, or transporting prisoners. These interactions create an interwoven system defined by each stakeholder's legal duty, budgetary restrictions, and structural composition, which impacts their interaction with one another and shapes the processes they employ to serve the residents of Marion County. Efficient processes provide the backbone for a just and equitable criminal justice system, while inefficient processes

[66] See illustration on previous page and see: http://prosecutor.cuyahogacounty.us/en-US/justice-system-performance.aspx

frustrate residents, slow the system, and hinder civil servants from fulfilling their duties to the citizens of Marion County.

The Taskforce set out to understand the interwoven processes of the Marion County criminal justice system by developing business process maps for critical actions of each agency and meeting with each of the agencies to discuss ways to improve processes. Business process maps detail, document, and clarify individual steps for processes in written and visual form. They allow stakeholders to pinpoint exact bottlenecks and inefficiencies within the flow, and to recommend changes to alleviate the obstacles.

A team of analysts led by Scott Hohl of Marion County Information Services Agency (ISA) met with each stakeholder on behalf of the Taskforce. The team of analysts conducted approximately 50 meetings with the criminal justice stakeholders, including IMPD, the Marion County Sheriff, the Marion County Prosecutor, the Public Defender, the Superior Courts, the Marion County Clerk, Marion County Probation, Marion County Community Corrections, Marion County Forensic Services Agency, and the Marion County Coroner.

The meetings produced the process maps attached and the following recommendations. These recommendations represent potential process improvements to increase efficiencies across the entire City-County government enterprise. The recommendations were gathered from the different stakeholder groups and presented to them for consideration. The increased efficiencies made possible by these changes will improve the functioning of the entire criminal justice system, communication across the stakeholder agencies, and the transparency of the Marion County criminal justice system.

PROCESS RECOMMENDATIONS

Give Identification Responsibilities (IDENT) to IMPD to Decrease Duplication

CURRENT PROCESS: IMPD and the Marion County Sheriff both identify arrested individuals. Each agency takes separate booking photos and verifies the individual's identity independently. The Sheriff finger prints the arrestee, and then IMPD verifies the print and maintains Automated Fingerprint Identification System (AFIS).

PROBLEM: Multiple agencies responsible for identification creates accountability and efficiency problems by increasing the number of steps in the process and dispersing ultimate responsibility amongst agencies and personnel.

PROPOSAL: IMPD IDENT staff should be responsible for the entire identification process. One booking photo should be taken and shared with other agencies, as needed. IDENT staff should print and verify arrests because this would decrease potential for error and increase identification accuracy.

Switch Entirely to Electronic Fingerprints to Expedite and Standardize Identification

CURRENT PROCESS: IMPD uses ink and electronic finger prints.

PROBLEM: This is duplicative and time consuming because it requires an ink print to be taken, and then a separate electronic print. This duplicity can lead to discrepancies, which can cause delays in identification. Additionally, the electronic print is the official record in AFIS.

PROPOSAL: IMPD should transition to electronic prints. E-filing has made the electronic print sufficient and this change will eliminate the need for ink prints.

Utilize Odyssey Case and Cause Numbers to Decrease Costs and Improve Charge Filing Times

CURRENT PROCESS: Marion County creates specific case and cause numbers for individuals arrested and charged. This was done to act as a placeholder for issuance of bond and posting of bond when the Courts' Odyssey electronic case management software system was first implemented.

PROBLEM: Creation of separate Marion County case and cause numbers leads to confusion because bond is posted on the Marion County case and not recognized on the filed case in Odyssey. This requires the prosecutor to file a request for the Marion County case to be dismissed and then refile the case to reflect the accurate system.

PROPOSAL: Marion County case and cause number creation should be discontinued and Odyssey usage should begin from the beginning. This will decrease additional work and cut down on delays.

Issue Only FBI Numbers for Everyone Arrested to Improve Information Sharing

CURRENT PROCESS: Marion County issues a unique Gallery Number for every arrestee. This number is in addition to the FBI number each arrested individual gets assigned to them.

PROBLEM: Due to identification errors, individuals could have more than one Gallery Number. Plus, Gallery Numbers are unique to Marion County and are not utilized by any other County in Indiana. The FBI number is assigned to every arrestee upon identification, which makes the Gallery Number a duplication.

PROPOSAL: Utilize FBI numbers instead of Marion County Gallery Numbers to identify arrestees. This would allow for easier sharing of information between agencies and departments in Indiana and the nation. No new technology would be required to make this shift.

Conduct Mental Health and Substance Abuse Screenings Prior to Filing Charges to Improve Public Health Impact Outcomes for Arrested Individuals

CURRENT PROCESS: The Arrestee Processing Center (APC) provides processing services for the county after an individual is arrested. Space limitations and building layout hamper the screening capacity of the APC and the services that can be provided to individuals upon arrest.

PROBLEM: The APC currently offers limited medical screening, limited mental health and drug/alcohol screening, no risk assessment at screening, and identification completed at the end of the process, which can lead to charges prior to accurate identification.

PROPOSAL: Conduct a full mental health screening of individuals brought to APC prior to the prosecutor screening the case for charges. This would include an approved risk and mental health assessment, which would be shared with all parties involved. Identification would also occur prior to prosecutor screening and each person would be assigned a FBI number.

Provide Flexible Placement Language in Orders to MCCC

CURRENT PROCESS: Individuals are ordered to Marion County Community Corrections (MCCC) by courts with orders that rarely provide flexibility in placement and programs. Changes require hearing in front of Judge to adjust order.

PROBLEM: This limits MCCC's ability to step-up, or down, an individual's placement and/or programming based on compliance or progress.

PROPOSAL: When deemed appropriate by the courts, provide language in MCCC orders to allow MCCC flexibility in placement and/or programming.

Consider Sentence Codes the Official Record for Release to Decrease Sentence Confusion and Increase Release Efficiency

CURRENT PROCESS: Inmate records include the sentence code and comments from Judges and court regarding sentence.

PROBLEM: The comments are often contradictory to the sentence code. The discrepancy between the sentence codes and the comments leads to confusion, which can require courts to be contacted to resolve the discrepancy, leading to delays in release and placement.

PROPOSAL: Sentence codes should be considered the official record for release, or placement, and overrule any comments.

Exclusively Utilize the Odyssey System's Bond Module to Decrease Bond Mistakes

CURRENT PROCESS: The court does not enter information into the Bond Module in Odyssey. Instead, bond information is placed into the Case Notes section of Odyssey. This requires the Sheriff's staff to review the notes.

PROBLEM: Extra time is required to read Case Notes because no Bond event information is sent to the Sheriff. This increases time required to determine Bond information and potential for errors.

PROPOSAL: Courts should utilize the Bond Module in Odyssey to decrease potential mistakes and increase efficiencies.

Transfer Property and Evidence Room Responsibilities to the Marion County Forensic Services Agency to Minimize Contamination Potential and Decrease Evidence Transportation Costs

CURRENT PROCESS: Evidence is collected by IMPD, or by Crime Lab technicians, and transported to IMPD's property room. If forensic testing is requested, evidence is retrieved from the property room and transported to the crime lab. Multiple testing requests require numerous evidence transports to and from property room and crime lab. Transportation requires handling of evidence by a technician, or staff personnel.

PROBLEM: Transportation and handling of evidence from property room to crime lab and back to the property room increases transportation costs, along with the increased potential for contamination of evidence.

PROPOSAL: Transfer responsibility for the Evidence Room from IMPD to the Forensic Services Agency (FSA). This will decrease transportation costs and potential for contamination.

Presumptively Test all Amounts of Drugs Confiscated at Crime Scenes to Unclog Court Dockets

CURRENT PROCESS: Amounts of drugs over 10 grams and under 1 gram are presumptively tested.

PROBLEM: Delay in getting information on drug arrests increases pre-trial incarceration and clogs court dockets.

PROPOSAL: Presumptively test all amounts of drugs discovered during an arrest.

Dedicate Investigative Personnel Specifically for Forensic Results to Increase Case Closing

CURRENT PROCESS: Investigative forensic results are sent to multiple points of contact at each IMPD district. There is a 21% hit rate for forensic results tying evidence to known individuals.

PROBLEM: There is a lack of follow through on these sent results, leading to delays in resolving cases with unknown suspects.

PROPOSAL: Dedicate an investigative detective from IMPD to follow-up on all investigative forensic results, or a deputy prosecutor dedicated by the Marion County Prosecutor's office to follow-up on all results, to increase closed cases with unknown suspects.

Search Warrants and Grand Jury Cases Remain with Original Judge to Maintain Consistency in Resolution of Amendment and Motions

CURRENT PROCESS: Judicial review of Grand Jury cases and Search Warrants for long-term investigations are done on a rotating basis. Grand Jury cases and Search Warrants for long-term

investigations can last multiple months, and even over a year. Any request for additional items in a Search Warrant, or update in evidence for a Grand Jury case, requires additional judicial review. Updates and/or amendments to Grand Jury cases, or Search Warrants, could be sent to multiple Judges over the duration of the investigation.

PROBLEM: The change in Judge for a Grand Jury case, or Search Warrant, often requires extensive explanation, in many cases requiring a complete review of the original Probable Cause, to bring the new Judge "up to speed" on the case. This results in unnecessary administrative time for both the Judge and prosecutor. It can also cause a delay in a time sensitive request regarding a Search Warrant.

PROPOSAL: Grand Jury cases and Search Warrants should remain with the original assigned Judge for the duration of the Grand Jury case or Search warrant. This will allow for quicker resolution of amendments and updates, as the Judge will already be familiar with the case and original Probable Cause. This will allow the process for Grand Jury cases and Search Warrants to be more efficient and provide more consistency in the cases.

Equip All IMPD Officers with Personnel Identification Devices to Improve Identification of Suspects in the Field

CURRENT PROCESS: Approximately 15 to 20 IMPD officers are equipped with Personal Identification Devices (PID's). These devices allow officers to take an electronic fingerprint in the field. This allows officers to properly identify individuals they encounter. It results in proper results for warrant searches and fewer arrest report mistakes due to false reporting of identity.

PROBLEM: The inability to properly identify an individual in the field can lead to two primary problems. The first is related to open warrants. An individual with open warrants could be released from the scene because his identity could not be verified, resulting in a potentially dangerous individual remaining loose. Second, false reporting on an arrest report can result in mistakes and

problems later in the charging and filing process. It is possible for charges to be filed and a case created before proper identification of the arrestee occurs. This results in the original case needing to be dismissed and a new charging decision and case creation occurring. This duplication of effort wastes time and can result in incorrect information on another individual's criminal history.

PROPOSAL: Equip all officers in the field with Personal Identification Devices (PIDs). This will allow for more accurate identification of individuals officers encounter. It will result in increased warrant arrests and fewer errors as a result of false reporting. This will create more efficiency and fewer errors in the screening and charging process. This can also work with IMPD's move to electronic Officer Arrest Reports (OAR). The electronic fingerprint from the PID could be added to the electronic OAR.

Utilize One Officer Arrest and Incident Report to Maintain Accuracy of Information

CURRENT PROCESS: IMPD officers complete a paper/carbon copy Officer Arrest Report (OAR) for every arrest. The OAR is sent with the arrestee to the Arrestee Processing Center (APC). At the APC, an ink fingerprint is put on the OAR to positively identify the arrestee. The data from the OAR is manually entered into the Sheriff's case management system. The OAR is used to identify and document the process of arrestees at the APC. The officer in the field must then complete an electronic Incident Report on their case management system.

PROBLEM: The information provided on the OAR is nearly identical to that entered into the Incident Report. This results in duplicative work for the officer in the field. This means more time spent completing paperwork and delaying the officer's ability to return to his beat. This also results in the reliance on paperwork for the APC and Inmate Records process. This can lead to delays and/or confusion with lost or misplaced paperwork.

PROPOSAL: The OAR and Incident Report should be combined into a single electronic form. There would be no need for duplicate data entry. The document could have an electronic print attached from the PID in the field. The report, with electronic print, could be sent directly to the Sheriff's case management system at the APC. Staff there would be able to identify and process individuals electronically, doing away with paper. This would allow for more efficiency, fewer mistakes and easier tracking of arrestees through the process. This would also be a step towards the Sheriff being able to make the Inmate Records process electronic, instead of relying on paper. The same data could be sent into IMPD's case management system to complete the Incident Report. The increased efficiency would allow officers to spend less time on paperwork, and more time on their beat.

All Traffic Tickets Should Be Issued Electronically to Improve Revenue Collection and Decrease Failure to Appears (FTAs)

CURRENT PROCESS: Most traffic tickets are issued on paper and handwritten. In addition, to avoid constant re-printing of ticket books, fine amounts, instructions and information on traffic court is not printed on the tickets. The paper traffic tickets are delivered to the Arrestee Processing Center and then transported to traffic court. At traffic court, the tickets are manually entered into Odyssey. A limited number of officers have access to IMPD's electronic ticketing system. These tickets are typed up electronically and printed off for the violator. The tickets automatically download into Odyssey.

PROBLEM: Issuing paper tickets creates multiple problems. Manually writing tickets leads to inefficiency. The officer must hand-write the ticket, then the ticket must be manually entered into Odyssey at traffic court. Issues with handwriting can lead to errors, or cause delays while awaiting clarification. Because no fine amounts or instructions are printed on the tickets, violators are expected to call an information line, or go online for fine amounts, payment options or court

instructions. This leads to uncontrollable call volume at traffic court. Violators don't pay tickets in a timely manner or Fail to Appear for scheduled court dates. This affects potential traffic ticket revenue and increases the traffic court docket due to unnecessary hearings and FTA's.

PROPOSAL: All traffic tickets should be issued electronically. IMPD should expand its electronic ticketing system to all officers, or should partner with the Indiana State Police and utilize their e-ticketing system. This will allow for quicker and more accurate tickets that can automatically download into Odyssey. This will save time and reduce errors. Instructions and fine amounts should be printed on all tickets. This will greatly reduce confusion for violators and make call volume manageable at traffic court. This can increase payments on traffic tickets, in a timelier manner. It can also result in far fewer instances of Failure to Appear for scheduled hearings and/or fewer suspensions of licenses due to missed hearings and/or non-payment.

Automatically Generate Summons Upon Ticket Being Issued to Increase Transparency and Access to Courts

CURRENT PROCESS: When paper traffic tickets are entered into Odyssey, a summons should be generated and sent out to the violator informing them of their court date. If an electronic ticket downloads into Odyssey, the summons should be created and sent to the violator.

PROBLEM: Summons are not sent on all traffic tickets. The problem is exacerbated by manually entering paper tickets. This results in high Failure to Appear rates for traffic court. FTA's lead to individuals losing their licenses due to missing hearings they were not aware of, and causes additional hearings to be scheduled to resolve a case.

PROPOSAL: Summons should be automatically generated with the entry of any traffic ticket into Odyssey. Utilizing only electronic traffic tickets could further automate this process. Upon the tickets being downloaded, the summons could be created and sent. The court date could also be

generated and printed on the electronic ticket at the time of issuance as well. This could lower the FTA rate, thereby reducing the amount of court resources needed for additional hearings. This would also reduce the number of individuals arrested and processed for FTA on traffic cases.

Maintain Evidence in a Central Repository to Minimize Transfers Between Agencies

CURRENT PROCESS: Evidence is transferred from one agency to another manually and/or multiple copies of the same item are made.

PROBLEM: Duplicate copies results in redundant storage, both electronic and/or paper. The manual transfer of evidence between agencies can cause delays.

PROPOSAL: Evidence should be maintained in a central location. A central repository for evidence (documents, audio and video files) could be accessed by all agencies as needed. This would also reduce the need for multiple copies of the same piece of evidence, thereby resulting in savings. One-Drive is a possible solution.

Develop Integrated Data Sharing Systems to Increase Communication Between Agencies

CURRENT PROCESS: When the County's prior criminal case management system, JUSTIS, was decommissioned as a court-case management system for Marion County, it resulted in each agency/department in the criminal justice system needing their own case/document management system: IMPD- "Interact," Prosecutor- "INPCMS," Public Defender- "PDIS," Sheriff- "OMS," Probation and Community Corrections- "Informer." The separate "CORE-Dexter" software had to be developed as a means of transferring data between the systems listed. The initial requests for data to be shared was completed successfully.

PROBLEM: Subsequent requests for additional data sharing or enhancements to the data sharing have been hindered by delays in updating programming or requirements by partner vendors. This has resulted in some data not being shared, causing delays and/or errors.

PROPOSAL: All criminal justice-public safety partners, and their vendors, should cooperate in a timely manner to ensure connections and data sharing between systems is achieved. If data sharing is limited due to system constraints, partner agencies should look to new operating systems which seamlessly integrate with other partner agency systems. No agency or department should operate on a system which is not capable of integrating with other systems. In addition, wherever systems are utilized by multiple agencies for similar processes, every effort should be made to partner to utilize one system as opposed to multiple systems.

Develop a Chief Data Officer for Marion County Government to Increase Transparency

CURRENT PROCESS: There is no individual responsible for overseeing all systems and/or data in criminal justice-public safety.

PROBLEM: This results in no oversight to ensure compatibility between systems within different agencies/departments. There is also no central contact for ensuring system-wide data is shared with the public.

PROPOSAL: The role of a Chief Data Officer should be explored. This individual would be responsible for ensuring compatibility, and the efficient and accurate sharing of data, between all systems within criminal justice-public safety. This individual would also lead the effort to make data accessible to the public to increase confidence in the system.

