And Justice for All: Families & the Criminal Justice System
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Chapter 2: Mental Illness and Jail Diversion Compassionate Justice for the Mentally Ill: The Advocates / Framingham Police Model

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Eventually my mother suffered a complete breakdown. They took her to the State Mental Hospital at Kalamazoo. My mother remained in the same hospital at Kalamazoo for about 26 years. My last visit was in 1952. I was twenty-seven. I can't describe how I felt. The woman who had brought me into the world, and nursed me, and advised me, and chastised me, and loved me, didn't know me. It was as if I was trying to walk up the side of a hill of feathers. (X & Haley, 1965, p. 98)

Individuals with a mental illness can unnecessarily enter the criminal justice system when their untreated or undiagnosed symptoms bring them to the attention of the police. Police departments across the country are struggling to find the most appropriate response to these scenarios; which increased post-deinstitutionalization. In Massachusetts, police departments have looked to their community-based partners to provide assessment services and treatment resources to their front line police officers.

This paper provides context for one such partnership and describes the creation and operation of the Advocates/Framingham Police Jail Diversion Program. The Advocates program model and outcomes are described while the benefits of this approach to communities, individuals and their families are discussed.

Deinstitutionalization and Mental Illness

Until the 1960s lifelong institutionalization in state hospitals was the primary treatment for individuals with a mental illness like Malcolm X's mother. Her isolation occurred for many reasons: the commonly held stigma that people with mental illness were more dangerous than the general population; a belief that individuals with a mental illness could only be helped in such restrictive settings, and a lack of resources at the community level (Kliewer, McNally, & Trippany, 2008). In the 1950s the first antipsychotic medication Thorazine was discovered and coupled with the subsequent passage of the 1963 Community Mental Health Centers Act (CMHCA) shifted support from lifelong institutionalization to community-based treatment. The CMHCA not only restructured how services were received but also who was to provide those services. No longer was treatment restricted to the medical profession. Therapeutic services to individuals with a mental illness were now assigned to a host of community based non-medical professionals. Additionally, increased civil rights were afforded to individuals with a mental illness and commitment statutes were refined, effectively restricting access to state institutions to the most severely impaired and/or dangerous individuals (Stubbs, 1998). Thus the era of deinstitutionalization began.

Advocates for deinstitutionalization expected the federal government to provide adequate funding for these new community-based mental health services. However, the money saved by limiting access to these expensive institutions was not transferred into additional community- based mental health services. Instead, the number of people who required services in the community far outweighed their availability. As a result of inadequate resources, the previously institutionalized were being treated by community-based agencies, some of whom were ill-prepared or lacked sufficient training on the nature of mental illness and associated behaviors. In addition, community providers lacked the means to adequately treat these complicated mental health needs (Hurwitz, 2000).

The intended benefits of deinstitutionalization are apparent : independence and a chance at a better quality of life. However, the problems associated with deinstitutionalization are significant. Deinstitutionalized individuals often

become homeless, isolated, and subsequently victimized on the streets while their symptomatic behaviors bring them to the attention of law enforcement officers (Kliewer et al., 2008).

Police and Individuals with a Mental Illness

The police are very often the first to respond to individuals with a mental illness in emotional or psychiatric crisis but are ill equipped to adequately respond (Lamb, Shaner, Elliot, DeCuir, & Foltz, 1995). Interventions with an individual with a mental illness use 87 percent more police resources than responses to individuals without a mental illness (Charette, Crocker & Billette, 2014). It is estimated that between 7 and 10 percent of all police calls involve an individual with a mental illness (Pinals, 2014). New York Police Department (NYPD) records reveal an average of 175 calls every day to respond to an 'emotionally disturbed person.' In addition to the frequency of the calls, police officers spend more time on these "mental disturbance" calls than they do on calls for burglaries, assaults, and traffic accidents combined (Cordner, 2006).

Most police encounters with individuals with a mental illness are occasioned by relatively minor nuisance offenses, and while time consuming, are not dangerous. However, police encounters with persons experiencing a more acute set of symptoms can result in volatile situations with risk of harm to both the responding officer and the individual. The Los Angeles Times reported that between 1994 and 1999, there were 37 incidents in which officers from the Los Angeles Police Department shot a mentally ill individual. Of those shootings, 25 were fatal (Berry & Meyer, 1999). Such fatal shootings have a profound impact not only on the victim's family, but on the officer involved and the community at large (Council of State Governments: Criminal Justice/Mental Health Consensus Project, 2002). While there are no national or state-level data available to calculate the rate at which these occurrences take place, a web-based search of "police shoot mentally ill" revealed news accounts of such events nationwide. These situations highlight the need for adequate training and/or mental health/police partnerships.

