

Connecticut's Criminal Justice Diversion Program: *A Comprehensive Community Forensic Mental Health Model*

By Linda Frisman, Gail Sturges, Madelon Baranoski, and Michael Levinson, Contributing Writers

Connecticut, like many other states, is coming to terms with an apparent increase in the number and proportion of inmates of the Department of Correction (DOC) who need mental health services. Approximately 12% of state inmates are in need of services (Solnit, 2000). This estimate is consistent with national studies such as Teplin's (1994) showing that over 6% of male inmates have a current severe mental disorder and that the rate of severe mental illness among women prisoners is about 15% (Teplin et al., 1996). The number of inmates wanting mental health care is about 16%, according to recent data from the U.S. Department of Justice (1999).

Connecticut's diversion program was originally a response to problems recognized in the courts. In 1994, court personnel in the Geographic Area (GA) 14 court in Hartford and staff members from Capitol Region Mental Health Center met to address problems related to defendants with serious mental illnesses. No one—not the judge, the public defender, nor the state's attorney—felt that justice was done by imprisoning offenders whose mental disorders were more serious than their crimes. The court could not access mental health treatment for defendants, except through an order for an evaluation of competency to stand trial. These evaluations, which had to be completed within three weeks, often did result in commitment to inpatient care. But they represented a back door to needed treatment, and one that made poor use of resources. Defendants might wait more than 14 days to be evaluated at all, and then were usually hospitalized for 90 days - much longer than the amount of hospital time typically needed to stabilize a person in crisis. Leadership at the mental health center, a facility of the Connecticut Department of Mental Health (now the Department of Mental Health and Addiction Services, or DMHAS) recognized the inefficient use of resources and the poor care resulting from this back door to the system. To remedy the situation, clinicians were deployed to work at the court and address the needs of defendants with mental illness.

Program Goals

In addition to avoiding unnecessary competency evaluations, DMHAS sought to provide clinical alternatives to arrest and incarceration, to ensure continuity of care for those who are incarcerated, and to facilitate community reintegration for those who are sentenced. Thus, the program does much more than divert people from jail. The diversion name has persisted because of the widespread use of that term, and because the court-based activities are most familiar within the Judicial Branch. More appropriately, it would be described as the community forensic services program.

Program Structure

Currently, DMHAS has diversion programs in six mental health centers, covering nine courts. Five of these mental health centers are operated by DMHAS. The remaining center, a private non-profit agency, is a DMHAS-funded local mental health authority. This center receives money from DMHAS to operate the diversion program. In contrast, most of the state-operated programs did not receive new funding to run their diversion programs. These mental health centers recognized the value of having staff members who are knowledgeable about the criminal justice system, and the efficiency of basing clinicians in courts, especially

since so many of their clients were arrested.

The diversion teams consist of one to three clinicians who spend from one to five days in the court per week. They focus primarily on arraignments of persons with mental disorders, but may become involved in all of the phases of their clients' court cases, as appropriate. The team may play a role at the time of plea, or sentencing, in addition to arraignment. (In Connecticut, arraignment is an activity of all of the GA courts, and is not necessarily in a distinct courtroom or at a particular time, unless the court is unusually large.)

Diversion team clinicians are employees of the mental health center who are able to work fairly independently. Usually this skill is reflected in their training and/or clinical license. The fact that they are employed by the mental health center, rather than the court, is an especially important one. They follow the rules of the mental health center with respect to the goals of their work (to assist the client, and not the court) and the rules of treatment consent and confidentiality. Thus, they must obtain permission from the client to work on his or her behalf. They also must obtain written permission in order to discuss the case with the court. Diversion clinicians do not share content of the case with people in the criminal justice system; i.e., they do not relate the diagnosis, and information about the nature of the mental illness. Rather, they describe the treatment plan and the ability of the mental health system to meet the client's needs. They do not coerce the client into treatment by promising to obtain a lighter sentence, or threatening that he or she must stay in treatment or go to jail. Their role is strictly that of mental health clinician.

The Diversion Process

Typically, the arraignment list is faxed to diversion clinicians on a daily basis to be checked against DMHAS's statewide information system. This cross-check enables the teams to identify current or recent clients of the mental health system. These clients generally have a serious mental disorder, such as schizophrenia, bipolar disorder, or major depression.

In addition to known clients, the team will assist defendants identified by the judge, the sheriff, the public defender, the bail commissioner, or the state's attorney. With the client's permission, the diversion clinician conducts a brief, unstructured assessment, usually in the lock-up area of the court. The nature of this assessment is to establish the types of symptoms the person is having, whether the defendant has been prescribed medication and is taking it, and whether and where the person is in treatment. Current treating agencies are usually contacted to ask for additional information, if the client does not object.

Diversion Not Automatic. Clients are not automatically diverted from the criminal justice system because they fall within any particular eligibility criteria. To aid in this process, the clinician considers the seriousness of the charge, the treatment plan indicated for the client, the risk posed by the client, and the extent to which the offense was related to the mental disorder. Similarly, the judge must weigh factors concerning the seriousness of the offense and the reasonableness of the options presented by the diversion team. The diversion team does not make the decision to divert; rather, it offers options to the judges. Most of the clients diverted have minor charges, including misdemeanors and lower-level felonies. However, clients with more serious charges may receive other services from the team.

Treatment Planning. If the person is willing to have the clinician share information with the court, the diversion team and the client can proceed to make a treatment plan. Diverted clients may be hospitalized, sometimes under a commitment paper. They may also receive

ambulatory care in a wide variety of settings. On the day of arraignment, the immediate treatment plan is presented by the clinician to the court, which may then be accepted or rejected. Most often, the judge releases the defendant on a written Promise To Appear with the condition that the client participate in the proposed treatment plan, and orders another pre-trial hearing two to three weeks later. At subsequent hearings, the case may again be continued, or prosecution may be dropped and the case nolle. If the court is concerned that the client will not follow through with treatment, or if the case is more serious, it may go to plea, resulting in the likelihood of the defendant being placed on probation with a treatment condition.