C. <u>The Indianapolis Model:</u> Identification, Assessment, Appropriate Diversion, and Treatment for those Suffering from Mental Illness and/or Addiction

The Challenge

On average, more than 40,000 arrests are made in Marion County every year.[67] Of those detained in the Marion County Jail, roughly 30-40% of detainees are classified as mentally ill.[68] In addition, roughly 85% are "diagnosed as suffering from substance abuse issues."[69] However, these numbers vastly underestimate the prevalence of such issues in the overall criminal justice system for three reasons. First, these numbers are based on those arrestees who make it to Marion County Jail I or Jail II. A significant number of low-level offenders are processed at the Arrestee Processing Center (APC) and released pre-disposition – never reaching either jail. Second, the extent of mental health and addiction screening that is done at the APC is minimal. BKD reports that while individuals are assessed for serious mental health conditions at the APC, "nurses are not present at the APC 24 hours per day.[70] Finally, and perhaps most critically, Marion County has no comprehensive policy with respect to the identification of those who may be suffering from mental illness and/or addiction at any stage of the criminal justice process from pre-arrest to entrance into either Marion County Jail I or Jail II.

Because the Marion County criminal justice system has a "processing" orientation rather than a "problem-solving" orientation, it is impossible to pinpoint and determine the scope of the

[67] See Appendix C, BKD Jail Capacity Data Analytics Strategic Plan for the City of Indianapolis – Marion County, October 20, 2016, at 10.
[68] Ibid at 34.
[69] Ibid at 3.
[70] See Appendix C, BKD Jail Capacity Data Analytics Strategic Plan for the City of Indianapolis – Marion County, October 20, 2016, at 35.

cohort of super-utilizers with mental illness and/or addiction. The collateral effects of this are profound. Without identification and assessment, comprehensive intervention and treatment is impossible. Without intervention and treatment, super-utilizers suffering from mental illness and/or addiction continue cycling through the criminal justice system. And the more often, and the farther, an individual penetrates the criminal justice system, the worse the outcome gets for both the individual and the community. Put better, if intervention does not occur, it costs taxpayers more (for example, $82 a day to detain an individual in Jail I) and makes the community less safe (criminal activity may escalate).

A Theory of Intervention

The Sequential Intercept Model ("SIM") is an approach aimed at addressing mental illness and addiction in the criminal justice system. At its core, SIM "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."[71] The SIM approach is driven in large part as a response to the "observation that people with mental illness often cycle repeatedly between the criminal justice system and community services."[72] SIM envisions a model that contains "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."[73] The SIM model details five opportunities for potential interception: (1) law enforcement and emergency services, (2) initial detention and initial hearings, (3) jail, courts, forensic evaluations, and forensic commitments, (4) reentry from jails, state prisons, and forensic

[71] Munetz, Mark R. and Patricia A. Griffin. "Use of The Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness". *Psychiatric Services*, vol 57, no. 4, 2006, at 544
[72] Ibid at 545.
[73] Ibid at 544

hospitalization, and (5) community corrections and community support services.[74] Ultimately, taking aim at each step in the model, "a community can develop targeted strategies to enhance effectiveness that can evolve overtime."[75] However, understanding that cities and counties must choose somewhere in the system to start, the best "'bang for the buck'" lies in those interventions that occur early in the model.[76]

Creating the Indianapolis Model

At the outset of the Task Force's work, representatives of the Mayor's Office reached out to the leadership of Health & Hospital Corporation of Marion County ("HHC"). Calling upon HHC's public health and clinical expertise, the Mayor's Office asked HHC to join the Task Force as an Enterprise Stakeholder and help design an integrated, evidence-based model of identification, assessment, and treatment to be implemented within the Marion County criminal justice system. HHC agreed and from that collaboration the following model emerged.

The Indianapolis Model starts with four simple tenets:

(1) If we systematically and effectively *identify* those that may be suffering from mental illness and/or addiction in the first place, we can recommend them for a fulsome assessment;

(2) If we properly *assess* such individuals, we then can pinpoint and clinically diagnose the underlying mental illness and/or co-occurring addiction that drives their behavior;

(3) If we effectively *assess and diagnose* the underlying condition, we can appropriately channel the individual to treatment;

[74] Ibid at 545
[75] Ibid at 548
[76] Ibid.

(4) If we effectively *channel and then treat* the individual, we can break the criminal cycle and reduce the resultant cost to taxpayers.

Importantly, and consistent with lessons from other communities, it is vital that this strategy be implemented as early as possible in the criminal justice process. The Indianapolis Model targets two key stages: pre-arrest intervention and post-arrest intervention. More specifically, to ensure the necessary evolution of services, infrastructure, and culture, the Task Force proposes incremental development toward an overarching architecture and design over three years – culminating in the full vision of a new operational criminal justice center for Marion County. As the medical and mental health contingencies and services are developed and expanded, the Task Force can collectively ensure that all of the identified and required elements for the appropriate routing, utilization, safety, and enforcement are developed and implemented by the appropriate agencies. This way, the collective entities can collaboratively develop best practices across otherwise disparate agencies.

RECOMMENDATION C1

PRE-ARREST INTERVENTION AND DIVERSION

The best way to prevent crime is to intervene before an officer determines that an arrest is warranted, before an addiction spirals into an offense, or before mental illness leads to illegal behavior. Given this, the first targeted point of intervention will be pre-arrest. Police officers are quite often the first called to address situations involving those suffering from mental illness and/or addiction.[77] In fact, "[l]aw enforcement experts estimate that as many as 7 to 10 percent of patrol

[77] Munetz, Mark R. and Patricia A. Griffin. "Use of The Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness". *Psychiatric Services*, vol 57, no. 4, 2006, at 546.

officer encounters involve persons with mental disorders."[78] But, while we often send officers in to address and resolve such situations, we do not sufficiently equip them. They arrive on the scene and have two options: arrest or don't. If they try to address and calm the situation without an arrest, all too often they are called back hours or days later. If they arrest, then the individual enters the criminal justice system and (as it currently operates) outcomes for both the community and the individual may only get worse. Indeed, arrest is often the last option, "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."[79] The question is how we can give officers a third or fourth option that effectively identifies those suffering from mental illness and/or addiction and gets them to a comprehensive assessment, opening up channels to treatment. The Task Force recommends a pre-arrest initiative with three interrelated components.

COMPONENT ONE: Crisis Intervention Team ("CIT") Training for Every E911 Operator and IMPD Officer

If the most critical initial component of the Indianapolis Model is identification, then CIT training is where everything begins. The Task Force recommends that every E911 operator and IMPD officer be fully CIT trained by the conclusion of 2018. First developed in Memphis, Tennessee, the so-called "Memphis Model" of CIT "is an innovative first-responder model of police-based crisis intervention" that "provides law enforcement-based crisis intervention training for assisting those individuals with a mental illness."[80] In short, CIT training provides E911 operators and police officers the ability to: (1) quickly and effectively identify those suffering from mental illness and/or

[78] Ibid.
[79] Ibid.
[80] See Appendix H, Randolph Dupont, Sam Cochran, and Sarah Pillsbury, "Crisis Intervention Team Core Elements," September 2007, at 3.

addiction upon dispatching, or being dispatched to, a particular incident, (2) address the immediate situation, and (3) initiate the appropriate channeling of the individual. The implementation of CIT in other communities has proven remarkably successful. In Memphis, after CIT was implemented, "officer injuries sustained during responses to 'mental disturbance' calls dropped 80%."[81] In addition, a study of officer perspectives on CIT noted that officers felt that "CIT is better at minimizing the amount of time they spend on mental disturbance calls, more effective at meeting the needs of people with mental illness and better at maintaining community safety."[82] What's more, CIT costs taxpayer dollars less money as "[p]re-booking jail diversion programs, including CIT, reduce the number of re-arrests of people with mental illness by a staggering 58%."[83]

The initiative starts with E911 operators. And that is for good reason, as they are quite often the key catalyst for the success of the overall CIT program. Indeed, "CIT depends on [E911 operators] familiarity with the CIT program, knowledge of how to recognize a CIT call involving a behavioral crisis event, and the appropriate questions to ask in order to ascertain information from the caller that will help the responding CIT Officer."[84] Training for E911 operators lasts minimally eight to sixteen hours with additional in-service training. Currently, only certain Indianapolis-Marion County E911 operators receive CIT training. The Task Force recommends that every E911 operator be CIT trained by the end of 2018.

As the individual charged with addressing the emergency situation and also appropriately identifying whether an underlying condition may exist, the responding officer is the centerpiece of

[81] See National Alliance on Mental Illness at: http://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT#sthash.oMM7sIqp.dpuf
[82] See National Alliance on Mental Illness at: http://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT#sthash.oMM7sIqp.dpuf
[83] Ibid.
[84] See Appendix H, Dupont, Randolph et al. "Crisis Intervention Team Core Elements". 2007, http://cit.memphis.edu/pdf/CoreElements.pdf at 12.

the CIT effort. In CIT training, police officers receive, at minimum, forty hours of training that "emphasizes mental health-related topics, crisis resolution skills and de-escalation training, and access to community-based services" through "didactics/lectures, on-site visitation and exposure to several mental health facilities, intensive interaction with individuals with a mental illness, and scenario based de-escalation skill training."[85] In particular, specialized skill courses include:

- Clinical Issues Related to Mental Illnesses
- Medications and Side Effects
- Alcohol and Drug Assessment
- Co-Occurring Disorders
- Developmental Disabilities
- Family/Consumer Perspective
- Suicide Prevention and Practicum Aspects
- Rights/Civil Commitment
- Mental Health Diversity
- Equipment Orientation
- Policies and Procedures
- Personality Disorders
- Post-Traumatic Stress Disorders (PTSD)
- Legal Aspects of Officer Liability
- Community Resources

Currently, roughly half of IMPD officers have received some form of CIT training. This is primarily the result of CIT training being instituted as part of the IMPD training academy curriculum. The Task Force recommends that every IMPD officer be CIT trained by the end of 2018.

COMPONENT TWO: Partnership with NYU School of Law to Develop a Mental Health Pre-Arrest Screening Tool

While CIT training is a significant part of pre-arrest intervention and diversion, additional, data-driven tools are available that enhance an officer's ability to utilize the CIT training they receive. The city, through the Office of Public Health & Safety, is in the process of entering into a

[85] Ibid at 14.

memorandum of understanding with the New York University School of Law to collaboratively develop a data-driven mental health screening tool specific to Indianapolis.

COMPONENT THREE: Creation, Training, and Deployment of Mobile Crisis Unit ("MCU") Service Line

Though CIT training and pre-arrest screening tools provide key assets in the effective identification of those suffering from mental illness and/or addiction, CIT response by officers can take a significant amount of time if the officer must handle the entire situation (from start to finish) by themselves. Given Indianapolis' movement to beat-based community policing, the potential time commitment CIT related incidents may drive could work at cross purposes with the underlying policing model. However, if the E911 operator and initial responding, CIT trained, beat-based officer can utilize their training to initially identify an individual as suffering from mental illness and/or addiction and then turn the ultimate resolution of the situation and channeling of the individual to another (enhanced) unit, a more efficient outcome would ensue. Given this, the Task Force recommends the creation, training, and deployment of a Mobile Crisis Unit Service Line.

Otherwise known as, or associated with, Enhanced Crisis Intervention Teams ("ECITs") and/or Behavioral Health Response Teams ("BHRTs"), MCUs consist of a police officer with more robust, enhanced CIT training that is paired with one or more public health professionals. The implementation of ECITs, BHRTs, and/or MCUs has proven markedly successful. The City of Portland, Oregon utilizes an ECIT approach and estimates that the unit's deployment saved the city $16 million in jail costs from 2008 to 2010.[86] In fact, over a period of study from May 10, 2014 to

[86] See Appendix C, BKD Jail Capacity Data Analytics Strategic Plan for the City of Indianapolis – Marion County, October 20, 2016, at 37.

December 2014, the City of Portland had over 609 calls that its ECITs responded to.[87] Of those 609 calls, only forty resulted in an arrest and only one involved the use of force by an officer.[88] Meanwhile, 130 of the 609 calls resulted in an individual being taken to the hospital.[89]

In the Indianapolis Model, IMPD and HHC (via Midtown Mental Health and Indy-EMS) will establish and pilot a collaborative MCU Service Line. The MCU will be comprised of a law enforcement officer (LEO), a social worker, and EMS personnel. The unit will expand todays existing IMPD Behavioral Health Unit to respond to 911 mental/emotional/substance-abuse calls as well as daily referrals and follow up care. The team will offload time-consuming, challenging, and complicated pre-arrest situations to a dedicated, specially-trained team that can better assess, engage, and route individuals to mental health and social services instead of the criminal justice system. This type of dedicated resource will drive culture change, standardize processes and triage, and more quickly educate IMPD officers to route potential offenders to diversion services. What's more, potential offenders will be better routed to appropriate care and neighborhood-based "beat" officers will be back in service to address other crime.

At the outset, MCUs will be piloted in one targeted IMPD district to operate twenty-four hours a day, seven days a week. The results of the pilot period will be analyzed to appropriately scale and then implement a city-wide deployment of MCUs.

[87] Ibid.
[88] Ibid.
[89] Ibid.

RECOMMENDATION C2

POST-ARREST INTERVENTION AND DIVERSION

Often, those suffering from mental illness and/or addiction are arrested for low-level, non-violent offenses, and then repeatedly arrested for the same or a similar offense again and again. This cycle continues because the underlying illness goes unaddressed. What's more, the more often (and further) an individual enters into the criminal justice system (even if only for a few hours or a few days) the worse the outcome for the individual and the community. This approach costs taxpayers' money, is wasteful, and makes residents less safe. And it is why a growing bipartisan chorus of current and former political and criminal justice system leaders have acknowledged and embraced the significance of effective intervention and treatment.[90] A program of identification, assessment, and diversion to treatment brings with it the prospect of better health outcomes for residents, reduced recidivism in our justice system, a lower long term cost to taxpayers, and safer streets.

Even when an effective system of pre-arrest intervention and diversion are in place, individuals suffering from mental illness and/or addiction will be arrested. While officers may determine that an arrest is necessary, if the officer (utilizing their CIT training) identifies the individual as suffering from some form of mental illness and/or addiction, significantly better outcomes can still result if services are provided as a result. Indeed, post-arrest intervention and diversion programs have proven markedly successful in other cities and counties – shrinking jail

[90] *See, e.g.,* Daniels, Deborah, "Heroin Abuse is a True Public Health Crisis," *Indianapolis Business Journal*, June 11, 2016. *And see*, Wiseman, Jane and Stephen Goldsmith. "Why We Need to Move Away from Jailing the Mentally Ill". *Governing Magazine*, 2016, http://www.governing.com/blogs/bfc/col-savings-diverting-mentally-ill-jail.html.

populations, saving taxpayer dollars, and reducing recidivism rates.[91] In many respects, Indianapolis is already leading on this issue.

The Marion County Superior Court's problem-solving courts includes the Drug Treatment Court ("DTC") and the Re-Entry Court ("REC") led by Judge Jose Salinas, the PAIR ("Psychiatric Assertive Identification and Referral") Mental Health Diversion Program led by Judge Amy Jones, the Indianapolis Veterans Court ("IVC") led by Judge David Certo, and the Behavioral Health Alternative Court ("BHAC") led by Judge Barbara Crawford. In addition to being key participants in the court programming listed above, the Marion County Prosecutor's Office has initiated a cutting-edge felony diversion program for certain qualifying offenders. Taken together, these assets provide a remarkable opportunity for post-arrest intervention and diversion in the Marion County criminal justice system. Unfortunately, such programs remain in many respects underutilized because arrestees are not adequately assessed and channeled down these paths. Currently, the primary way an individual gets to one of these problem-solving courts or diversion programs is by happenstance (a public defender or private defense counsel identifies an underlying issue and applies for the individual's case to be transferred accordingly). Put better, without effective identification and assessment on the front end, the Marion County criminal justice system does not systemically channel qualifying offenders to these programs. The Task Force proposes the following five components to achieve appropriate post-arrest intervention and diversion.

[91] See Appendix C, BKD Jail Capacity Data Analytics Strategic Plan for the City of Indianapolis – Marion County, October 20, 2016, at 25.("Those with mental health needs not diverted at the point of arrest may be more appropriately sentenced via specialty mental health courts, which have been shown to significantly reduce recidivism compared to standard court processing.")

COMPONENT ONE: Identification of Candidates

In the Indianapolis Model of post-arrest diversion, CIT trained officers (or an MCU) may, in making an arrest of a low-level, non-violent offender that they believe is suffering from an underlying mental illness and/or addiction – nominate the individual for enhanced assessment upon normal arrestee processing.

COMPONENT TWO: Representation of Candidates

Because an enhanced assessment exists outside of typical arrestee processing, candidates for post-arrest intervention and diversion may be provided defense counsel immediately upon arrival and initial processing.

COMPONENT THREE: Assessment of Candidates

Once normal arrestee processing is complete, and upon advice of defense counsel, a candidate will enter the Assessment & Intervention Center (see Facilities chapter of this report) for enhanced assessment by public health professionals of Health and Hospital Corporation of Marion County. Enhanced assessment will include, but not be limited to, physical health, mental health, addiction, housing, family, and veteran status.