Without the support of additional training or access to specialized response programs, police officers have more negative attitudes toward individuals with a

mental illness than toward the general population. Some of these attitudes include erroneous beliefs that individuals with a mental illness are always dangerous and violent, that they cannot care for themselves and that they need to be housed in a secure setting (Watson, Corrigan, & Ottati, 2004). A lack of understanding about mental illness by police officers, who use traditional police tactics when responding to individuals with a mental illness, can lead to the use of force (Watson, Morabito, Draine, & Ottati, 2008). Academy training to prepare police officers for handling individuals with mental illness varies from state to state but is widely regarded as insufficient. The initial training of new NYPD recruits lasts for 8 months yet only 12 hours are devoted to dealing with individuals in psychiatric crisis (Cordner, 2006).

The police most often encounter the mentally ill when they are called out to their aid or in response to the erratic, disruptive, or annoying behaviors and not necessarily because they are engaged criminal activity. Abram and Teplin (1991) state, "although American Bar Association (ABA) standards state that misdemeanants who are mentally ill should be diverted into the mental health system, in practice, they are often arrested" (p. 1036). Because many of these behaviors fit the definition of minor crimes, arrest is an available disposition choice for police officers (Teplin, 2000). Police officers are usually the initial contact with the criminal justice system for these individuals, often for low level offenses. Without training in how to intervene, there is a "disconnect in the process" (Teplin, 2000 p. 236). Appropriate police training, money and collaborative community support are needed to address this disconnect (Tucker, Van Hasselt, & Russell, 2008).

To a patrol officer, the successful resolution of a police encounter with a mentally ill person is one which at least holds through to the end of that officer's shift. The immediate goal is a rapid resolution of the call and return to patrol service. Officers may feel compelled to detain the mentally ill person under two distinct circumstances; the individual is publicly 'exceeding community tolerance for deviant behavior;' and/or when there is likelihood that without official action, the behavior will not stop and they will have to respond again (Teplin, 2000 p.13). Under these circumstances the officer will either transport to the hospital emergency room or conduct an arrest. If the officer knows the individual and has

had similar contacts with him/her in the past, an arrest may be more likely. This is particularly true if the officer had initiated a psychiatric evaluation in the past which appears to have made no impact on the individual's behavior (Teplin, 2000). By 'resolving' this issue for a few hours, police officers could therefore be assured that they would not have to come into contact with that individual again during their shift. As a result of the lack of appropriate mental health treatment options, arrest may have become the default choice for officers who wish to resolve such a call quickly. Typically, persons with a mental illness are arrested for misdemeanor offenses, often symptoms of their mental illness (Torrey, 1997).

Mental health professionals have referred to the arrest of individuals with a mental illness for their symptoms as the "criminalization of mental illness." They note that these same individuals, previously treated by the mental health system, have instead been "shunted into the criminal justice system" (Teplin, 2000, p. 12). The probability of being arrested is 67 percent greater for individuals displaying symptoms of a mental illness compared with those who are not. Mentally ill citizens are therefore often being treated as criminals (Teplin, 2000). Police officers have considerable discretion when determining what their response to a misdemeanor offence should be. Without clear and available alternatives to arrest, police officers may feel that arrest is their only option. However, "substantial discretion in arrest decisions raises some questions about equal justice and without appropriate guidelines, similar behaviors could easily be described as criminal or psychiatric" (Cooper, 2004, p. 297).

Incarceration and Individuals with a Mental Illness

Tough on crime policies such as mandatory minimums, and three strikes laws, have increased the rate of incarceration in the US. Between 1980 and 2012, the number of individuals incarcerated in prisons grew from 319,598 to 1,483,900. When local jails were included, the number rose to well over 2 million people in 2012 (Bureau of Justice Statistics, n.d.). Punitive sentencing was prompted in large part by the perception, and the public's fear, that serious and violent criminals were "getting off easy" (Biderman, 1995). In response to this public outrage, the likelihood that convicted offenders would serve time increased as did the length of time they spent once incarcerated (Tonry, 1992). While these

policies promised increased protection for the public from serious and violent offenders, they also yielded high rates of confinement for non-violent offenders. Caught in the more punitive net, individuals convicted and sentenced for non-violent offenses increased more rapidly than the number of violent offenders (Gilliard & Beck, 1996).