On return trips to court, the diversion clinician's role is to report whether or not the client is continuing in treatment. If a client is not attending treatment, there is no "punishment" for the failure to follow through. Rather, the case is returned to the regular docket and the court proceeds as if there had not been a diversion effort.

The services to which a diverted client is referred are individualized. While Connecticut has a fairly rich array of services, the number of program slots is often inadequate to serve people immediately. It may take from a few days to a few weeks to arrange for needed services for diversion program clients. During this period, the case may be continued. The most frequent services used by diverted clients are mental health hospitalizations and ambulatory mental health services.

Integrated Treatment Available. An advantage of the Connecticut system is that there is a single state agency in charge of both mental health and substance abuse. DMHAS is moving toward integrated treatment. While integrated treatment for co-occurring disorders is not available statewide, many clinicians in the mental health system have received training in treatment of substance use disorders. The community mental health centers of the two largest cities (Bridgeport and Hartford) have Assertive Community Treatment teams that specialize in integrated treatment, using the New Hampshire model of care (Drake, McHugo, Clark, et al., 1998).

Services Available to Non-Diversion Clients

Despite its name, the Diversion Program in Connecticut is a comprehensive forensic model that encompasses many other activities. Because not all clients can be diverted, it is especially important to connect clients entering correctional facilities with needed services. The team calls the mental health staff at the jail to which a client is being admitted to ensure that the jail personnel are aware of medications and other treatments needed by the client. They may also make recommendations about placement in DOC specialty programs. The diversion teams also work with clients being released from correctional facilities, to ensure a smooth transition back into community-based mental health services. In addition to these efforts made on behalf of individual clients, diversion teams often work with the police to educate officers about mental illness and to avert unnecessary arrests.

Contrast With Other Diversion Efforts

Connecticut's efforts to divert people with treatment needs pre-date the diversion program. The Division of Court Support Services in the Judicial Branch contracts with a large number of community substance abuse treatment providers and offers alternative sanctions for persons who have substance use disorders. This system was originally developed for offenders who were about to be sentenced, but it has been expanded to include defendants

at earlier stages of the court process (e.g., at arraignment, during pre-sentence proceedings, etc.) This system works well, but is not available to clients with serious mental disorders. It was especially important for the state to develop a diversion program to provide similar opportunities to clients with mental disorders.

Although mental health courts do not represent a uniform model, there are several ways in which the Connecticut diversion program is distinct from mental health courts. First, defendants stay on the regular criminal docket, rather than being referred to a courtroom with specialized mental health staff; thus the potential of stigmatization is reduced. Second, defendants who are interested in being served by the team have ready access to assistance, since there are few restrictions on the population to be served. However, not all clients served are diverted from jail. Third, the diversion team is employed by the mental health center, and does not relay information about the person's situation except the treatment plan and the compliance with that plan. The diversion team connects the client with services that will continue as long as they are needed and wanted; these services do not terminate with the end of the court's involvement in the case. Finally, Connecticut's diversion model is simpler and less costly to implement than mental health courts, because the judicial system does not need new staffing or training, as required by mental health courts. Moreover, the diversion team performs other important forensic work besides diversion.

Update

Since this article was originally published, the Connecticut legislature and Governor's Office approved funding to enable DMHAS to enhance existing diversion programs and to create new programs so that jail diversion would be available to all 22 G.A. courts. The decision to provide such funding was based in part to the following factors: (1) legislative concern regarding prison overcrowding and the desire to seek innovative alternatives to building more prisons; (2) a report to the legislature, "The Cost & Effectiveness of Jail Diversion", which was based on a collaboration by DMHAS, DOC, the Judicial Branch and NAMI. This report demonstrated a reduction in jail days for defendants in courts where a jail diversion program existed, compared with similarly situated defendants in courts without such a program. (3) Strong advocacy by NAMI, and other advocacy groups concerned with the criminalization of persons with mental illness.

Based on this report, \$3.1 million was provided to DMHAS to expand the jail diversion programs. DMHAS determined each community provider's allocation based on the volume of criminal cases seen annually by their area court(s). Each program includes one or more of the following: a licensed clinician on site at the court, a forensic case manager, and a transitional or respite bed. Additionally, a project director position was funded to oversee implementation, provide quality monitoring, and to assure best practices through the development of a training curriculum. As of June 2001 DMHAS provides jail diversion programs statewide on site at all 22 G.A. courts.

- *Gail Sturges*

References

Drake, R.E., McHugo, G.J., Clark, R.E., Teague, G.B., Xie, H. & Miles, K. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance abuse disorders: A clinical trial. *American Journal of Orthopsychiatry*, 68: 201-215.

Teplin, L.A. (1994). Psychiatric and substance abuse disorders among male urban jail

detainees. *American Journal of Public Health*, 84: 290-293.

Teplin, L.A., Abram, K.M. & McClelland, G.M. (1996). Prevalence of psychiatric disorders among incarcerated women. *Archives of General Psychiatry*, 53: 505-512.

Solnit A.J. (2000). The costs and effectiveness of jail diversion: A report to the Joint Standing Committee of the General Assembly. Hartford, CT: The Department of Mental Health & Addiction Services, February 1, 2000.

U.S. Dept. of Justice (1999). Mental health and treatment of inmates and probationers. Bureau of Justice Statistics Special Report. July, 1999. NCJ 174463.

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