COMPONENT FOUR: Review of Appropriateness and Type of Diversion

Once the arrestee processing process and enhanced assessment are complete, the prosecutor will make a determination about how the individual will continue to process through the system. In so doing, the prosecutor may elect to consult with the candidate's defense counsel. Fundamentally, the prosecutor may elect to: (1) offer the candidate a diversion agreement that would encompass a treatment plan developed by a medical professional with other legal

requirements, (2) charge the individual, but refer the case to the appropriate problem-solving court, or (3) determine that the case will proceed in the normal course.

COMPONENT FIVE: Treatment Plan and Services

Once a determination has been made as to the candidate's placement within the criminal justice system, and wherever the individual ends up, the treatment plan developed as a result of the enhanced assessment will prove fruitful.

The Task Force recommends implementation of this program as a pilot. Similar to the pre-arrest intervention and diversion pilot, the results of the post-arrest pilot period will be analyzed to appropriately scale the operations and construction of the proposed Assessment & Intervention Center.

RECOMMENDATION C3

BAIL REFORM

Communities and courts all over the country are moving away from the so-called "cash bail" system. At bottom, proponents of bail reform "argue that cash bail denies freedom to thousands of people who are presumed innocent but can't afford the bond."[92] In Indiana, the Indiana Supreme Court has signaled its intent to move Indiana courts away from the cash bail system. On September 7, 2016, the Supreme Court issued an order adopting Criminal Rule 26. More specifically, Criminal Rule 26 now states:

> *If an arrestee does not present a substantial risk of flight or danger to themselves or others, the court should release the arrestee without money bail or surety subject to such restrictions and conditions as determined by the court except when:*
> *(1) The arrestee is charged with murder or treason.*

[92] Schuppe, Jon, "Cash Bail, a Centerpiece of the Justice System, Is Facing Its Undoing," NBC News, Oct. 23, 2016. See: http://www.nbcnews.com/news/us-news/cash-bail-centerpiece-justice-system-facing-its-undoing-n669206

> *(2) The arrestee is on pre-trial release not related to the incident that is the basis for the present arrest.*
> *(3) The arrestee is on probation, parole or other community supervision.*
> *. . .*
> *In determining whether an arrestee presents a substantial risk of flight or danger to self or other persons or to the public, the court should utilize the results of an evidence-based risk assessment approved by the Indiana Office of Court Services, and such other information as the court finds relevant. The court is not required to administer an assessment prior to releasing an arrestee if administering the assessment will delay the arrestee's release.*[93]

Required by Rule 26 is the use of an evidence-based risk assessment, approved by the Indiana Office of Court Services, to determine whether an arrestee presents a significant risk of flight or danger to self or others. County courts must begin utilization of an evidence-based risk assessment by January 1, 2018. Given this, the Task Force recommends that the Office of Public Health & Safety work in conjunction with the Marion County Superior Court to position Marion County ahead of the curve by seeking grant funding for the study, design, and implementation of a pre-trial risk assessment tool specific to Marion County's needs.

RECOMMENDATION C4

PRE-TRIAL SERVICES FUNCTION WITHIN THE MARION COUNTY PROBATION DEPARTMENT

The vast majority of individuals in the Marion County criminal justice system are currently at a stage in the process prior to case disposition. And given this, most are not detained in jail while awaiting trial but rather released back into the community. Unfortunately, this is when many often violate the terms of their release and/or reoffend. Nationally, a successful model has emerged centered on the concept of pre-trial services. Pre-trial service agencies connect pre-disposition individuals to services targeted at their specific needs and engage in a variety of other best practices

[93] Order adopting Indiana Criminal Rule 26, available at: http://www.in.gov/judiciary/files/order-rules-2016-0907-criminal.pdf

that promote adherence to the terms of pretrial release and the prevention of recidivism (for example, something as simple as a call or text reminding an individual of a pending court hearing).

Utilization of an evidence-based risk assessment tool (see Recommendation C3) is only part of the issue surrounding pre-trial populations. The second aspect is the level of supervision for this group. Along these lines, the Task Force recommends that the Office of Public Health & Safety work in conjunction with the Marion Superior Court to develop a pilot pretrial services program within the Marion County Probation Department, seek grant funding for the program, implement the services program concepts, and analyze the resulting collaboration for effectiveness (primarily such services effect on recidivism).

CHAPTER 6
FACILITIES

A. Introduction and Background: A History of Inadequate Criminal Justice Facilities and Pleas to Replace Them.

On May 11, 2016 in his State of the City Address, Mayor Hogsett stated in simple terms "while a new jail may be necessary, it is certainly not sufficient." Over the past three decades, city and county officials have grappled and debated various solutions to our inadequate criminal justice facilities. These deficiencies in our current jails, community corrections facilities, and courthouse are well-documented, and are summarized below. Since the early 1990's, numerous space studies, task forces, lawsuits, and expert analyses targeting all or parts of our criminal justice facilities have occurred. For over 25 years, all those who have looked at Marion County's jail and court facilities have unanimously concluded that our existing facilities do not meet the safety, security, or basic operational needs of the county justice system. These studies include the following:

G. 1972-2007: Jail Overcrowding Class Action Litigation: *Marion County Jail Inmates v. Sheriff Frank Anderson,* 72-0424-C-B/S; Federal District Court of the Southern District of Indiana.

H. 1991: Marion County Governmental Space Study called for by 1990 City-County Council Special Resolution No. 55.

I. 1997: Indiana Supreme Court Caseload Study

J. 1998: CourtWorks Space Study

K. 1999: Court Needs Assessment

L. 2002: Justice Center Task Force

M. 2004: Crim. Justice Planning Strategic Plan Facility Utilization Plan, Marion County Court

N. 2013: Greater Indianapolis Progress Committee (GIPC) Preliminary Study of Need & Development Options for a Comprehensive Criminal Justice Complex

In particular, starting in the fall of 2013, the Mayor's Office, Criminal Courts, Marion County Sheriff's Office, Community Corrections, and City Council earnestly began addressing how the City could develop a new consolidated justice complex in a cost-effective and responsible manner that sought protections for Marion County taxpayers, while also achieving considerable capital investment and addressing the many problems of the existing system and facilities. The GIPC report was one result of the 2013 effort. That report was far-reaching and called for a potential capital investment of well over $600 million. The GIPC report provides a strong analytical foundation for the CJR Task Force's facilities recommendations.

Another result of these stakeholders' 2013 efforts was Mayor Ballard's proposed Marion County Justice Complex Project. This project began with a December 2013 solicitation of potential bidders and solutions for a Public Private Partnership ("PPP" or "P3") to address many of the facilities needs identified in the GIPC report. The Ballard Administration procurement process was ultimately based on a facilities delivery method by which one private entity or joint venture was intended to design, build, finance, operate, and manage ("DBFOM") all the facilities to be included in the Marion County Justice Complex.

The proposed Marion County Justice Complex included the following facilities:

- Jail: a 3,000 bed detention facility with on-site medical;
- Community Corrections: 960 bed minimum security/transitional community corrections facility;
- Courthouse: 27 courtrooms and 10 hearing rooms and related offices for Criminal Judges and proceedings;

- Offices and facilities for the Marion County Sheriff's Department;
- Parking facilities; and
- Space for a future law office building for the Marion County Prosecutor, Marion County Public Defender Agency, and others with associated structured parking as a separate development.

The Ballard Administration's Justice Complex Project did not fail as a result of significant deficiencies in this facilities plan or design work as proposed. Instead, concerns as to the affordability of the proposed annual payments to the selected vendor, as well as related concerns about the cost-effectiveness of the predetermined delivery method, ultimately led the proposal to stall before the City-County Council.

The Ballard Administration prepared a great deal of valuable design, planning, and pricing work-product to support its proposed Marion County Justice Complex Project. The City maintains ownership of all of the intellectual property and documents prepared for the Justice Complex Project, including the planning and design work of the City's design consultant on the Project HOK (formerly Hellmuth, Obata + Kassabaum), as well as both the site location analyses performed by the City and all the proposals submitted by the selected and non-selected PPP bidders. This documentation and a continued consulting relationship with HOK formed the starting point for the Task Force's analyses, and strongly influenced the Task Force's ultimate recommendations as to facilities.

Notwithstanding the tremendous value provided by the Ballard Administration's work on the Justice Complex, that P3 project was largely and likely necessarily limited to financing, building, and operating new facilities. While the various documents, notes, and proposals identified potential

criminal justice reform opportunities scattered throughout, the primary goals of the Justice Complex Project were limited to a construction project and a building operations contract to address current criminal justice facilities problems.

By contrast and as has already been described in previous chapters of this report, the CJR Task Force has far broader policy and process goals. The Task Force's facilities recommendations derive from those policy and process goals. American architect Louis Sullivan coined the phrase "form (ever) follows function." The "form" of the Ballard Administration's Justice Complex Project was explicitly intended to improve upon how the county's current inadequate facilities serve the *current* justice system. The CJR Task Force, however, endeavored to envision an improved criminal justice system and recommend facilities tailored to *that* system – new form to follow *new* functions.

Recognizing this need on the same day as his May 2016 address, Mayor Hogsett signed an Executive Order creating the Criminal Justice Reform Task Force and gave it the following task:

> *Based on recommendations for the systemic reform and optimization of the current county criminal justice system, identify requirements for the location, construction, and/or renovation of county criminal justice facilities.*

The following section of the Task Force Report attempts to accomplish this task by (1) summarizing previous and updated assessments of the county's current criminal justice facilities and (2) describing a new, re-envisioned facilities program built to outperform current facilities and to facilitate the criminal justice system changes recommended in this Report.

The current problems with the county's criminal justice facilities are obvious, immediate, and must be solved in any set of new facilities constructed or renovated to serve the Marion County justice system. Further, the Task Force recognizes that technologies, institutions, and legal requirements are ever-evolving and will necessarily determine future uses of these facilities. The

facilities must be adaptable and expandable. The Task Force stresses that the facilities should be developed in a manner that suits the future criminal justice system that city and county officials, non-governmental stakeholders, and our residents purposefully choose as best for the Indianapolis community. Our community should not allow current or past operational inertia to drive the design of our criminal justice facilities over and above a developing consensus as to the future needs of an optimized justice system.

B. Assessment of Current Facilities: Where do we stand?

i. The Arrestee Processing Center

The Arrestee Processing Center (APC) is the entry point into the Marion County Criminal Justice System. All of the 52,000 individuals arrested each year in Indianapolis/Marion County are processed into the system through the APC. During the intended average processing time of 9 hours, each arrestee is identified, undergoes a limited background investigation, and receives a limited health screening. The arrestee is then remanded to a deputy prosecutor who decides whether the arrestee is to be charged with a crime and sent to a preliminary hearing in the court located in the APC. If an arrestee is charged by the prosecutor and the judicial officer agrees there is probable cause to support the charges, the judicial officer sets cash bail according to predetermined bail matrix and determines whether the arrestee qualifies for a public defender. If the arrestee, ultimately, (1) is denied bail, (2) chooses not to make bail, or (3) is unable to make bail, the individual is assigned to one of the three Marion County Jails to await further prosecution.

The APC is one of only a few facilities in the country that provides an independent "booking" process of arrestees that is physically separate from and prior to entry of arrestees into the county jail. The original purpose of the APC was to allow assessment of charges, screening, and an initial

hearing before the arrestee goes to jail, thus minimizing the number of "non-threatening" jail inmates.

Numerous stakeholders have agreed that the current APC space is problematic in several ways and does not currently perform as intended. The APC is a converted warehouse customized to a specific booking process in limited space that causes security and safety risks to staff and other arrestees. It does not provide adequate facilities to detain individuals when the screening process and charging determinations take longer than 12 hours, such as sufficient space for sleeping and personal hygiene. The APC does not provide adequate space for individuals to consult counsel prior to initial hearings and/or during initial assessments and screening. Further, the space currently provided is not sufficient for individuals to receive a thorough assessment and/or consult with medical staff, social workers, and other service providers from a variety of agencies. The current APC also has inadequate technology for identifying and tracking detainees throughout the criminal justice system and across facilities and agencies within that system.

Additionally, stakeholders and design consultants have commented that:

- The facility has excessive wear and tear from high-utilization
- The facility has very limited and confined secured space for arrestees during meal times and "lock down" which leads to safety and security risks
- The garage has several columns throughout, limiting the useful space and making it difficult for vehicles to maneuver
- Many vehicles have been damaged in the garage/ sally port
- The space is roughly 1/3 the size necessary to operate efficiently
- There is not adequate separation between men and women in the facility, increasing the risk of sexual harassment

- The size of the facility and the volume of people inside makes the facility loud, which contributes to poor safety
- The APC's remote location from the jail requires more staffing than a collocated booking unit at the jail would require
- Lack of work stations delays processing of arrestees
- Insufficient work space slows pre-screening
- The APC lacks areas of privacy for arrestees to discuss medical and mental health screening issues in a discreet manner meeting HIPA requirements
- Distance from jail medical facilities requires more arrestees to be delivered to public hospital for routine medical issues
- Lack of a sufficient number of restrooms for inmates requires holding cells be used as restrooms
- Finishes are not sufficiently hygienic nor easily cleanable, leaving some areas vulnerable to communicable diseases.

ii. Reuben Engagement Center

Set to open in early 2017, the Reuben Engagement Center will be collocated with the APC and will provide an alternative for intoxicated and homeless individuals in crisis who otherwise would be sent to an emergency room or incarcerated in the Marion County Jail. The Engagement Center is intended to provide a safe place for homeless individuals who are experiencing drug or alcohol intoxication to be diverted from jail or an emergency room while still gaining access to emergency shelter options despite active substance abuse.

Individuals who are homeless and intoxicated will be provided a safe environment during their period of intoxication, have the opportunity for engagement with and connection to services, and be offered a safe place to detox. The Engagement Center will work closely to enhance successful transition of individuals to permanent supportive housing and placement into treatment and long-term rehabilitation depending on each individual's specific circumstances.

The Engagement Center is intended to serve several purposes including:

- Reduction of unnecessary and costly hospitalizations and incarcerations;
- Provision of shelter for individuals who are homeless, intoxicated and on the streets;
- Engagement with treatment providers and other support services; and,
- Linking those who are experiencing chronic homelessness to permanent supportive housing and other housing options.

Unfortunately, the Engagement Center will not be equipped or appropriately staffed to perform several other potentially impactful functions, including:

- The Engagement Center will not include a medical clinic and will only provide very limited access to paramedic-administered medical treatments.
- The Engagement Center will not provide sufficient space for behavioral health clinicians to provide specialized mental health and addiction assessments and treatment planning.

iii. Marion County Jail Facilities

Arrestees should be detained before trial because they pose either a threat to the safety of our community or because they might flee the county's jurisdiction. The construction of detention facilities to house pretrial arrestees should be guided and limited by the fundamental principle of threat reduction. Accordingly and as stated in prior sections, the modern criminal justice system must successfully differentiate individuals who pose such threats from those who do not. As a corollary, Marion County should not build new detention space for arrestees whose problems may be more appropriately addressed through alternative treatments. And, consequently, Marion County should, if possible, build space to facilitate such alternative treatments, if such space is not currently being adequately supplied by other institutions.

Detention facilities must meet certain standards under the U.S. Constitution. The Eighth Amendment to the United States Constitution states: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." The rights of pre-trial detainees are protected under the Fourteenth Amendment which ensures that pretrial detainees "retain at least those constitutional rights . . . enjoyed by convicted prisoners." *Bell v. Wolfish*, 441 U.S. 520, 545 (1979). Under the Eighth Amendment, prison officials have an affirmative duty to ensure that detainees receive adequate food, clothing, shelter, and medical care. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994). The Eighth Amendment protects prisoners not only from present and continuing harm, but also from future harm. *Helling v. McKinney*, 509 U.S. 25, 33 (1993). Detainees have a constitutional right to adequate medical and mental health care, including psychological and psychiatric services. *Farmer*, 511 U.S. at 832. Detainees' constitutional rights are violated when prison officials exhibit deliberate indifference to their serious medical needs. *See Estelle v. Gamble*,

429 U.S. 97, 102 (1976). Detainee living conditions must be "reasonably sanitary and safe." *Farmer* 511 U.S. at 832.

The current Marion County detention facilities include approximately 2,500 beds across four (4) sites (including the APC). The Sheriff has indicated that only 2,200-2,300 beds can be filled at any given time as a result of an inefficient design. For example, areas of the building are segmented off for certain populations (e.g., women or juveniles) which must be housed in separate units. Specifically, the four detention facilities are as follows:

- **Jail I (40 S. Alabama Street):** Jail I is a publicly run jail that houses those inmates that are the highest security risk or the least healthy. The Constitutional capacity (commonly referred to as the bed count) of Jail I is 1,135. Violent adult males, high-security females and juveniles remanded to adult court are housed in Jail I. The average stay for Jail I inmates is 88 days, and approximately 200 inmates are serving sentences ranging from just a few days to one year by virtue of HEA 1006. Inmates sentenced to more than one year are sent to a state prison or some other Department of Corrections facility to serve their sentence. The logistics of housing inmates in Jail I are complicated by its demographics. A mixture of adult men, adult women and male and female juveniles are assigned there. Because of the severity of their offenses, the juveniles in Jail I have been remanded to adult status by the court. Since it is the policy of the Marion County Sheriff's Office to not house women and juveniles in the same cell blocks as the general population, whole special cell blocks are dedicated to segregating relatively small numbers of women and youthful offenders from each other and the adult males.
- **Jail II (730 E. Washington Street):** Marion County Jail II is a publicly owned, but privately run facility. Core Civic (formerly Community Corrections of America (CCA)) has

been under contract with MCSO since 1996 to operate Jail II. Jail II has a capacity of 1,233 beds, but, like Jail I, it routinely operates below that capacity. Jail II houses only adult males and is a medium security facility. Consistent with the contractual agreement with MCSO, Core Civic provides minimum heath care for the Jail II inmates. If the illness or injury suffered by the inmate requires care that exceeds 48 hours of hospitalization, then that inmate is transferred to the custody of Jail I.