In all three tiers of incarceration in the United States, inmates present with symptoms of a mental health disorder. In 2005, 60 percent of inmates in local jails, 49 percent of inmates in state prisons and 40 percent of inmates at federal prisons met the criteria for a mental health disorder (Bureau of Justice Statistics, 2006). Additional concern about individuals with a co-occurring disorder (both mental health and substance abuse) is well founded. The research on the jail population, which houses both men and women, suggests that up to 72 percent of jail detainees have a co-occurring substance use disorder (National GAINS Center, 2001).

Women are especially impacted by these criminalization practices. They have higher rates of mental health problems than their male counterparts in both the state prisons and local jails; 73 percent of women versus 55 percent of men in state prisons and 75 percent of women versus 63 percent of men in jails (Women in the Criminal Justice System, 2007). The impact of women's incarceration for non-violent and drug related offenses cannot be overstated. The availability and quality of gender appropriate treatment in jails and prisons does not match the need. Additionally, families suffer due to the incarceration of women; "among female state prisoners, two-thirds are mothers of a minor child. For many women incarceration may last for a significant part of their child's formative years, and in some cases lead to a loss of parental rights" (Women in the Criminal Justice System, 2007).

Individuals with a mental illness are often incarcerated because the community-based treatment programs are non-existent, at capacity, or the police don't know how to access them. Police often arrest mentally ill individuals when treatment is not readily available. They feel that the individual needs to be confined because of the danger s/he poses (Abrams, 1991). Deinstitutionalization coupled with a lack of community resources therefore make incarceration a more frequent

recourse. Short term misdemeanor custodial sentences are less expensive than lifelong hospitalization, but these cost savings should be achieved by treating individuals in community based treatment and not during short term incarcerations.

In Pennsylvania, for example, “state hospitals cost $90-$100,000 per year per patient,” while in prison, “a seriously mentally ill individual is imprisoned and treated for around $35,000” (Human Rights Watch, 2003). It costs approximately $17 billion per year to house individuals with psychiatric disorders in jails and prisons at an average cost of $50,000 per person annually (Bureau of Justice Statistics, 2006). In addition to being costly, jails and prisons have now become the de facto institution in which mental illness is treated. In 2012, there were estimated to be 356,268 inmates with severe mental illness in prisons and jails. There were approximately 35,000 individuals with severe mental illness in state psychiatric hospitals. Thus, the number of mentally ill persons in prisons and jails was 10 times the number remaining in state hospitals (Treatment Advocacy Center, 2014).

Not only is the probability of being arrested greater for suspects exhibiting symptoms of mental illness but many are unable to make bail and remain incarcerated in jails pending trial. Arrestees with a mental illness are also detained because they are considered to be a high risk for release under personal recognizance (Teplin, 2000). People with mental illness are often charged by police with more serious offenses than non- mentally ill individuals arrested for similar behaviors (Hochstedler, 1987; Massaro, 2004). In addition, those with mental illness are frequently charged, convicted and sentenced more severely than others who have committed similar crimes (Massaro, 2004).

In 2002, the Council of State Governments Justice Center released a report detailing the outcomes and recommendations of their Criminal Justice/Mental Health Consensus Project. The report produced 47 policy statements intended to improve the criminal justice system’s response to individuals with a mental illness. The Consensus Project determined that individuals with a mental illness spend between two and five times longer in jail either awaiting trials or once sentenced than persons without mental illness (Council of State Governments:

Criminal Justice / Mental Health Consensus Project, 2002). These offenders average sentences of 8 ½ years in prison which is 15 months longer than other offenders charged and sentenced for similar crimes. The largest differences in time served were among violent and property offenders. The mentally ill serve an average of at least 12 additional months for violent and property offenses (Ditton, 1999). In many cases, prisoners with a mental illness face additional criminal charges for behavioral infractions committed while in prison.

According to the Bureau of Justice Statistics (Ditton, 1999) 36.7 percent of mentally ill state prison inmates have been in fights since admission, compared to 24.4 percent of other prisoners. Similarly, 62.2 percent of mentally ill state prisoners have been charged with breaking prison rules, compared to 51.9 percent of other prisoners. Such rule violations, even if attributable to mental illness, are routinely punished without mercy as corrections officials feel they must apply the rules consistently if they are to maintain order.

The Clinical Impact of Incarceration on Mental Health

There is a significant clinical impact of 'doing time.' The culture in jails and prisons differ greatly from the therapeutic hospital milieu. Whereas openness and sharing of information is encouraged in a group home/ hospital setting, once incarcerated, these same behaviors can result in injury or even death. The inmates' unwritten code of respect and strength can place the mentally ill inmate at increased risk (Treatment Advocacy Center 2014). Individuals with mental illness may wish to avoid being labeled as 'crazy' and so be reticent to take 'psych' meds. Without medications, individuals with severe mental illness can decompensate rapidly which can result in behaviors which can be interpreted as disrespectful and weak by other prisoners and put them at further risk of victimization (Rotter, 1998).

In addition to being labeled and stigmatized by fellow prisoners, the symptoms of untreated schizophrenia and paranoia can mimic non- compliance with authority. This in turn can prompt an inmate's placement in solitary confinement for 'observation'. Such sensory deprivation exacerbates existing symptoms and lead to significant distress among inmates with mental illness. Individuals with mental illness often have difficulty complying with the strict prison rules,

particularly when there is little flexibility in their enforcement. Therefore those who cannot comply with the rules are disproportionately represented among prisoners in isolation or segregation (Haney, 2003). In addition to finding themselves in isolation, incarcerated individuals with a mental illness are also at increased risk of suicide. In Massachusetts, there were 18 inmate suicides spanning 2007-2011. This is more than five times the rate of suicides in the non-incarcerated Massachusetts population (Hayes, 2011).

In 1999, the state of New Jersey settled a class action lawsuit brought by prisoners with a mental illness residing in the state prison system. One expert involved in that suit noted that, "as a result of (the) disciplinary process that all but criminalizes the most common symptoms of mental illness as well as the lack of alternative housing facilities, mentally ill inmates are almost three times more likely to be found in administrative segregation than they are in general population" (D.M. vs. Terhun, 1999, p. 4). New Jersey settled the suit and agreed to spend $18 million a year to improve the correctional mental health systems in the state-operated correctional facilities (D.M. vs. Terhun, 1999).

In 2003, Human Rights Watch issued a report on prisons and jails in the U.S. and their treatment of inmates with a mental illness. Human Rights Watch is a nonprofit, nongovernmental human rights organization made up of more than 275 members around the globe. The report states that the prolonged solitary confinement of prisoners may amount to torture or other cruel, inhumane or degrading treatment and punishment (Human Rights Watch, 2003). The European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment, which has reviewed a number of prison settings akin to U.S. segregation and 'supermax' facilities, has noted that isolation can undermine reform and rehabilitation and can impair physical and mental health (Human Rights Watch, 2003). Forensic psychologist Keith Curry concluded that, "of the 68 mentally ill inmates reviewed for whom the length of stay could be roughly estimated from the medical record, the average length of stay in segregation appeared to be 5.2 years with a range of one month to seventeen years" (Curry, in Human Rights Watch, 2003, p. 153). In the same report, Dr. Terry Kupers identified another problem facing the mentally ill inmate: "Improper supervision and treatment can also leave the mentally ill vulnerable to

each other. At the Phillips State Prison in Georgia in 2001, two prisoners who were mentally ill died violent deaths at the hands of other prisoners" (Kupers, in Human Rights Watch, 2003, p. 57). Additionally, Hans Tochs' study of prisoners led him to conclude that suicidal prisoners can be easily pushed to their limit while pathologically fearful prisoners can regress into a psychologically crippling panic reaction (Toch, 1975).

Reentry and Individuals with a Mental Illness

If eligible for parole, mentally ill prisoners are also at greater risk than others of being denied. Concerned about their prison behavior and the mental illness itself, parole boards are reluctant to release them (Human Rights Watch, 2000). In addition, the lack of adequate community services makes it difficult for parole boards to develop satisfactory post-release supervision and treatment plans. Baillargeon et al., (2009) researched the association between co-occurring serious mental illness and substance abuse disorders with parole revocation in Texas. This retrospective cohort study included 8,149 inmates who were released over three months in 2006. Those with mental illness alone (no substance abuse) demonstrated no increased risk of having their parole revoked on a technical violation or new criminal charges. However, those with a co-occurring disorder had a substantially increased risk of having their parole revoked on a technical violation or as the result of a new set of charges (Baillargeon et al., 2009).

Given the lack of available community services, families are often left to navigate the reentry process for their loved ones upon release. Their support is needed for reintegration to be successful and can include assistance with housing, financial and emotional support. As a result of the stigma associated with mental illness, negative consequences for the family include being blamed, shamed and avoided which can lead to social isolation and withdrawal. If the family resides in a resource poor community, accessing treatment is difficult and can require transportation that may not be available. In addition, stigma around mental illness can make it difficult for family members to access the necessary resources (Gela & Corrigan, 2015).