- **City-County Building- "Hope Hall" (200 E. Washington Street):** There are 139 beds located in the East Wing of the City-County Building on a dedicated floor known as "Hope Hall." Those arrestees who are remanded to the jail system receive final processing in the City-County Building before they are transported to the other MCSO jails. Since the majority of the Marion County Criminal Courts are located in the City-County Building, Hope Hall also serves as a holding site for inmates transported from the other jails for court appearances. The beds in the City-County Building are otherwise primarily occupied by lower security females and inmate workers.
- **Arrestee Processing Center (752 East Market Street):** (Described above)

Inmates in all three Marion County Jails are classified and housed often in segregated units based a variety of factors including the severity of their crimes, gang affiliations, age, gender, and mental and physical illness. On average, 30-40% of the inmates are classified as mentally ill. 85% have substance abuse problems.

Marion County employs Correct Care Solutions (CCS), a healthcare provider that is currently responsible for the entire detainee healthcare system. Eskenazi Hospital is a subcontractor with CCS. The subcontract calls for Eskenazi to provide off-site inpatient and acute outpatient medical care in a secured environment when such care is warranted. CCS provides medical care that

includes intravenous medication therapy, dialysis, radiology, laboratory draws, infectious disease management, and chronic care clinics (hypertension, asthma management, etc.). There is a Special Care Unit (SCU) in Jail I with a capacity of ten beds. More than 37,000 patients are treated in the SCU each year.

However, patients may still encounter acute medical situations which would require the use of hospital services – situations such as chest pain, diabetic ketoacidosis (DKA), trauma events, delivery of a baby, etc. Acute care patients are transported to Eskenazi Hospital emergency room. In all circumstances, CCS works to keep the care of the patient within the most appropriate medical facility.

A good deal of the hospital care (and cost) is attributed to *arrestee* healthcare (not inmate health care) – i.e. arrestees taken from the point of the arrest to the hospital. 90% of the arrestees taken to Eskenazi are not admitted, suggesting that if more advanced treatment could be provided at the APC or the jail there could be greater potential for reducing hospital visits. While there have been significant recent improvements, Marion County sends a large number of arrestees to the emergency room- largely as a result of physical and operational limitations of the health care facilities within the jail to treat more acute health problems.

Additionally, many inmates also go to the hospital or stay at the hospital from the Jail, again because there are not adequate facilities onsite. Inmates severely injured may have to go to the hospital emergency room, instead of being treated onsite. Also, inmates today must stay at the hospital for post-operative services. The inpatient rooms generally are not collocated within the hospital; so again, the Sheriff's Office loses control of its personnel costs while securing inmates admitted to different areas at the hospital. At the hospital, it often requires one officer for each inmate in a room.

On an average day, approximately one third of the inmates in the Marion County Jails (600-650 individuals) are also classified as mentally ill. Under the care of CCS personnel, more 700 prescriptions are distributed to mentally ill inmates every day at a cost of $650,000 per year. The contractual cost of the care for mentally ill inmates is $5 million per year and the cost of separate security for mentally ill inmates in $2.1 million annually. The Sheriff has estimated that the total cost for the care and custody of mentally ill inmates is $7.7 million. The segregation of mentally ill inmates in separate jail units or isolated "suicide watch" units further drives personnel costs as a result of the need for increased direct supervision. Beyond the provision of drugs and segregated units, there is little space or opportunity for continual assessment and treatment of inmates with mental illnesses and/or often co-occurring drug and alcohol addictions while incarcerated at the jail.

For these reasons, the current jail facilities and resulting operations are not cost-effective or efficient. The separate locations and essential services (e.g. kitchen, laundry, etc.), lack of coordinated planning and functionality, and deterioration of the facilities are resulting in ever-increasing resources being expended to move detainees, deliver security, provide physical and mental health care, routinely operate the facilities, and undertake necessary capital repairs and maintenance. Millions of dollars are spent on these inefficiencies and will continue to be spent until these problems are solved.

iv. Marion Superior and Circuit Courts

The Marion County Circuit Court and the large majority of Marion County Superior Courts are located in the City-County Building in Downtown Indianapolis. The Juvenile Division of the Superior Court is located 2451 N. Keystone Avenue (4 miles / 10-minute drive from the City-County

Building). The Traffic Court of is located at 8115 E. Washington Street. In addition, the Arrestee Processing Center houses court facilities for initial hearings and bond settings.

The Circuit Court's jurisdiction is exclusively civil jurisdiction over all Marion County tax collections, name changes, and hardship driver's licenses. It also provides supervision to the Marion County Small Claims Courts. The Circuit Court also has responsibility for Paternity Court, which hears paternity issues and child support collection cases. The Marion Circuit Court and Marion Superior Court exercise concurrent jurisdiction over all other civil issues.

The Marion Superior Court is comprised of 36 elected Judges, 29 commissioners and magistrates and over 750 staff employees. The Court is structured with 4 divisions: Civil, Criminal, Juvenile, and Probate. The Civil Division handles general civil cases, juvenile cases, probate and environmental cases and domestic relations matters. The Juvenile Division has civil jurisdiction over the following cases: acts of delinquency, status offenses, emancipation, and children in need of services (CHINS). The Juvenile Division consists primarily of the Juvenile Court, Juvenile Detention Center, and the Juvenile Probation Department.

The Criminal Division has exclusive jurisdiction over all criminal cases filed in this county. It handles all criminal charges filed by the Prosecutor's Office including Misdemeanors, D Felony, Major Felony, Domestic Violence and Drug cases. Criminal Division Courts are further organized by the types of cases assigned to particular Courts. In a typical year the Superior Court as a whole will resolve nearly 40,000 criminal cases, 200,000 traffic cases and nearly 50,000 civil cases. The Marion Superior Court is one of 92 county court systems in the State, yet accounts for approximately 20% of all cases filed and disposed of the entire State each year.

The courts currently occupy approximately 195,000 net square feet of space over 10 floors within the City-County Building. Original plans for the City-County Building were drawn over 50

years ago with the main focus of the building to be office space. Today there are 36 courtrooms/hearing rooms compressed into an office building originally designed for 16 courts.

According to several elected Judges, one set of drawbacks to both the numerous courthouse facilities and the courts' specialized administrative organization is physical, operational, and jurisdictional "silos" that exist between and among the several types of Marion County Courts. For example, one individual or family could have several cases pending in several different courts before different Judges but perhaps stemming from the same crises or set of circumstances. For example:

1. A domestic violence or major felony criminal case in Superior Court- Criminal Division
2. A divorce and civil protective order in Superior Court- Civil Division
3. A child support case in Circuit Court
4. A CHINS case set in Juvenile Court, and (eventually)
5. A guardianship for the individuals' children in Probate court

It is conceivable that a single event or set of related incidents with the same individual, family, and witnesses could have generated all of these separate cases. Each of these cases hypothetically involving the same people and events have separate Judges with separate jurisdictional powers and limitations, separate caseloads and dockets, separate administrative norms and work rules, separate and distinct access to courtrooms and hearing rooms, and even separate geographical locations to appropriately address and dispose of each separate case. In situations like these, no single Judge assigned to one of these cases is truly able to organize or perhaps even know of all of the legal and social issues facing the particular family, much less direct a comprehensive outcome. Many of these separations derive from rules and norms that Marion County Judges have imposed upon themselves via local rule. Others derive from and are amplified by the physical separation of court facilities.

Some Judges see the "one family, one court" consolidated case assignment concept, in appropriate situations, as potentially able to provide better problem-solving outcomes for families in crisis. The Criminal Division Courts have, in fact, attempted to consolidate criminal cases pending against the same individual. With greater collocation of the criminal, civil (Circuit and Superior), and juvenile divisions, some Judges see the opportunity to further consolidate cases across organizational boundaries to perhaps provide better, more organized resolutions to related cases.

Although the jurisdictional and administrative separations exist, one benefit of the current courthouse facilities is that the vast majority of courts are at least collocated within the City-County Building. The collocation of courts within the same building allows litigants and lawyers to effectively access the Marion County court system for both related and unrelated cases each day and with minimal transportation and other logistical roadblocks. The collocation of courts also facilitates efficient court administration. Court personnel (magistrates, commissioners, translators, etc.) are more easily supervised, evaluated, and redeployed based on the day-to-day operational needs of judiciary. Collocated courts also permit the optimal utilization of courtroom and hearing room space in that Judges are able to share their court space with other Judges when there is a need and when it is not otherwise being used.

The opposite is true, however, with respect to Juvenile Court, which is located four miles from the City-County Building. Granted, Juvenile Division is a highly-specialized Court with very strong policy justifications for maintaining Juvenile Court and detention facilities separate from adult facilities. But because the Juvenile Court is not physically collocated with the other Superior Courts, Juvenile Court is currently not able to easily benefit from additional courtroom and hearing space, personnel, and other resources potentially available at the City-County Building. In fact, many

of the hardships currently suffered by the Juvenile Court derive from the lack of additional court space and personnel to address the current significant spike in CHINS cases.

Notwithstanding the benefits of collocation of most courts within the City-County Building, numerous Judges and other stakeholders agree that the City-County Building is not suitable for housing a modern court system of the number and types of courts that currently exists in Marion County. The Courts have been forced to retrofit and occupy floors and spaces within the City-County Building that were never intended for use as hearing rooms, court rooms, holding cells, or jury deliberation rooms. As a result, much of the court space in the City-County Building woefully lacks adequate security design or features. Potentially violent offenders routinely travel through unsecured areas of the City-County Building, albeit escorted from Jail by at least one and more often several County Sheriff's officers. These in-custody inmates travel through public garages, hallways, and elevators. These inmates travel through court offices within inches of court staff and within feet of Judges' chambers. This lack of secured space greatly amplifies the need to provide additional Sheriff's personnel on each floor, in each court, and with each inmate or group of inmates while in transit. Additional security personnel equally amplify the Sheriff's Office personnel budget.

Even the space originally designed as court space is inadequate for modern legal practices, courtroom operations, and administrative processes. The City-County Building does not include space near courtrooms within which attorneys and clients can consult confidentially. The technology available at the City-County Building, although improving, provides limited speed and bandwidth for current court operations like electronic case filing, much less modernizations like a robust video-conferencing program for each courtroom, hearing room, and Judge's chambers. Courtrooms and hearing rooms also are not large enough and are often laid out too awkwardly to accommodate modern audio-visual equipment for the presentation of evidence.

v. Community Corrections

Marion County Community Corrections (MCCC) was established by local ordinance in 1983 following the passage of the Community Corrections statute (currently I.C. 11-12-1-1 and 11-12-2-1) and began operating that November. MCCC currently operates four (4) residential facilities:

- **Duvall Residential Center (350 beds):** The primary residential facility for non-violent males who are serving work release sentences with Marion County Community Corrections;
- **Brandon Hall (95 beds):** A residential facility for male offenders split between (1) general work release population, (2) the Community Transition Program that assists felons transition from prison to the community, and (3) the Mental Health Component for qualified convicted felons with serious mental illnesses.
- **Craine House (40 adult beds):** residential work release facility serving non-violent women who are pregnant or mothers with infants to preschool aged children where women may live with their children while serving their community corrections sentence.
- **Theodora House (112 beds):** a residential and non-residential work release and reentry facility for women.

In addition to providing these facilities, MCCC also provides electronic monitoring services including GPS monitoring, home detention, and alcohol monitoring. Further, MCCC provides Addictions Intervention services, which include intensive case management for non-violent offenders with a history of repeated substance abuse, probation violations, or who are awaiting a direct commitment for a bed in a residential facility. Addictions Intervention program participants also receive substance abuse treatment, have frequent contact with their Community Supervision Manager, and submit to frequent drug and alcohol testing.

vi. Marion County Forensic Services Lab; IMPD Property Room; and Marion County Coroner

The Indianapolis-Marion County Forensic Services Agency ("Crime Lab") is an accredited full service forensic laboratory through the American Society of Crime Laboratory Directors (ASCLD/LAB) under the ASCLD/LAB International (ISO 17025) program. Forensic scientists, crime scene specialists, and other forensic support personnel provide forensic processing and testing services to various criminal justice agencies. These services include DNA and serology testing, crime scene investigation and evidence processing, drug chemistry testing and identification, trace chemistry testing, firearms and ballistics testing, forensic evidence collection and documentation, latent print analysis, and handwriting analyses and other "questioned document" evaluations.

The current Crime Lab is located on the premises of Jail I at 40 S. Alabama Street that is too small to accommodate many of the improvements recommended by the agency, as well as those recommended in prior sections of this report. The current Crime Lab facility does not have space available for its Biology/DNA Unit or its Forensic Evidence Technician Unit, both of which are currently located in the Marion County Coroner's Office (MCCO) facility two miles away. The current severely limited lab space prohibits the Crime Lab from adding additional forensic scientists and lab technicians to process existing backlogs in particular work groups. Space limitations also inhibit the Crime Lab's ability to process and test vehicles and other similarly large items. The Crime Lab has identified a current need for 75,000 to 90,000 square feet of space to facilitate its desired operational benchmarks.

Additionally, the majority of evidence collected and stored for Marion County Criminal Court proceedings is stored at the IMPD Property Room Annex / evidence storage on the far East side of Indianapolis (9049 E 10th St.) ("the Annex"), as well as the IMPD Property Room in the basement

of the City-County Building. The Annex needs 100,000 to 120,000 square feet of space. Transfer of evidence from the Annex to the Property Room at the City-County Building and then eventually to the Crime Lab occurs daily and requires exceedingly long lead-times for request, retrieval, and delivery of evidence to the Property Room and Crime Lab. IMPD Property Room employees who retrieve evidence for testing from the Annex on behalf of the Crime Lab must travel approximately 17.8 miles per day round trip (89 miles per week) to the IMPD Property Room Annex. In total, an estimated, 1,170 work hours are spent each year in evidence transport and transport preparation by IMPD and Crime Lab employees.

The Crime Lab's Forensic Evidence Technicians assist MCCO pathologists during autopsies and provide photography support in death investigations. But this inter-agency cooperation is operationally inefficient due to the travel of these types of technicians between the Crime Lab and MCCO pathology labs. Presently, 15 FSA employees occupy 5,500 square feet of space at the Coroner's current location to assist the MCCO with examination services for only about twenty-five percent (25%) of the Coroner's autopsies. Additionally, the Crime Lab houses its entire serology and DNA testing units on the second floor of the MCCO. This too is not optimal due to increased transportation times, logistics, and inherent security vulnerabilities, which, in turn, delay and risk endangering Crime Lab test results.

Independent of the limited collocated Crime Lab space, the MCCO needs approximately 22,000 square feet of space to properly function. The current lease for the MCCO facility is expiring, and the building is no longer meeting the MCCO's needs. Consequently, the Coroner has initiated a search to find new space and engaged with a real estate broker and developer to draft a plan for the MCCO to move operations to a location on near eastside of Indianapolis and submit to a 15-year

lease. The Coroner's Office relocation has stalled as the County Coroner and other criminal justice stakeholders review and pursue alternatives to meet the MCCO's current space needs.

vii. Marion County Prosecutor and Marion County Public Defender Agency

The Marion County Prosecutor's Office and the Marion County Public Defender Agency, respectively, are parties to long-term leases in privately-owned commercial office buildings in close proximity (i.e. walking distance) from the City-County Building. While both leased spaces could be improved to mitigate normal wear and tear, the spaces are currently meeting the operational needs of both agencies, respectively. One current benefit to both agencies is the physical separation of their offices in different buildings. This separation reduces the risk of attorneys from either office revealing case strategy or accidentally creating a security problem by the inadvertent comingling of victims, alleged offenders, and/or witnesses in elevators or common areas, which could occur if the respective offices were located in the same building.

C. Justice System Facilities Recommendations: A Modern Marion County Justice Campus

The Task Force recommends building constructing new facilities to suit the criminal justice design and process changes discussed in preceding chapters of this Report, as well as to improve upon deficiencies in the current facilities summarized above.

FACILITIES RECOMMENDATION NO. 1

CONSTRUCT AN ASSESSMENT AND INTERVENTION CENTER ("AIC") TO FACILITATE EXPANDED ASSESSMENT AND DIVERSION INITIATIVES

The CJR Task Force recommends constructing a specialized receiving/diversion center for appropriate arrestees to (1) be assessed for mental health and substance abuse treatment needs,

(2) receive short-term detoxification and crisis behavioral health treatment, (3) engage with clinical social workers, defense counsel and prosecutors, (4) be referred and routed to appropriate long term evaluation and/or treatment services as determined by patient-specific treatment plans prescribed by clinicians and the county prosecutor or courts, and (5) receive a supervised and therapeutic transfer, or "warm hand-off", from the AIC to treatment/social services to ensure a continuum of care for the individual's specific treatment plan.