In sum, incarceration impacts individuals with a mental illness in profound and disturbing ways. Once incarcerated, the mentally ill spend more time in jails and prison than their non-mentally ill counterparts, spend increased time in segregation and are subject to further criminalization for their symptoms. Once discharged from incarceration, the road to reentry can be challenging and the burden of navigating the treatment options often falls on families. Police departments across the United States have begun to address these issues by developing jail diversion programming to shift low level misdemeanant offenders with a mental illness away from an arrest by offering mental health training for police officers and developing innovative jail diversion programming. There are clear and pressing reasons why the incarceration of low-level nuisance mentally ill offenders should be avoided and diversion of the mentally ill should be a top priority. Jail Diversion Programs provide police with the tools which they need to deliver a more humane and clinically appropriate resolution; more compassionate justice for the mentally ill.

Addressing the Problem: The Emergence of Jail Diversion

In 1999, the Council of State Governments (CSG) responded to calls for assistance from several states on how to respond to individuals with a mental illness who were encountering the criminal justice system. In 1999, the CSG facilitated the first meeting of a small group of leading police and mental health policy makers from across the nation. Following this meeting a steering committee was created that developed and led an 18-month initiative with a wide range of stakeholder agencies including Police Executive Research Forum and the National Association of State Mental Health Directors. Together they developed policy and practice recommendations to improve the criminal justice response to individuals with a mental illness. The subsequent report produced by the Criminal Justice/Mental Health Consensus Project (2002) includes the result of weeks of meetings, surveys administered to governmental officials in 50 states, hundreds of hours of interviews with directors of innovative programs, and thousands of hours reviewing research, promising programs and legislation.

The Consensus Project recommends the development of partnerships between police departments and local mental health providers. In addition, policy statements recommend changes to increase the effectiveness of limited police

resources. One of the many empirical findings of the Consensus Project report is that there is a direct link between inadequate community mental health services and the growing number of mentally ill who are incarcerated. Front line law enforcement practitioners and mental health advocates agree that individuals with a mental illness often come into contact with law enforcement as a result of the mental health system either having failed or as a result of individuals and their families being unable to navigate and access the treatment. Furthermore, members of the project agree that if those individuals with a mental illness actually received the services they needed, they would typically not find themselves charged with a crime, arrested or jailed (Council of State Governments: Criminal Justice/Mental Health Consensus Project, 2002). Budget constraints at the state and federal level have further impacted access to community based treatment, "since 2007, state budgets for mental health services have been cut by $2.2 billion. During that time, demand for community mental health services increased by 56%" (Asking Why? Reasserting the Role of Community Mental Health, 2011, p. 8).

Many police departments have responded to increased encounters between police and persons with a mental illness by offering expanded mental health training for officers. In states where police have shot and/ or killed mentally ill individuals, the mental health community has led calls for increased police training in responding to the mentally ill. The Memphis, Tennessee Police Department significantly enhanced their training practices after police officers, responding to a 911 call, shot and killed a mentally ill man in 1988. Memphis created around-the-clock specialized Crisis Intervention Teams (CIT). Officers assigned to these teams spent 40 hours training with representatives of the mental health system. Part of the training involved learning how to talk to 'mentally disturbed people' during standoffs and studying the effects of various medications. This CIT model has since been replicated in more than 50 law enforcement agencies nationwide (Council of State Governments: Criminal Justice/Mental Health Consensus Project, 2002).

Another model is the pre-arrest co-responder jail diversion program; designed to provide police officers immediate access to trained clinicians at the time that their discretion is called for. By providing an alternative disposition option for

the police, clinicians can facilitate a therapeutic placement for the individual with a mental illness versus an arrest. With input from a trained clinician, police no longer have to shoulder the burden of making decisions without all the relevant information or resources at their disposal. If the clinician is available and responds to the scene, the officer can feel comfortable with an arrest diversion, knowing that the individual will be receiving appropriate and needed treatment and not simply 'getting away with it.' The officer is pleased to return to more serious police work; avoiding time spent arresting, booking and guarding the individual for a typically minor offence.

The Framingham Jail Diversion Program: A Police/Mental Health Partnership

In 2002, the Framingham Police Department joined forces with a local mental health provider, Advocates, to respond to the call for action in the Consensus Project report. The Framingham Police Department is a medium-sized department with over 150 employees and Framingham is a large town located twenty miles west of Boston. Framingham had a population of 68,318 with a relatively large Hispanic/Latino population of 13.4 percent compared to 9.6 percent in Massachusetts. There is a large immigrant population (particularly Hispanic and Brazilian) – 25.8 percent foreign-born compared to 14.8 percent statewide — and also a significant population that speaks a language other than English at home – 34.9% percent compared to 21.7 percent statewide (US Census Bureau, 2010). Advocates is one of the largest service providers in Massachusetts offering quality human services and health care alternatives. They are a leading provider of residential services for adults; home-based intervention for children and families; outpatient mental health services; psychiatric emergency services; and elder and youth prevention services amongst others. The mission of Advocates is to help people achieve their hopes and dreams within the fabric of their communities (Advocates, 2014).

The Framingham Jail Diversion Program was created to respond to police officers' concerns about calls involving individuals with a mentally illness in their community. Jail Diversion Program clinicians have been trained to assist the police in responding to calls involving the mentally ill by helping to deescalate

the mentally ill who present in crisis; providing on-scene assistance with respect to evaluation, referral and placement.

The Framingham Jail Diversion Program Model

The Framingham Jail Diversion Program (JDP) is a pre-arrest, co- responder program that pairs mental health clinicians from Advocates with Framingham Police officers to respond to calls in the community which involve an individual with a mental illness. The primary goal of the program is to provide officers with an immediate treatment-based alternative to arrest e.g. psychiatric hospitalization, for individuals whom the police and clinician determine are in need of treatment. The author is one of the founders of the Framingham JDP and has worked closely with the Framingham Police Department since 2002. The following scenario is typical of a JDP response to a police call involving a person with mental illness.

It's 9:30 pm on a Wednesday evening and raining hard in Framingham MA. A 911 call comes in to dispatch. "It's him again" the dispatcher yells over to me. I immediately know who she is referring to a young man we'll call David (to protect his identity). The dispatcher continues, "It's the third time tonight, he says he can't stop himself from calling 911, I think he needs your help." I had heard about the '911 caller' from a Sergeant who had recently responded to a 911 call originating from David's address. During that encounter, David acknowledged that he was calling the police but was okay. Sergeant E had warned him about calling 911 unnecessarily and told him that he could be arrested for this behavior if it continued. Under normal circumstances this may be an adequate deterrent and would most likely cease the behavior, but David truly could not help it. His hands had a life of their own due to an obsessive-compulsive disorder which manifested itself as compulsions to call emergency services. I decided that I should take a ride over there and asked Sergeant E to accompany me.

Upon our arrival David answered the door and allowed us entry. I explained why we were there, and he told us how he had tried to stop himself from calling 911 but was unsuccessful. David was not taking his medications as prescribed and showed us several phones in varying states of disarray. One of them had the

number 9 pulled off the dial while another was bound in duct tape so as to avoid being used. The police had a dilemma; they could not allow this young man to continue to call 911 and waste the police and fire department's time and money but by arresting David and charging him with a misdemeanor, they would clog up the court systems and use their resources on the processing of these minor crimes. In Framingham due to an innovative collaborative effort, another option was available to the police department. Instead of arresting David, the police asked me to conduct a mental health assessment which resulted in David being admitted to an inpatient facility to restart his medications. He has stopped calling 911 and remains back in the community without incident. (Abbott, 2005)

Advocates developed the Jail Diversion Program in response to a need felt by the Framingham Police Department (FPD) as well as Advocates Psychiatric Emergency Services (PES) personnel. Several concurrent situations in the town encouraged the creation of the JDP. In November 2001, an elderly Framingham woman with a major mental illness stabbed her husband to death. The Framingham police were very familiar with this couple, to whose home they had been called over 100 times prior to the murder. A consensus emerged within the police department that perhaps the situation might have ended differently if they had paid attention to the underlying mental health concerns. The police also recognized that they were repeatedly re-arresting the same individuals for minor criminal or nuisance offenses and were unable to address the underlying issues and longer-term needs of these individuals. In 2002, when the elite FPD SWAT/ hostage negotiation team started receiving consultation and training from the Advocates medical director Dr. Chris Gordon, it became apparent that the 'regular' police officers lacked comparable access to mental health consultation. The police therefore became interested in having access to social workers who could be based within their own station.

The Advocates model responds to the most consistent research findings that police officers want rapid on-site assistance from a qualified mental health clinician when responding to individuals with mental illness in the community (Lamb, Weinberger & DeCuir, 2002). Studies in NY and CA have shown that at least 30 percent of mentally ill patients seen in Emergency Departments were brought there by police officers (Lamb et al., 1995) which supports the belief that if officers have an alternative to arrest available, they will use it.

In February 2003, members of the Advocates Psychiatric Emergency Services team (PES) a 24-hour psychiatric community-based intervention team based in Framingham, MA began orientation training for the Framingham Police Department in preparation for the launch of the Jail Diversion Program which became operational in April 2003. All 120 members of the Framingham PD received the training which was 4 hours in length. The orientation training consisted of two components: the first provided an overview of the different categories of mental illness, common signs and symptoms, medications used to treat mental illness and de-escalation techniques for first responders. The second component covered the genesis of the Jail Diversion Program, the operational aspects of the program, information on how to access the clinicians and scenarios under which the program clinicians could be helpful.