In short, the Assessment and Intervention Center will serve as the bridging space between various potential "off ramps" from the criminal justice system and the expanded diversion plans and behavioral health treatment providers as described in Chapter 5, Recommendations C1 and C2. As such, the Assessment and Intervention Center could also serve as a destination and support facility for individuals intercepted at points further down the criminal justice system spectrum, including Community Corrections services, Probation services, diversions from "Problem-Solving Courts", and perhaps most importantly, Re-entry Services (i.e. immediate diversion prior to any opportunity for recidivism).

Individuals generally would come to the Assessment and Intervention Center following contact with law enforcement which results in involuntary, in-custody arrest and transport to the processing unit of the Marion County Jail. Individuals not in custody may also potentially self-report through the front door of the AIC or may be referred by a ECIT or MHU street/outreach team.

Most AIC clients will be processed through ordinary identification procedures at the processing unit (as they come to the processing unit via a typical arrest). The identification process will help confirm their eligibility for AIC services and determine if the client has open warrants, and ICE hold, or other out-of-county holds. The identification process will include a check of any protective orders to ensure than no client will encounter a person covered by a non-contact order.

Males and females will be separated. Clients will be searched for weapons and contraband. The AIC will include a security area with camera monitoring. Clients will be subject to eligibility protocols and determinations established by the Marion County Prosecutor's Office in consultation with defense counsel provided during intake procedures at the Jail Intake Unit. Such protocols and determinations will be informed by the enhanced initial assessment tools described in Chapter 5.

Timelines will vary based on individual needs, with a focus on recovery readiness support and stages of change engagement. It will be necessary to (1) assess the individuals, (2) stabilize them and/or initiate the detox process, (3) obtain clinical sobriety, and (4) then engage them with participating health professionals for inpatient and outpatient care referrals and follow-up care. Referrals to non-medical service providers/programs for housing, job training/placement, family services, etc. are also often vital to successful outcomes and will be available at the AIC. Stays may be as short as 4-12 hours (4-hour minimum to provide safe shelter, reduce intoxication, provide initial link with a resource coordinator to offer services) and as long as two weeks.

FACILITIES RECOMMENDATION NO. 2

CONSTRUCT A NEW CONSOLIDATED MARION COUNTY JAIL

The Task Force recommends constructing a new, consolidated Marion County Jail to replace the current detention facilities. Detainees and prisoners currently occupy over 2,600 beds among all current Marion County funded detention facilities, including some beds in the Elkhart County, Indiana jail. In 2015, the Ballard Administration proposed constructing an Adult Detention Center providing 3,000 beds. The CJTF recommends a facility with general population beds within a similar range of 2,600 to 3,000 beds to safely and humanely accommodate the current detention facility occupancy levels. While site planning for build out to accommodate potential long-term needs

should be an important design consideration, the CJTF does not recommend constructing detention center space beyond the capacity needs that Marion County is currently experiencing.

The Task Force further recommends that the new Marion County Jail include many of the design elements from the Ballard Administration's 2015 proposed Justice Complex Project. The Jail, for example, should facilitate a cost-effective hybrid of direct and indirect supervision methods for inmate management as determined in consultation with the Marion County Sheriff's Office. As proposed in the Marion County Justice Complex Project, the hybrid approach has been found to be very staff efficient in other detention facilities throughout the country, many of which HOK has programmed and designed. For instance, previous Justice Complex Project detention center proposed hybrid supervision program, which included the manning of an elevated post that can observe four housing units at once, 256 inmates, at all times. This post could monitor all activity, with the help of cameras and control doors and other mechanical aspects of the unit.

This type of post could be supplemented by two fulltime officers for the four units, plus other rovers for inmate movement. This staffing method places pod officers in the units at all times, with a remote supervisor present as well. At night, when inmate activity is at a low level, these posts can

be collapsed to one per floor in the elevated post vs. three during the day. Floor officers may be able to be reduced as well. That approach results in a great deal of cost savings for the sheriff's department.

Units within the Jail should be self-sufficient and include cells that house varying numbers of beds each, video visitation booths, private court hearing video booths, inmate phones, dining, activities, pill call and exam, multi-purpose rooms for programs, and outdoor recreation space that is open in good weather and can be enclosed in poor weather. Units and/or floors within the Jail should include adjacent contact visitation rooms for attorney visits and significant space for additional programming to offer education, substance abuse counseling, and other programs aimed at problem-solving and thus reducing recidivism.

Housing units should be designed for maximum viewing into the units for officers on rounds. Unlike the current facility, units that are not required due to reduced bed needs should be capable of being completely shut down, and redeployed. Housing units, as well as the entire Jail should be designed to maximize access for all inmates, meeting all Americans with Disability Acts (ADA) requirements. In addition, this facility should meet all American Correctional Association (ACA) and Prison Rape Elimination Act (PREA) requirements.

One key to the increased safety and effectiveness of a new Jail facility is the potential for the sheriff's department to better classify and house inmates. Purpose-built units should be constructed to facilitate the management of inmates and lend itself to better outcomes for inmates and for the staff that has to manage them. To optimize and reduce the sheriff's staffing needs, virtually all inmate activities should take place in the inmate's housing unit to reduce movement and thus supervisory needs for inmates. By contrast, currently, most of inmate activities take place out of housing pods today – resulting in a great deal of inmate movement in the current facility,

which requires increased direct supervision and escorts. In the new facility, eating, video visitation, outdoor recreation, medical pill pass, routine exams, and inmate programs should take place in the unit, with no inmate movement required. The only times inmates should need to leave their assigned unit within the Jail, would be to go to court, transfer out, or go to the clinic if they are very sick.

Again, the size of the new, consolidated Jail should be based on current occupancy needs. To the extent "new beds" and new spaces are to be built, their purposes should be tied to providing both efficiencies and better long term outcomes for individuals in criminal justice system. Accordingly, any potential additional spaces or "new beds" should largely be limited to space for a larger intake or booking unit, acute health care unit, and mental health unit as follows:

a. Admissions and Evaluation "Booking" Unit

The new Marion County Jail should include sufficient purpose-built space to facilitate a more robust identification, initial assessment and screening of arrestees to replace the current Arrestee Processing Center (APC) and the Intake Center at the City County Building. This will allow the sheriff's department to reduce staffing from the current level required at the APC due to its remoteness by over 50%.

The intake/processing center should include a dignified, professional, and welcoming entry way and reception area to promote respectful behavior and minimize decompensation of mentally ill individuals in custody. It should also include a large vehicle sally port that can park numerous vans and two buses inside, and accommodate numbers as much as three times more than the current overcrowded APC. Another departure from the current APC includes dedicated space for medical screening and mental health interviews to quickly assess and determine the needs each new arrestee. The intake area should include a pre-booking area where arrestees determined to

have a medical need can be taken immediately to the Jail clinic's triage and emergency care center, thus dramatically reducing the need for arrestees to be taken to the hospital for similar care.

The unit should include dedicated space for more robust initial transfer, release, classification, physical health, and behavioral health assessments. There, pretrial specialists could interview defendants who are being booked to learn information related to the defendants' residence, family, employment, and community ties. In this space specialists would also do identification and access local and national criminal justice databases to compile criminal history information. This space should also provide consultation rooms and interview space, as well as be outfitted for appropriate technology to facilitate communication of assessment information across criminal justice agencies.

As a result of better, more spacious initial assessment during "booking," Sheriff's Office personnel will be better equipped to understand the needs of inmates to provide better, more proactive medical, mental health, and substance abuse treatment during and inmates stay, as well as better informed and more targeted re-entry services and referrals upon release. Additional consultation space for defense and prosecuting attorneys could lead to better communication, negotiation, and problem-solving cooperation between opposing attorneys, thus leading to quicker case dispositions and creative diversion and other problem-solving results for arrestees.

Waived youth would be designed and staffed like the other special needs Jail units, but should be completely isolated from the adults in the Jail.

b. Acute Health Care and Mental Health Units

The new ADC should include new state-of-the-art special needs beds to facilitate better treatment and outcomes at the new Jail than are possible in today's under-resourced Jail health facilities. The current facility only includes 10 medical beds and some units that are classified for

mental health treatment that are not purpose-built for these types of beds. Like the previously proposed Justice Complex Project, the new Jail facility could include up to 170 mental health beds and 140 medical beds, as well as a new 30 bed infirmary and clinic. The offices of all medical professionals should be located within close proximity of all of these beds.

Specifically, the mental health beds must include segregated single bunk cells for acute treatment and suicide watch, but also dormitories for stepped-down regulated mental health. The Detention Center should include enough separate units that some may be designated for further step down, less acute mental health and classification, where inmates can be assessed and live in a simulated general population unit that can acclimate them to a more regular type of setting. In this way, the new facility would be able to deal with a wide variety of inmates and provide a continuum of care for all persons that pass through the facility.

The majority of medical beds should be assigned as low acuity beds for geriatric and chronic care inmates, but still also include a substantial number of acute care beds in the infirmary, including negative pressure beds to combat communicable disease in the Jail facility. The Acute Health Care Unit for inmates and arrestees also provides an opportunity for significant health care cost savings for the Marion County Sheriff's Office. The unit should be purpose built to provide suitable health care treatment for larger and more acute health issues within the Jail to reduce arrestee and inmate offsite care at Eskenazi Hospital. The future facility should allow for pre-operative and post-operative care to take place on-site at the Jail, resulting in a potential 50% reduction in inmate offsite care costs, by some estimates.

The new consolidated Marion County Jail should also include sufficient space to accommodate the Marion County Sheriff's administrative offices.

FACILITIES RECOMMENDATION NO. 3

CONSTRUCT A NEW CONSOLIDATED MARION COUNTY COURTHOUSE THAT INCLUDES THOSE COURTS AND DESIGN PARAMETERS AS DETERMINED BY THE JUDICIARY ITSELF

Based on feedback from all stakeholders – but most importantly the Circuit and Superior Court Judges themselves – the CJR Task Force recommends collocating Criminal Courts, Juvenile Division (including detention center if economically feasible), Circuit Court, and Civil Superior Courts on the same campus as the new Jail and Assessment Center. Ultimately, however, the determination of which courts and design programing to include in a new consolidated courthouse should come from the Marion County Judiciary itself - not the political branches of government.

Collocated and consolidated Marion County Court facilities with Jail facilities and the Assessment and Intervention Center will provide significant benefits and efficiencies that would be squandered if appropriate courts – most significantly the criminal courts – were left dislocated. These benefits and efficiencies include, but are not limited to the following:

- In-custody defendants delivered more quickly, cost-effectively and safely to court and staged within a Jail transfer unit
- Eliminates the need for central holding within the courthouse
- Enhances user/public experience and convenience of use for visitors and staff in a consolidated facility
- Provides a safe and secure environment for visitors, jurors and Judges
- Designed to accommodate future evolution of the criminal justice system needs with collaboration between all “on-campus” agencies

- Optimizes the total amount of parking required reduced by scheduling shift changes between courts and Jail
- Provides combined support services for central plant and maintenance

Importantly, Judges and Court Administration staff have identified numerous system improvements and operational benefits to be gained from consolidating all, or a specific subset of civil courts in Marion County (including the Juvenile Division), such as:

- Co-location of some civil courts will be helpful for case consolidation and problem solving with existing criminal cases for same defendants and/or families- i.e. "one family, one court."
- A large number of lawyers do both criminal and civil case work with a large volume of associated court appearances – often on the same days. Making them travel between Court locations will be burdensome that segment of the bar and will in all likelihood require more continuances in both civil and criminal cases.
- Co-location presents an opportunity to "right-size" the civil courts and provides economy of scale as determined by each Judge's docket's space requirements. For example, not every civil court requires an attached jury-ready courtroom for daily use, where a state-of-the-art hearing room and/or video-conferencing would suffice for the vast majority of daily civil court proceedings.
- Co-location of civil and criminal courts avoids costs associated with splitting and duplicating civil and criminal court support services (i.e. two clerk's offices, two jury pools, court personnel, double security, etc.)
- Co-location of civil and criminal courts on-campus, increases the number of higher income civil servants and visitors (i.e. lawyers, business clients, expert witnesses, etc.)

on the campus, which consequently increases the economic development prospects for the property and surrounding neighborhoods.

- Failure to collocate will be highly disruptive to the assignment and supervision of court magistrates, commissioners, translators, and court administrators who are jointly responsible for criminal and civil proceedings, and administrative matters writ large.
- Most (but admittedly not all) of the Judges (among both Criminal and Civil Divisions) want the continued collocation of civil and criminal Courts to continue benefiting from collegial and often mentoring relationships among their fellow Judges.

From previous iterations of this project, significant work has been completed and programed for the collocation of the criminal courts with the Jail. However, insufficient work has been done to adequately envision and plan for relocating the Circuit Court, Civil Division, and/or Juvenile Division. That said, enough programing and cost estimating has been done to reasonably conclude that the mere replication and improvement of the current courthouse facilities program at a new site is not financially achievable with available funds. Based on our numerous meetings with individual and groups of Judges, an exact replication of the current courthouse program does NOT appear to be the judiciary's goal. Instead, numerous Judges have suggested that the prospect of constructing a new courthouse facility creates the opportunity to re-envision, optimize, and modernize how Marion County courts utilize technology and built space to provide better and more efficient access to justice for the citizens of Indianapolis. Specifically, it appears that the will and technology are now available to drive efficiencies in the areas of:

1. Hearing room and courtroom scheduling and utilization based on the space needs of specific proceedings
2. Video conferencing for non-evidentiary court proceedings

3. Electronic case filing and document management

Such opportunities could influence the design of a new courthouse to reduce physical space needs enough to potentially make a new, more comprehensive courthouse affordable with available funds. However, such programmatic and administrative changes and potential efficiencies must be driven by the Marion County judiciary itself – not imposed by fiat of the executive or legislative branches of government.

It is also important to point out that the Judiciary's planning should not take place in a vacuum, as its space and operational decisions will affect the operations of law firms and other businesses, as well as several City and County agencies- most directly, for example, the Marion County Circuit Court Clerk.

For these reasons, the CJR Task Force recommends that the Circuit and Superior Courts convene a planning group to develop and provide a final proposed courthouse program to the Marion Superior Court general term for approval or disapproval by May 1, 2017. The CJR Task Force's current design professionals are available to consult with the planning group as needed. The group will be responsible for developing a final courthouse program, including all courts the Judiciary determine should be relocated to the new consolidated campus, as well as specific design parameters intended to ensure construction costs remain within the scope of available funding for the project. We recommend that the planning group include:

1. 3-5 representative Judges approved by the Superior Court Executive Committee and Judge of the Circuit Court
2. The Circuit Court Clerk
3. Representative(s) the bar practicing and whose principal place of business within Indianapolis

4. Representatives designated by the Mayor for ease of communication
5. Representatives designated by the City-County Council for ease of communication

An Important Contingency: The Relocation of the Marion County Prosecutor's Office and Marion County Public Defender Agency

As previously stated, the MCPO and MCPD attorney offices are currently housed in separate privately-owned facilities pursuant to respective long-term leases. One unfortunate but unavoidable drawback to recommending that the Judiciary continue the courthouse design programming work beyond the date of this Report is the ambiguity as to the office space needs of prosecutors and public defenders. These attorneys greatly benefit from their offices being located in close proximity to the criminal courts. If the Judiciary ultimately chooses to relocate the criminal courts to the new Justice Campus, the office space for the MCPO and MCPD should presumably follow suit.

The Ballard Administration's proposed solution to this contingency was to eventually offer the existing leases of these agencies as "anchor" tenants for a potential privately-owned building built to suit these sets of attorneys. This solution still has merit, but is complicated by the existence and potential extension of their respective long-term leases. If the relocation of criminal courts is part of the final project design, the Office of Finance and Management, Office of Corporation Counsel, and these agencies would have to explore options for managing the currently ongoing MCPO and MCPD leases by sublease, early termination, or other potential solutions. Further and depending on the ultimate design program chosen by the Judiciary, it could be possible to include office space for the MCPO and MCPD within the new consolidated courthouse, or elsewhere on the campus.

FACILITIES RECOMMENDATION NO. 4

RENOVATE THE CURRENT CITY-OWNED JAIL II REAL ESTATE TO ADD AND/OR CONSOLIDATE MARION COUNTY COMMUNITY CORRECTIONS RESIDENTIAL FACILITIES

The Ballard Administration's Marion County Justice Complex Project included the construction of an on-campus, 960 bed Marion County Community Corrections residential, programming, and electronic monitoring facility. A new consolidated Community Corrections facility does two key things:

(1) A new consolidated facility allows MCCC to have far more usable beds than they have today. The system could support more beds now, but because of overcrowding at the Jail and at Community Corrections, people eligible for using these beds cannot get access to them when they are scheduled (some wait months), and cannot serve their time in this less expensive and more program-oriented facility. Further, a new MCCC facility would provide greatly need space for expansion and improvement of mental health, substance abuse, job training, educational, and life skills programming that underpins all public policies supporting the existence of local community corrections agencies statewide.

(2) A larger, more secured MCCC residential facility in a more conspicuous location will likely enhance the visibility and credibility of MCCC residential programming and build confidence in the MCCC among criminal justice system stakeholders. Enhances resident's interface with the outside world. Residents of the facility will be processed at a much larger facility that can effectively handle much larger numbers.