Jail Diversion Program Operations

On April 1, 2003, the Framingham Jail Diversion Program began. The Framingham JDP operates within the Framingham Police Department in three ways. The first is the on-scene assessment provided by the in-house JDP clinician, who is on the road during the shift on a 'ride along' with a police officer and co-responds to all calls involving the mentally ill. The second is through the annual in-service training program and orientation for new recruits. The third is through the monthly operations meeting in which members of the FPD (representatives from the patrol division, police administration and Chief's office) and the JDP (clinicians and program director) discuss the day-to-day program operations, monthly statistics, difficult cases, and community updates.

Ride Alongs and Psychiatric Assessments

At inception, Advocates provided 40 hours of clinician coverage in the police station to co-respond with police officers to calls for service and 911 calls involving the mentally ill. Due to demand, the number of co-responding hours for JDP clinicians has doubled to 80 hours per week. JDP clinicians are Advocates employees but are embedded at the Framingham Police Department. They are provided with office space, a phone, computer and a police radio. Clinicians attend police roll call at the beginning of their shift and pair up with a police partner for the shift. These partners then go out on police patrol in a police cruiser and co-respond to police calls together. When a suspected 'mental health'

call is received, the police dispatcher will send the JDP clinician and officer to the call. Once on scene, the police and clinician will jointly assess the situation and where appropriate, the officer may choose to divert the individual from arrest and into mental health treatment. A secondary benefit of the ride along model is that the clinician can also be helpful with non-mental health calls. Individuals are frequently experiencing emotional distress when the police arrive on the scene. In all encounters, JDP clinicians can assist with de-escalation and provide a calming presence at these often-chaotic scenes. Examples of these include motor vehicle accidents, victims of violent crimes and next of kin death notifications. The JDP clinician's primary role is to provide support and resources to the individual experiencing an emotional or psychiatric crisis.

JDP clinicians are at the FPD station on most days between 8am-12am with back up provided by clinicians at the Advocates Psychiatric Emergency Services (PES) offices who are available for call out or phone consultation in the clinician's absence. These PES clinicians are not on- site but function as a resource to the police and can provide the same clinical services as the JDP clinician. Additionally, members of the FPD know that when they transport individuals with a mental illness to the Framingham Union Hospital Emergency Department (ED), they will be met by a member of the PES team who is stationed there.

Co-response and Jail Diversion

The services which the JDP clinician provides range in accordance with the individual encountered and the preference of the police officer. The police retain control of every situation but use their discretion and allow the clinician to intervene with individuals exhibiting criminal behaviors and divert them from arrest. Individuals who are diverted are usually low-level misdemeanor /nuisance offenders. Not all police calls involving individuals with a mental illness are criminal in nature but due to their presence, JDP clinicians frequently assist with these calls also. Clinicians will assess the needs of the individual and make treatment recommendations regardless of the nature of the call. The only criterion for referral to the JDP is police involvement, either current or past.

The Psychiatric Assessment Process

During a psychiatric assessment, the JDP clinician gathers the information needed to recommend treatment services. This information includes, but is not limited to:

- Presenting problem, including onset and duration of symptoms
- Current safety issues, including plan and means
- History of safety issues, including suicidal ideation, homicidal ideation, self-injurious behavior, and assault.
- Medications (including dosages), allergies, and medical problems
- Support system and outpatient providers
- Substance abuse, if applicable
- Legal history

The assessment considers the natural support network available to the individual, the individual's ability to reliably contract for safety, and the individual's current access to services.

Options for immediate crisis management intervention include:

- Emergency medication evaluation
- Detoxification program, if warranted
- Advocates Crisis Stabilization Program offers a staffed program in an unlocked residential setting. Individuals can stay up to two weeks while referrals are made for treatment and medication is evaluated.
- Partial Hospitalization Program is 3 days to 2 weeks of group focused day treatment with psychiatry and individual treatment
- Inpatient authorization for 23 hours to stabilize the individual
- Inpatient, traditional hospital setting

- Acute Residential Treatment provides those under 18 with a therapeutic environment and focused services in a staff secure setting for up to 14 days.
- Family Stabilization services provide 3 to 6 weeks of in-home treatment for families. It provides case management and individual and family treatment. Addressing the mental illness within the context of the family is critical to the success for the identified client.
- Crisis Counseling, including up to three follow-up sessions.

At the conclusion of the assessment, the individual is presented with a treatment recommendation plan. This plan includes:

- Referrals with appointments to appropriate outpatient, rehabilitation, day treatment, psychiatry and case management services
- Plan for support and behavioral interventions
- Crisis management plan
- Recommendation for the case manager, therapist or inpatient unit to follow up with entitlements, if needed
-

Training

In addition to the on-scene assessment, JDP clinicians provide annual in-service training and all new Framingham police recruits receive a formal orientation to the JDP by program staff. Police officers and police dispatchers are trained to recognize the behavioral signs of mental illness and substance abuse so that they may make appropriate referrals to the clinician. Over the years, JDP clinicians have provided more advanced training to police supervisors on Massachusetts commitment statutes, special populations and hoarding.

Operations Meetings

The purpose of these monthly meetings is to review the program's monthly statistics and ensure that the program is achieving the desired outcomes. These

include diversions from arrest, referrals into appropriate treatment and a reduction in the inappropriate use of police resources. Local service providers, emergency services clinicians and the police participate monthly to discuss cases that involve the FPD. Information about the individual's history of involvement with the police is shared. All information is kept confidential and is shared only with the individual's consent. When consent is not provided, the group discusses the individual in general hypothetical terms. Where appropriate, the individual also is given the opportunity to meet with this group to review what has been helpful, what could have been done differently and to share their own insights about what happens when they come in contact with the police.

Data Collection and Evaluation

Information about individuals who receive the services of the jail diversion clinicians is entered into a database for ongoing analysis. Data are collected to measure the impact of this program and to ensure that the program is meeting the goals and outcomes established prior to implementation. Table 1 shows the outcomes as (a) the number of joint mental health/police responses to individuals in emotional/psychiatric crisis; (b) the percentage of arrest diversions; and (c) a decrease in the number of police-involved evaluations at the local hospital emergency department (E.D.). Data on E.D. were not collected until 2009.

Table 1: Framingham JDP Outcomes 2003-2014

	Total Responses	**% Arrest Diversion**	**E.D. Diversions**
2003	469	48%	-
2004	413	68%	-
2005	448	59%	-
2006	512	74%	-
2007	477	73%	-
2008	672	85%	-
2009	623	99%	45
2010	743	89%	61

2011	688	81%	63
2012	790	70%	43
2013	969	86%	52
2014	950	91%	76
TOTAL	7,754	AVG 77%	340

Police Response to the Framingham Jail Diversion Program

The JDP has been unequivocally embraced by all officers at the Framingham Police Department. It is very common to hear officers say, 'how did we respond to these kinds of calls before the JDP?' Indeed, 96 percent of police officers in Framingham who have utilized the JDP clinician report that the JDP program is valuable (Abbott, 2011). Officers noted that because they are action oriented; they don't want to get "tied up" with one mental health call for a long time.

The presence of the JDP clinician expedites the resolution of these calls, freeing up the officer to respond to more serious 'criminal' calls (Perlman, 2004). In the words of one officer, "a weight is lifted off our shoulders" by the presence of the JDP (Perlman, 2004 p.10). Unfortunately, other police departments in the Commonwealth do not have the luxury of having clinicians at their side on the streets and do the best they can with the tools at hand. When responding to individuals who are mentally ill; without the benefit of specialty response programs, police officers often have had no choice but to arrest the mentally ill.

The presence of the Framingham Jail Diversion Program had widened the number of options available to street officers on patrol which not only places a new tool firmly on their belts but undeniably benefits the members of the communities in which they serve.

Participant Response to the Framingham Jail Diversion Program

Individuals who have received Framingham JDP services, have been positive about the impact this has had on their lives. Prior to the program's inception, unnecessary arrests for minor offences have placed these individuals in the criminal justice system, which has created further barriers to wellness. These

include reduced access to housing, employment and student loans (Hirsch, 2002). Family members have reported they were reluctant to call the Framingham police due to fear that their relative would be arrested for behavioral symptoms; and therefore, only called when the situation was out of control. They now report that they feel better knowing that a social worker will accompany the police to their home and assist with accessing services for their relative in their greatest time of need.

The great promise of deinstitutionalization has all but evaporated and left behind an often-fractured system of mental health care for those with the serious and persistent mental illness. Police officers have therefore been on the front line in their responses to individuals in psychiatric and emotional crisis, which they report feeling ill equipped to effectively manage. Jail diversion program models have sprung up around the country to bridge this gap. The Framingham Jail Diversion Program appears to be delivering 'compassionate justice' to individuals who would have been arrested prior to the inception of the program. In addition to the reduction of unnecessary arrests, the program model ensures that acute crisis intervention services are available to the police when and where they need them. Delivering these critical services alongside the police reduces the usage of emergency departments and the associated costs. The Framingham community undoubtedly benefits from this more humane and appropriate response.

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