The Ballard Administration Justice Complex Project proposed to construct the new MCCC facility within the Justice Complex at the former GM Stamping Plant at a cost of over $60,000,000. Ultimately, the Justice Complex Project stalled due to concerns over the affordability of the P3

contract. Further, while it might prover marginally more operationally efficient to collocate MCCC facilities near the Courthouse for ease of post-sentencing transfers, collocation of MCCC facilities with the Jail and Courthouse does not appear to create discernible development/construction cost savings or overall budget efficiencies.

Considering continuing cost and affordability concerns, the CJR Task Force recommends that the county forego the additional costs of developing and constructing a *new* Community Corrections facility to provide those benefits identified above and, instead, renovate and retrofit the city-owned real estate currently occupied by Jail II to suit MCCC's residential facility needs. The Jail II building currently has capacity for over 1,200 medium security beds. At the current capacity and with minimal renovation work to suit MCCC's programing needs, the Jail II building would provide 30% more work-release housing space than even the Ballard Administration's Justice Complex Project proposed to provide. Granted, there are currently only enough MCCC work-release residents to fill just over half of that bed space. But this provides much-needed space for growth of both Community Corrections residential space and programming space between now and the ribbon-cutting on criminal justice facilities recommended in this Report.

FACILITIES RECOMMENDATION NO. 5

RENOVATE THE CURRENT CITY-OWNED PROPERTIES TO CO-LOCATE: (1) MARION COUNTY FORENSIC SERVICES AGENCY (CRIME LAB); (2) IMPD PROPERTY ROOM/EVIDENCE ANNEX; AND (3) MARION COUNTY CORONER'S OFFICE FACILITIES

As identified above, there exist numerous operational efficiencies to be gained by expanding collocating the Crime Lab facilities with the IMPD Property and Evidence Annex and the Marion County Coroner's office:

- Collocation will greatly improve the Crime Lab's access to the evidence it is obligated to process and test by controlling security and chain of custody concerns and greatly reducing transportation time and costs.
- Collocation will provide the Crime Lab and Coroner's office with larger and more technologically advanced facilities to improve timeliness and accuracy of their respective work tasks.
- Collocation of the Crime Lab and Coroner's Office facilities, which respectively require similar and expensive building mechanical systems and designed space (e.g. specialized HVAC systems, electrical and lighting systems, etc.), will reduce overall renovation/construction costs by permitting two separate work groups to benefit from shared use of the same specialized building systems.

The Task Force recommends assessing the costs and design layouts of city-owned properties that will be vacated as a result of the construction of new the proposed new justice facilities, namely the current Arrestee Processing Center; the current Jail II property; and the City-County Building space potentially vacated by the Courts. Renovating existing city-owned built space would likely reduce overall construction costs by avoiding the design and construction of new buildings from the ground up and maintain the productive use of publicly-owned property.

D. <u>LOCATION OF CONSOLIDATED JUSTICE CAMPUS</u>: A Welcome and Accessible Community Investment

The CJR Task Force further recommends that the new facilities be located within in a campus setting that is accessible, well-planned, and enhances the aesthetics and economic and community development prospects of surrounding neighborhoods. The location of the proposed new Criminal

Justice campus has not been determined. Preliminary work has begun. The final site selection recommendation from the CJR Task Force will occur on or before January 31, 2017.

The Task Force has greatly benefited from and adopts the site location analyses of the 2003 GIPC Study, as well as the two assessment reports prepared for the Ballard Administration's Justice Complex Project. In particular, the GIPC Real Estate subcommittee provided the following excellent analysis:

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There are a variety of factors that must be considered when selecting a site. Some factors are critical, while others impact design and cost, but are not threshold factors.

The threshold factors are as follows:

- *Public Safety. The highest priority for any criminal justice facility is to add to a system that protects the public and provides justice for its residents. Public safety has to be one of the major factors in selection of a location for the facility. Therefore, adjacent uses, such as residential, churches and schools should be minimized.*
- *A site that accommodates all facilities. The focus of this study and the conclusion of multiple studies from the past 25 years (or more) is that a combined, efficient facility is the best option for cost, efficiency and public safety. A site that cannot accommodate all facilities in one location should not be considered, unless it can be physically tied together with tunnels or bridges. The site can be small and force a vertical design or large and allow for a campus-style horizontal design, but it should all be together. Site size will impact cost and that is a factor to consider (discussed below).*
- *Cost structure. The size of a site will impact cost. A small site will force the facility to be built vertically, compared to a large site that would allow a horizontal, lower cost*

design. If the facility components are the same, but the costs are higher for a particular site, it may render the option financially non-feasible.

- *Proximity and Access to Constituent Groups. The primary constituent groups for a new facility are participants in criminal court proceedings, detainees and related family/friends, attorneys, Judges and sheriff's deputies.*
    - *For court proceeding participants, detainees and related family/friends, the facility should not only have public transit access, discussed above, but should be centrally-located within the service area and to the center of population. Given that the facility will serve the entire county, it should be located near the center of the county, or near downtown.*
    - *For attorneys, the facility should be located near their base of activity. Many law offices are located downtown. This allows them access to the Statehouse, other courts, primary office buildings, etc. Having the Marion County Courts and Jail within easy driving or walking distance to these law offices would be beneficial for the attorneys.*
    - *For Sheriff's deputies and related personnel, their primary activities are within the facilities and in conjunction with the IMPD. As such, these constituents have no real estate anchor tying them to a specific location.*
    - *For bail bondsmen and related businesses, these are typically located near the Courts and Jail facilities; and so the only impact would likely be a move to a new location from the existing location, if the facility moved more than a few blocks.*
- *Proximity and Access to Public Transportation. The Jail and Courts facilities serve many constituencies, including those without any form of private transportation. However,*

those involved in the criminal justice process are expected to report to Court or Jail at precise times. Without a car or other motorized vehicle, access is limited to public transportation (IndyGo), bicycle or by foot. For any new facility, a centralized, easy-to-access stop on IndyGo routes is critical. This is not to say that a new facility needs to be on existing bus routes, but that if one does not exist where the new facility is located, one should be created.

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With these concepts as its analytical basis, the Task Force proposes to continue its work and provide a recommendation as to the location of the proposed Consolidated Justice Campus by January 31, 2017.

The CJR Task Force's location evaluation work is well underway and has centered on the prior analyses of the Ballard Administration's preliminary real estate evaluations, which ultimately led to the selection of the GM Stamping Plant. While that location is still part of the CJR Task Force's current "list" of possible locations, circumstances have changed as to the owner's development intentions such that a criminal justice campus is an unlikely fit for that site.

The referenced location analyses from the prior project include:

a. *CBRE, Inc. Criminal Justice Complex Market Survey, November 2013*. This survey identifies particular locations and broadly describes many important attributes and concerns with respect the individual locations studied. For each location the report provides information about its size, address, parcel no., zoning district, and ownership, as well as generalizations as to its particular strengths and weaknesses as a potential site.

b. *Criminal Justice Facility Analysis of Potential Sites, November 2013*. This analysis focuses on the accessibility of potential locations for criminal justice facilities user groups, namely employees, arrested individuals, and county resident's writ large. The document looks at "accessibility" in terms of both proximities to user groups and access to public transportation. One particularly valuable aspect of this analysis is its use of residential density "heat maps" to show proximity of various user groups to identified potential site plotted on the map.

The Task Force will further review and narrow these identified locations, as well as other locations proposed by Enterprise Stakeholders and Community Stakeholders throughout the last six months of the Task Force's work.

In addition to and based on the threshold factors identified in the GIPC Study, the CJR Task Force has identified priorities for its continued site selection work: (1) fully explore a central location to promote access to Courts and services from all parts of county; (2) low/no acquisition cost, as the Task Force prioritizes investments in improved programming and building construction over and above acquiring new tracts of public property; (3) improve and be welcomed by nearby neighborhoods – also, as a corollary, minimize potential harm to existing neighborhood assets and community and economic development initiatives.

CHAPTER 7
FINANCE

The proposed reforms to our local criminal justice system will be an important investment in our city's future. Construction of a new criminal justice facility as a key component of the reform will be a costly undertaking, so any solution must be rooted in a detailed analysis of our capacity to pay for it in a way that is in the best interest of the taxpayers. Instead of starting with a preferred location, delivery, and financing model and later figuring out how to pay for it, we must begin by looking closely at what we currently can afford. The financing of this project should not be based on a presumed tax increase. At the same time, paying for this project cannot stretch city/county budgets beyond capacity.

Between the summer of 2013 and fall of 2015, the City of Indianapolis spent a significant amount of money and committed thousands of hours of staff time in hopes of delivering the construction of a new Jail and criminal courthouse. Though in the end the City-County Council did not pass that proposal, the underlying work-product remains useful, and the lessons learned during that process have been invaluable. But more importantly for the finance team, the in-depth research and analysis that produced the affordability studies by both Mayor Ballard's team and the City-County Council's staff provides the basis for this current review. Without this work from the previous project, we would not have the same confidence level in our numbers.

A. What Can We Afford?

The approach to this financial analysis is conservative and is based, to the greatest extent possible, on objective numbers. A conservative approach is necessary in the current environment, where city and county agencies face budget pressures over and above the need to finance a new criminal justice facility. As with any sound financial analysis, this affordability review is based on a number of assumptions about future events and transactions that may not occur as expected, and the resulting difference could be material. Additionally, any financial model selected will require consideration of statutory limitations on issuing debt, impact on credit ratings, and any impact on fund balances and reserves.

The analysis starts with current savings that can be achieved by building a new facility. For example, Marion County Community Corrections (MCCO) pays yearly rent in excess of $1.5 million. The development of a new facility that would house MCCO eliminates the need for that payment. Therefore, $1.5 million can be added to the available funds to finance the project, whether in the form of debt service or a lease structure. The financing vehicle has not yet been determined, but could involve issuance of bonds and/or notes, a long-term lease-to-own arrangement, or a combination of those.

In addition to being built on the previous administration's affordability analyses, the current approach is based on input from every criminal justice agency. The previous analysis demonstrated the importance of gathering and documenting actual numbers directly from agencies in an open and transparent fashion, as well as the need to verify those numbers. For this analysis, the finance team, which includes the City Controller and the Council CFO, solicited budget information from each agency in a survey asking for detailed, objective facilities expenditures (rent, utilities, etc.).

Additionally, the Council CFO and Controller met with each agency to confirm these numbers and determine additional savings that could be realized with a new facility. These savings figures were then tested and verified by the Controller's team.

Based upon the data gathered during the process described above, we have identified the following amounts that we reasonably expect will be available on an annual basis to fund construction and operational expenses as well as new programs developed as part of the overall reform process:

AGENCY	Personnel Savings	Rent & Upkeep	Contractual Services	Revenue	Total Available per Year
Sheriff	**$5,200,000**	**$4,020,737**	**$16,500,000**	**$1,900,000**	**$ 27,620,737**
Courts		**$4,625,000**			**$ 4,625,000**
APC		**$401,000**			**$ 401,000**
Community Corrections		**$1,546,000**			**$ 1,546,000**
Coroner		**$462,000**			**$ 462,000**
Crime Lab		**$193,000**			**$ 193,000**
Property Room		**$238,000**			**$ 238,000**
TOTAL AVAILABLE					**$ 35,085,737**

Notes:

Sheriff personnel savings from reduction in transportation expenses and overtime
CCA contract estimated savings at $14 million. Additional $2.5 million in savings from Medicare reimbursements
Revenue from HB1006 inmates at $35 per day. Estimating 150 inmates

To summarize, the finance team's work to date has confidently and conservatively identified just over $35 million available on an annual basis to fund a new justice facility that would include the components listed above and all related costs. Our work to identify all funds available for this project is ongoing. Continuing communication with internal stakeholders strongly indicates that there will be additional efficiencies identified that will add to the funds available for this project. Additional funding for this project could result from efforts to repurpose sites that will be vacated by criminal justice agencies. We note that time is of the essence in completing these efforts to identify the full and final funding amounts available to take advantage of the current favorable interest rate environment for municipal issuers of debt. While interest rates for tax-exempt municipal debt are expected to rise, the cost of borrowing remains comparatively low for Indianapolis, given its strong credit ratings. Finally, we strongly recommend that decision-makers consider taking advantage of additional revenues that may become available as a result of the actions of other taxing authorities.

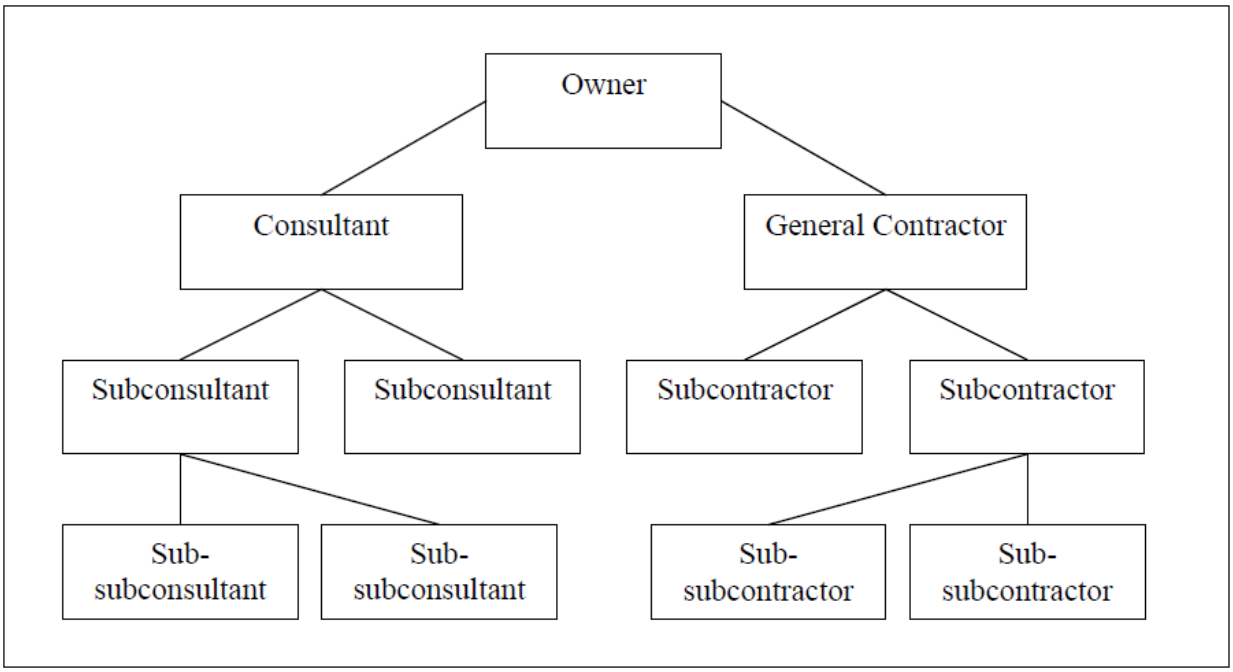
B. Possible Project Delivery Methods

Over the last three years, Marion County has spent considerable time and money reviewing the best delivery model for a project of this magnitude. The City-County Council published a report in March of 2015 that compared two delivery methods – Public/Private Partnership (P3) and Design-Build model. While the conclusion was that a Design-Build model in the long run was a more cost effective way to deliver a new Jail and court house structure, it is in the best interest of all involved to take another look at the various options available to the county.

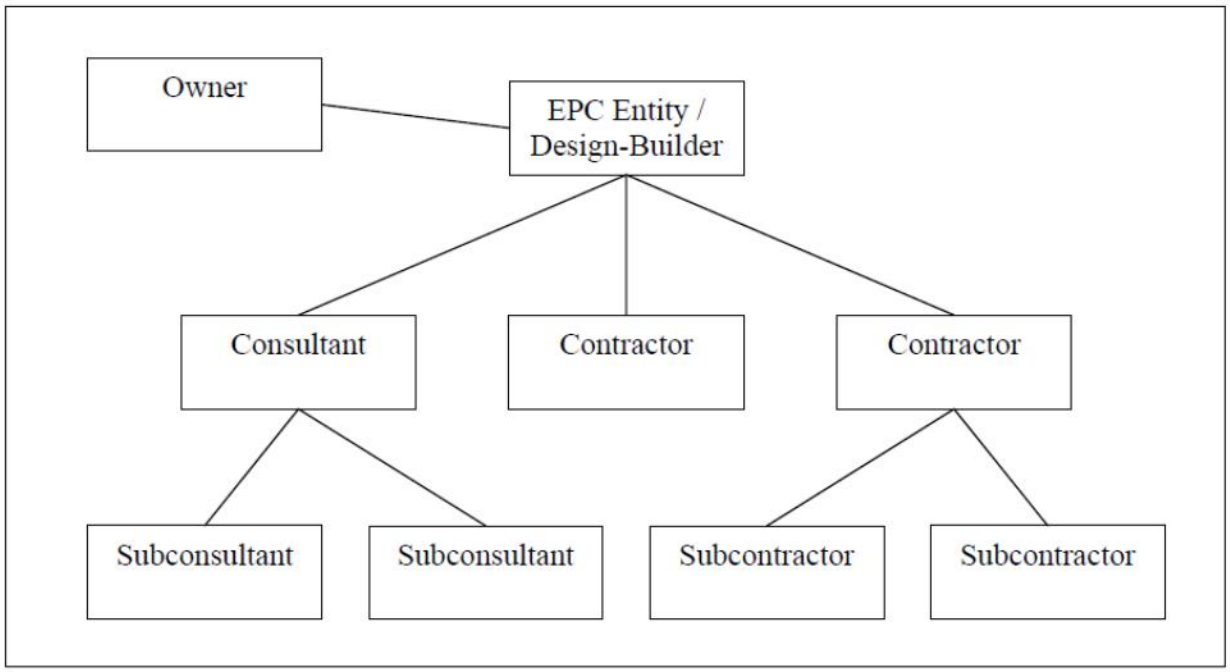
C. The Models

From our analysis we have determined there are five delivery models that should be considered and evaluated, all of which are authorized by statute. We list them in no particular order of preference.

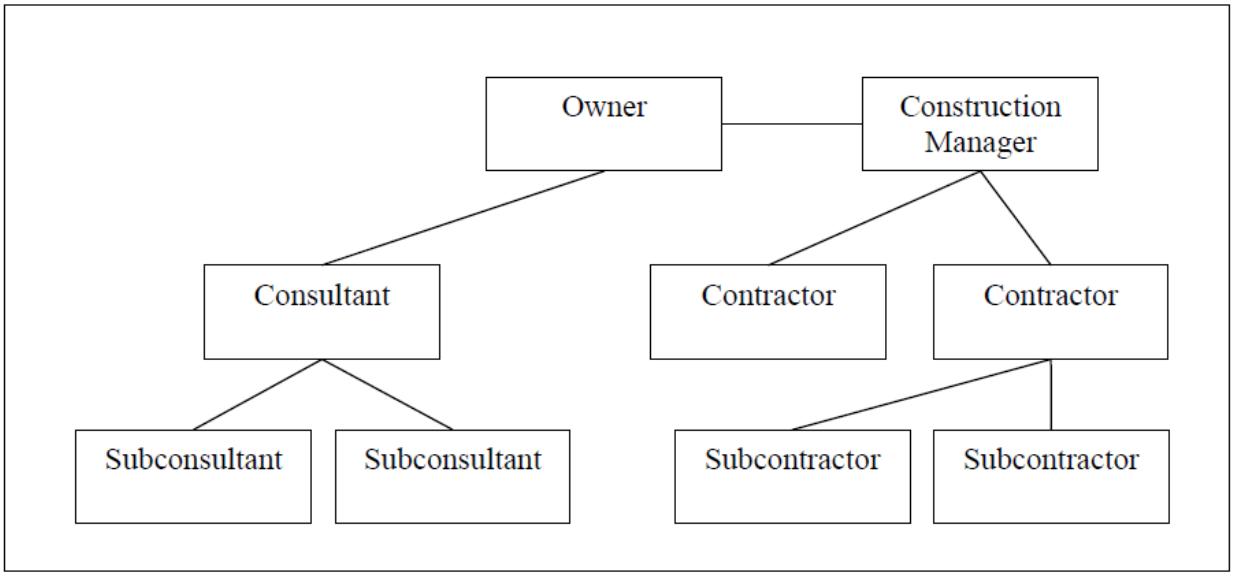
Design-Build-Bid (DBB): The traditional U.S. project delivery method, which customarily involves three sequential project phases: design, procurement, and construction. Financing is typically secured via tax-exempt bond market. Cost guaranteed after project is fully designed and bid. Award usually goes to lowest price bid.



Design-Build (DB): A project delivery method that combines architectural and engineering design services with construction performance under one contract. Guaranteed costs are established early in design. Financing secured via tax-exempt bond market.



Construction Management At-Risk (CMAR): A project delivery method in which the Construction Manager acts as a consultant to the owner in the development and design phases, but assumes the risk for construction performance as the equivalent of a general contractor holding all trade subcontracts during the construction phase. This delivery method is also known as CM/GC.



Public/Private Partnership (P3): Similar to Design-Build except financing is done through private entity. A private entity or consortium of investors provides some or all of the required capital with a commitment to deliver a completed project for a public sector owner in exchange for revenue that the completed facility is anticipated to generate. Cost guaranteed upfront. This method is widely used in U.S. for transportation projects.

D. Considerations in Selecting a Delivery Method

City and county leaders have several areas of concern when embarking on a construction program or project. It is necessary to choose an overall project delivery and contracting strategy that effectively and efficiently delivers the project. The following guidelines offered by the Construction Management Association of America (AN OWNER'S GUIDE TO PROJECT DELIVERY METHODS, 2012) are some of the key considerations that will influence the selection of the project delivery method:

- Budget: Determining a realistic budget before design to evaluate project feasibility, to secure financing, to evaluate risk, and as a tool to choose from among alternative designs or site locations is a primary need. Once the budget is determined the project must be completed at or below the established budget figure. Decision makers must decide how quickly they need to establish final project costs and with what risk level of exceeding this cost.
- Design: Of foremost importance to stakeholders is that the desired facilities function as envisioned while successfully fulfilling the needs of the users. Therefore, the design team should be well qualified in the type of facility being designed. In addition, the team must ensure that the program needs are clearly conveyed to the design team. Since the design of the facilities must be buildable and design intent must be properly communicated, and the design documents are constructible, complete, clear and coordinated. The documents should properly incorporate unique features of the site to include subsurface conditions, interfaces with adjoining properties, access, and other characteristics. Stakeholders must decide how much control they need to have over the design elements of a project.
- Schedule: Stakeholders have similar needs in the area of scheduling. The dates of design commencement, construction completion and ultimately the operation of new facilities can be critical, either in terms of generating revenue from the facility, or in terms of providing needed functional space by a particular deadline. Therefore, a realistic assessment of project duration and sequencing needs to be performed early in the planning process. The schedule must then be monitored and updated throughout the design, construction and pre-occupancy phases to achieve the desired goal. An owner must decide how critical it is to minimize schedule duration for a project.

- Risk Assessment: In construction, issues of risk are closely tied to the status of the local construction market, on-site safety, the schedule and the budget. City and county leaders require an understanding of the risks involved in construction, and should make a conscientious decision regarding allocation of these risks among project participants, so that all areas of exposure are properly understood. In considering risk allocation, decision makers should strive to assign risks to those parties that can best exercise control over those aspects. For example, it would typically be problematic to require that the contractor correct problems due to design errors or changes at no extra cost since a contractor generally has little control over the cause or magnitude of such errors or changes. City and county leaders must decide how much project risk they are comfortable in assuming.

Generally, the level of control provided to the owner of the project correlates with the level of risk, as illustrated in the following chart:

P3	Design-Build	CMAR	D-B-B

CONCLUSION AND RECOMMENDATIONS

During his State of the City Address in May, Mayor Hogsett called upon the Task Force to take a hard look at what real criminal justice reform will require. Over the past seven months, the Task Force has worked with stakeholders across Marion County who have echoed and amplified the Mayor's concerns that simply building a new Marion County Jail may not be sufficient and demonstrated widespread consensus that systemic reforms—not just new buildings—are overdue. The Task Force has built upon the studies, findings and conclusions reached over the past 25 years to recommend workable, dynamic and data-driven changes to our criminal justice processes as well to the facilities where those processes take place.

One component of the Task Force recommendations involves the development of modern, efficient criminal justice facilities on a new government campus. Any such development must be woven into the larger fabric of an optimized system. To achieve that end, the Task Force has recommended development of an Assessment and Intervention Center that is connected to a 2600-3000 bed Adult Detention Center. It has also called for a courthouse facility to house Criminal, Juvenile, Circuit and Superior Civil Courts. In the current budget environment, any such development will require long-term financing.

The findings and analyses of consultants hired in 2013 have been useful in identifying potential delivery and financing models for facilities that support systemic reform. However, the current approach is different in that it first asks, "what can we afford?" as opposed to "what should we build?" The Task Force has taken the first steps toward identifying funding through existing

dollars being used to support the current overburdened system and making new and better use of them to create a system that is fair, effective and responsive to the needs of all stakeholders in the criminal justice system. Our work to date has identified $35 million available on an annual basis, without additional tax revenue. The affordability analysis is an ongoing process. Additional savings and efficiencies may be identified, and any further recommendations on new facilities must be limited by the amount of funding available. We also must incorporate the savings or additional costs that could result when facilities are vacated by agencies that will relocate to a new Justice Center Complex. Future recommendations by the Task Force and decisions by elected officials on finance and delivery models must be deliberative and informed by budget constraints, a rising interest rate environment and changes in available sources of revenue.

Criminal Justice Reform Summary Report
December 12, 2016

I. Goal

On May 11, 2016, in his inaugural State of the City Address, Mayor Joe Hogsett set Indianapolis on a path toward holistic, data-driven criminal justice reform by signing Executive Order No. 4, 2016, launching the Indianapolis Criminal Justice Reform Task Force (the "Task Force").

"The Mayor hereby creates and orders his staff to support the Criminal Justice Reform Task Force whose mission shall be to assess, research, examine, and ultimately report recommendations for the systemic reform and optimization of the current county criminal justice system."

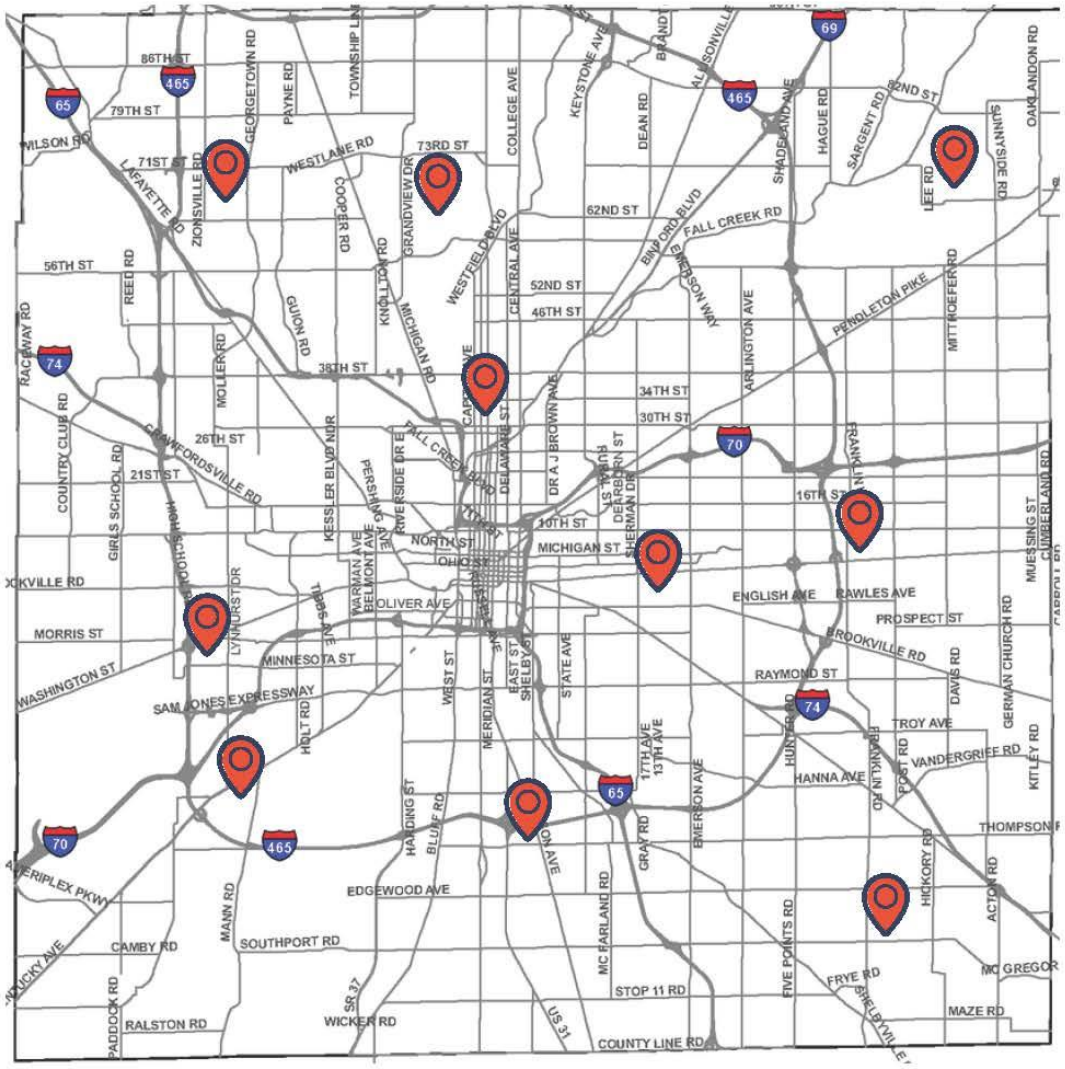
In a report released on December 12, 2016, the Task Force recommends a series of reforms to the criminal justice system that will improve health and safety in Indianapolis, prevent crime, and redirect offenders back to a successful life in the community at the earliest possible point in time.

II. Organization and Community Engagement

From the outset, the Task Force was dedicated to a culture of inclusion that would build consensus and credibility among community and neighborhood groups. To assist in that effort, ten community engagement events were held across the city over the last few months to provide all citizens an opportunity to have their voices heard. In addition, invaluable input was gathered from the following stakeholder organizations:

ACLU of Indiana
Central Indiana Community Foundation
EmployIndy
Greater Indianapolis NAACP
Greater Indianapolis Progress Committee
Health Foundation
Indiana Department of Corrections
Indiana University Health
Indy Chamber
Indy Chamber Workforce Policy Council
IndyCAN
Marion County Reentry Coalition
Mental Health America of Indiana
Recycle Force
The Richard M. Fairbanks Foundation
Indianapolis Bar Association

COMMUNITY FORUMS ON CRIMINAL JUSTICE REFORM



- 5401 W Washington St
- 501 N Post Rd
- 3935 W Mooresville Rd
- 6501 Sunnyside Rd
- 9010 E Southport Rd
- 4107 E Washington St
- 4925 Shelby St
- 5353 W 71st St
- 6701 Hoover Rd
- 3243 N Meridian St

Additionally, the Task Force includes bipartisan representation from all twenty-five members of the City-County Council and the Chief Financial Officer of the Council.

Finally, and most importantly, the Task Force includes internal government stakeholders who work every day in the Marion County criminal justice system. These individuals participated in dozens of work sessions over the past six months. The following offices and agencies are represented on the Task Force:

- Health & Hospital Corporation of Marion County
- Indianapolis Metropolitan Police Department
- Indianapolis Office of Public Health & Safety
- Indy EMS
- Marion County Circuit Court
- Marion County Clerk's Office
- Marion County Community Corrections
- Marion County Coroner's Office
- Marion County Forensic Service Agency
- Marion County Prosecutor's Office
- Marion County Public Defender Agency
- Marion County Sheriff's Department
- Marion County Superior Court

III. Findings

A. Condition of Facilities

The need for new facilities to improve the safety, security and basic operations of the Marion County justice system is well established and has been studied extensively over the past 30 years. Criminal Justice stakeholders currently operate in a variety of buildings in multiple locations around the county.

The Marion County Superior and Circuit Courts have operations at four separate sites, including the City-County Building, Juvenile Detention Center, Traffic Court and the Arrestee Processing Center (APC). The Sheriff detains and houses incarcerated offenders at four separate facilities, including the Arrestee Processing Center, Jail I, Jail 2, and Hope Hall in the City-County Building. The aggregate capacity of detention space is 2,300 inmates, after making allowances for the need to certain segments (e.g., gender, juvenile offenders, gang members) of the population for security reasons.

Marion County Community Corrections (MCCC) operates four (4) residential facilities, comprised of 597 beds, for offenders sentenced to work release, transition, mental illness treatment, re-entry programming and related programming. MCCC also provides substance abuse treatment, drug and alcohol testing services, electronic monitoring and case management services.

The Marion County Forensic Services Lab, IMPD Property Room and Marion County Coroner's Office have intertwining operations that are carried out in multiple spaces, including Jail I, the City-County Building and the Coroner's Office. All three are housed in spaces that are insufficient for space needs, inefficient for technical needs, or hamper operations.

The Marion County Prosecutor's Office and the Marion County Public Defender Agency, respectively, are parties to long-term leases in walking distance from the City-County Building that meet the operating

needs of both agencies. The location of the offices in separate buildings secures confidentiality, security and segregation of witnesses, offenders and victims.

Finally, the Reuben Engagement Center, set to open in early 2017, will offer shelter and connection to community services, but will not be equipped with space for medical and behavioral health services envisioned under a reformed criminal justice system.

With the exception of the Prosecutor and Public Defender operations, most current facilities were not originally designed for their current use and significantly hamper the ability of Criminal Justice partners to realize economies of scale, use resources effectively – staff, technology and space – and engage in an integrated flow of work.

A Criminal Justice Campus that accommodates the collective needs of a reformed and modern county justice system would incorporate the use of technology such as e-filing, courtroom video conferencing; appropriate spaces for counsel/client conferences; the provision of medical, mental health and social services for both diversion and in-house cases; house flexible courtroom spaces; allocate appropriate number of beds for inmates, but also for mental health and addiction patients diverted from incarceration; and support the efficient flow of a system that is based upon the reforms recommended in this report.

B. Offenders

Inmates in all three Marion County Jails are classified and housed often in segregated units based a variety of factors including the severity of their crimes, gang affiliations, age, gender, and mental and physical illness. On the average, 30-40% of the inmates are classified as mentally ill. 85% of the inmates have substance abuse problems. More than 37,000 patients are treated for medical services at the Jail Special Care Unit each year.

84% of detainees in Marion County's jails are under custody in pre-disposition, or prior to trial or hearing.

Under the care of our current contracted health care provider, more than 700 prescriptions are distributed to mentally ill inmates every day at a cost of $650,000 per year. The contractual cost of the care for mentally ill inmates is $5 million per year and the cost of separate security for mentally ill inmates in $2.1 million annually. The Sheriff has estimated that the total cost for the care and custody of mentally ill inmates is $7.7 million. The segregation of mentally ill inmates in separate jail units or isolated in "suicide watch" units further drives personnel costs as a result of the need for increased direct supervision.

<u>Drugs and Addiction</u>

Over the course of 45 years and after the expense of more than $1 trillion, the War on Drugs (focused on Crack Cocaine in the 1980s and Opioids more recently) has resulted in a more than 10-fold increase in the number of incarcerated drug offenders in state and federal prisons. These drug epidemics also

impact the families of drug addicts, evidenced as on example, by increased cases of the number of Children in Need of Services (CHINS) – more than a 65% increase in Marion County over five years.

Mental Illness

Insufficient points of access, inability to maintain engagement, and inadequate service capacity for poor and homeless with mental illness has made Marion County jails a default provider for mental health and addiction treatment.

Mass incarceration

Studies and current data make clear the disparate impact of mass incarceration policies on people. For example: those who are poor and in custody because they cannot afford to pay fees or bail; ethnic and racial misrepresentation; and the question of how to reduce the numbers of arrestees. African Americans comprise 52% of the jail population in Marion County as compared to 28% of the County population. Whites are 46% of the jail population and 65% of the county population.

Repeat Offenders

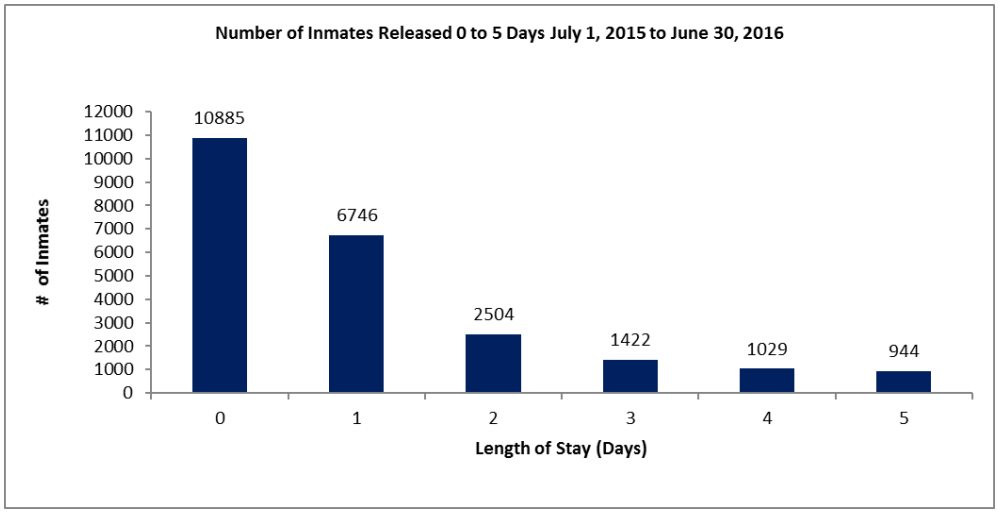
A report by BKD on the Marion County criminal justice system concluded that "a significant number of individuals with multiple arrests can be identified, and these arrestees take up a disproportionate number of criminal justice resources." These repeat offenders can be described as "super utilizers" or individuals who interact with a particular public safety or public health agency repeatedly at great expense to taxpayers.

C. Process Delays

Marion County criminal justice organizations are many, and they interact deeply with one another in myriad ways. Issuing arrest warrants, transporting, holding, and identifying offenders, assessing risks, deciding and communicating sentences. The number of organizations and interactions makes criminal justice a highly interwoven system of many parts, driven by each stakeholder's legal duty and influenced by leadership, budgets, structure, process design, and flow of information.

Approximately 50 meetings with the criminal justice stakeholders, including IMPD, the Marion County Sheriff, the Marion County Prosecutor, the Public Defender, the Superior Courts, the Marion County Clerk, Marion County Probation, Marion County Community Corrections, Marion County Forensic Services Agency, and the Marion County Coroner were held to map and analyze current processes. Multiple points of rework and delay were identified for improvement.

The chart below shows the number of offenders who spend 5 or fewer days in jail, only to be released. Unintended delays result in harm to offenders – such as decompensating mental health and loss of employment. Diverting a greater number of offenders from incarceration would reduce the costs to the County. At the taxpayer cost of $83.17 per day, the cost to jail these 23,530 inmates is estimated at $2,972,579. Disposition of even half of the cases with a stay of one or less days generates an estimated $700,000 savings.



IV. Recommendations

A. Address Root Causes of Crime

In Mayor Hogsett's Inaugural Address, he outlined three challenges facing the city: a violent crime epidemic, the exponential rise in poverty, and a $50 million a year structural deficit. The intersection of mental illness, substance abuse, as well as addiction and poverty exacerbates these challenges – overburdening the criminal justice system, creating cycles of recidivism, and contributing to generational poverty.

The Task Force's recommendations focus on identifying non-violent, low-level offenders suffering from serious mental illnesses and drug addiction and diverting them from the criminal justice system. This begins with providing every officer and E911 operator with crisis intervention training and a mental health assessment tool to aid in identifying underlying conditions. The report also proposes a new system for diverting individuals to treatment before an arrest is even warranted with the creation of Mobile Crisis Units made up of officers, paramedics, and crisis counselors. Lastly, the Task Force recommends the creation of an Assessment and Intervention Center for those suffering from mental illness and addiction.

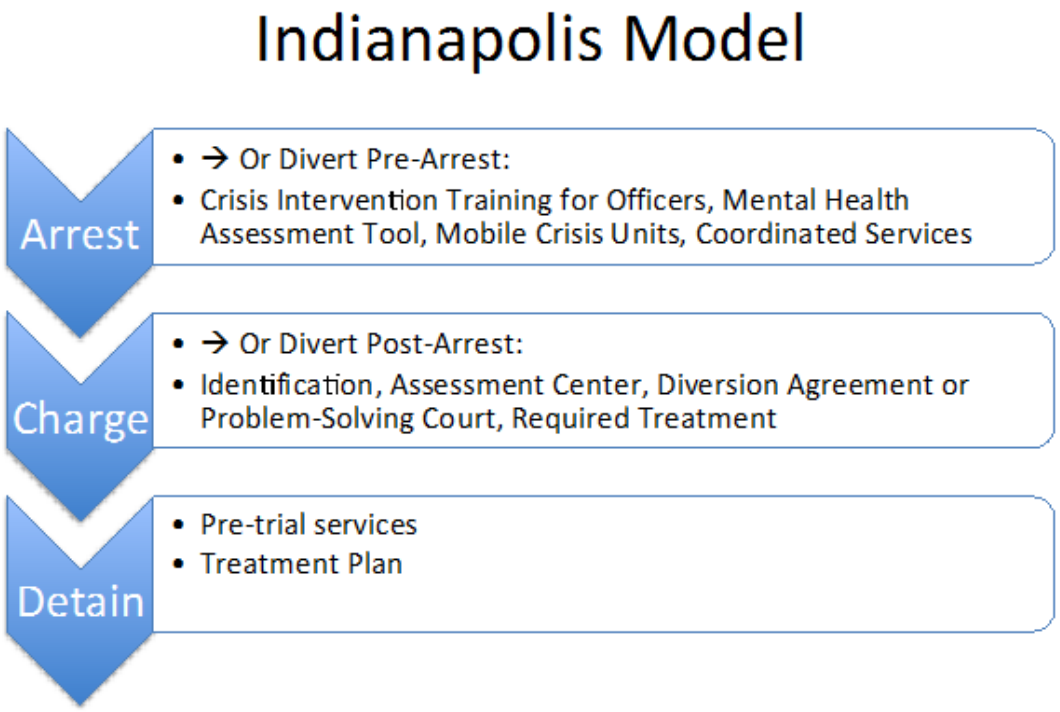
B. Sequential Intercept – The Indianapolis Model

The Sequential Intercept Model (SIM) addresses mental illness and addiction in the criminal justice system. SIM provides a framework for communities to design the interface between the criminal justice, mental health, and social service systems[.]

SIM defines 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. Those points include: (1) law enforcement and emergency services, (2) initial detention and initial hearings, (3) jail,

courts, forensic evaluations, and forensic commitments, (4) reentry from jails, state prisons, and forensic hospitalization, and (5) community corrections and community support services.

The task force recommends the Indianapolis Model - a pre-arrest, post-arrest, pre-trial services and detention initiative:



1. Pre-Arrest Diversion

a) CIT Training

The Task Force recommends that every E911 operator and IMPD officer be fully CIT trained by the conclusion of 2018. CIT training provides E911 operators and police officers the ability to: (1) quickly and effectively identify those suffering from mental illness and/or addiction upon dispatching, or being dispatched to, a particular incident, (2) address the immediate situation, and (3) initiate the appropriate channeling of the individual.

b) Mental Health Assessment Tool

Data-driven assessment tools enhance an officer's ability to utilize the CIT training they receive. The city, through the Office of Public Health & Safety, will work with the New York University School of Law to develop a data-driven mental health screening tool specific to Indianapolis.

c) Mobile Crisis Units

Mobile Crisis Units consist of a police officer with enhanced CIT training paired with one or more public health professional. IMPD and HHC (via Midtown Mental Health and Indy-EMS) will establish and pilot a collaborative MCU Service Line. The MCU will be comprised of a law enforcement officer (LEO), a social worker, and EMS personnel. The unit will expand todays existing IMPD Behavioral Health Unit to respond to 911 mental/emotional/substance-abuse calls as well as daily referrals and follow up care. At the outset, MCUs will be piloted in one targeted IMPD district to operate twenty-four hours a day, seven days a week. The results of the pilot period will be analyzed to appropriately scale and then implement a city-wide deployment of MCUs.

2. Post-Arrest Diversion

Often, those suffering from mental illness and/or addiction are arrested for low-level, non-violent offenses, and then repeatedly arrested for the same or a similar offense. The more often (and further) an individual enters into the criminal justice system (even if only for a few hours or a few days) the worse the outcome for the individual and the community.

a. An officer or MCU may, in making an arrest of a low-level, non-violent offender that they believe is suffering from an underlying mental illness and/or addiction, nominate the individual for enhanced assessment upon normal arrestee processing.

b. Because an enhanced assessment exists outside of typical arrestee processing, candidates for post-arrest intervention and diversion may be provided defense counsel immediately upon arrival and initial processing.

c. Once normal arrestee processing is complete, and upon advice of defense counsel, a candidate will enter the Assessment & Intervention Center for enhanced assessment by public health professionals of Health and Hospital Corporation of Marion County. Enhanced assessment will include, but not be limited to, physical health, mental health, addiction, housing, family, and veteran status.

d. Once the arrestee processing process and enhanced assessment are complete, the prosecutor, perhaps in consultation with the candidate's defense counsel, may elect to: (1) offer the candidate a diversion agreement that would encompass a treatment plan developed by a medical professional with other legal requirements, (2) charge the individual, but refer the case to the appropriate problem-solving court, or (3) determine that the case will proceed in the normal course.

e. A treatment plan is developed.

NOTE: The Task Force recommends implementation of this program as a pilot. Similar to the pre-arrest intervention and diversion pilot, the results of the post-arrest pilot period will be

analyzed to appropriately scale the operations and construction of the proposed Assessment & Intervention Center.

3. Pre-Trial Services

The vast majority of individuals in the Marion County criminal justice system are pre-disposition and most are not detained pretrial. Pre-trial service agencies connect pre-disposition individuals to services targeted at their specific needs and offer a variety of other best practices that promote adherence to the terms of pretrial release and the prevention of recidivism (for example, something as simple as a call or text reminding an individual of a pending court hearing).

The Task Force recommends that the Office of Public Health and Safety work in conjunction with the Marion Superior Court to develop a pilot pretrial services program within the Marion County Probation Department, seek grant funding for the program, implement the services program concepts, and analyze the resulting collaboration for effectiveness (primarily such services effect on recidivism).

C. Bail Reform

Communities and courts all over the country are moving away from the "cash bail" system. Proponents of bail reform argue that cash bail denies freedom to thousands of people who are presumed innocent but can't afford their bond. On September 7, 2016, the Indiana Supreme Court issued an order adopting Criminal Rule 26 that states:

> *If an arrestee does not present a substantial risk of flight or danger to themselves or others, the court should release the arrestee without money bail or surety subject to such restrictions and conditions as determined by the court except when:*
>
> *(1) The arrestee is charged with murder or treason.*
>
> *(2) The arrestee is on pre-trial release not related to the incident that is the basis for the present arrest.*
>
> *(3) The arrestee is on probation, parole or other community supervision.*

The Task Force recommends that the Office of Public Health & Safety work in conjunction with the Marion County Superior Court to get Marion County ahead of the curve by seeking grant funding for the study, design, and implementation of a pre-trial risk assessment tool specific to Marion County's needs.

D. Process Changes to Reduce Rework and Delay

The Task Force recommends implementation of the following process changes to improve performance of the current system of criminal justice:

- Identification of offenders – take one photo and use electronic fingerprints
- All agencies use the FBI number
- All agencies use standard sentence codes
- All agencies use the bond module
- Sheriff has defined authority and flexibility of offender placement
- All confiscated drugs are tested
- Use electronic traffic tickets and automatic summons
- Central evidence storage under forensic services

E. Data Driven Continuous Improvement as One Indy

The task force is encouraged by the collaboration among highly motivated leaders of Indianapolis health and criminal justice systems. We will continue to support and grow the collaboration. We will glean all we can from our information, provide visual analysis for stakeholders, discuss best methods, test actions, and make decisions. We will continue to track our results and adjust our strategies as indicated by the data.

F. Facilities

The Task Force recommends constructing new facilities to suit the criminal justice design and process changes discussed in this report. The following are included in the recommended features and design:

1. **Assessment and Intervention Center** where arrestees are assessed for mental health and substance abuse treatment needs, receive short-term detoxification and behavioral health treatment, have access to social services, defense counsel and prosecutor staff, receive referrals to longer-term treatment plans and engagement with the wraparound care services based on individual treatment plans.

2. **A 2,600 - 3,000 bed jail to replace current detention facilities**, with design elements that increase safety for jail staff and inmates by facilitating improved admission and inmate management

3. **Acute health care and mental health units** that accommodate state-of-the-art care including suicide watch, geriatric and chronic disease care.

4. **A consolidated Civil and Criminal Courthouse** that incorporates the design elements defined by a Courts Planning Group and collocated with the AIC and new Jail. The final determination of design and courts included will be made by the Marion County Judiciary.

5. **Contingent relocation of the Marion County Prosecutor's Office and Marion County Public Defender Agency** if the Criminal Courts are relocated to the new Justice Complex.

6. **Renovate and reuse the APC, Jail II facilities and space in the City-County Building** if vacated by the courts, for Community Corrections and collocation of the IMPD Property Room, Crime Lab and Marion County Coroner's Office.

<u>Parameters for site selection</u>

The CJR Task Force further recommends that the new facilities be located in a campus setting that is accessible and enhances the aesthetics and economic and community development prospects of surrounding neighborhoods. Additional considerations in site selection include:

- Public Safety, taking into account and minimizing adjacent uses such as residential areas, churches and schools.
- Ability to accommodates all facilities, as a combined, efficient facility is the best option for cost, efficiency and public safety.
- Cost structure
- Proximity and Access to Constituent Groups a, central location, and access to public transportation

V. Finance

The proposed reforms to our local criminal justice system will be a costly undertaking and an important investment in our city's future. The financing of the project begins by determining what the City can afford without a tax increase.

So far, the Task Force Finance Team has identified an annual $35 million from current resources that can be reallocated to fund costs of construction, operating expenses and programming of a reformed criminal justice system.

AGENCY	Personnel Savings	Rent & Upkeep	Contractual Services	Revenue	Total Available per Year
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- Additional funding for this project could result from efforts to repurpose sites that will be vacated by criminal justice agencies.
- We recommend utilizing exisitng revenues that may become available as a result of actions of other taxing authorities

Project Delivery Methods

The following project delivery models are authorized by statute and will be evaluated for the best fit with the criminal justice reform project:

a) Design-Build-Bid (DBB)
b) Design-Build (DB)
c) Construction Management At-Risk (CMAR):

d) Public/Private Partnership (P3)

These models are discussed in greater length within the full Task Force report.

The following factors will be considered in the selection of a project delivery method:

- Budget
- Design
- Project Schedule/Timeline
- Risk Assessment

VI. Timeline

December 12, 2016: Presentation of report to county's Criminal Justice Planning Council

January 31, 2017: Criminal Justice Reform Task Force makes justice complex location recommendation

February 28, 2017: Task Force completes cost estimate

March 31, 2017: Announce finance and construction plan

May 1, 2017: Judiciary announces courts plan

July 1, 2017: Release of bids for justice campus project

November 1, 2017: Bid responses due back to city

January 1, 2018: Bid selected and proposal to Council