



Hawai`i County Post-Booking Jail Diversion Project

Program Manual

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ACRONYMS

AMHD	- Adult Mental Health Division
BHIS	- Behavioral Health Information System
CMHC	- Community Mental Health Center
CMHS	- Community Mental Health Services
DSM-IV	- Diagnostic and Statistical Manual Fourth Edition
HCJDP	- Hawai'i County Jail Diversion Program
ICM	- Intensive Case Manager
ISC	- Intake Service Center
JDCM	- Jail Diversion Case Manager
LOCUS	- Level of Care Utilization System for Psychiatric and Addiction Services
SAMHSA	- Substance Abuse Mental Health Services Administration
SMI	- Serious Mental Illness
SPMI	- Severe and Persistent Mental Illness
TAPA	- Technical Assistance and Policy Analysis Center
TCM	- Targeted Case Manager

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INTRODUCTION AND HISTORY

In June 2002, the Substance Abuse Mental Health Services Administration (SAMHSA), Community Mental Health Services (CMHS) invited applications for proposals for jail diversion programs. As defined by Steadman et al.,¹ jail diversion generally refers to:

Specific programs that screen arrestees in contact with the criminal justice system for the presence of mental disorder; they employ mental health professionals to evaluate the arrestees and negotiate with prosecutors, defense attorneys, community-based mental health providers, and the courts to develop community-based mental health dispositions for mentally ill arrestees. The mental health disposition is sought as an alternative to prosecution, as a condition of reduction in charges, or as satisfaction for the charges, for example as a condition of probation. Once such a disposition is decided on, the diversion program links the client to community-based mental health services.

Generally, there are two types of diversion programs: pre-booking (police-based) and post-booking (court- and/or jail-based). Within post-booking programs, there are three subtypes: pre-arraignment diversion, post-arraignment diversion, and mixed.²

The Adult Mental Health Division (AMHD) responded to SAMHSA's request for applications and proposed the development, implementation, and evaluation of a post-booking pre-arraignment jail diversion program for Hawai'i County. The proposed program targets individuals with severe and persistent mental illness (SPMI) who have been arrested and booked for less serious, nonviolent crimes. In October 2002, the Department of Health and Human Services announced that the AMHD was one of 10 successful applications who will receive approximately \$300,000 per year for a total of three years for capacity development of diversion programs. Funding was also awarded to a national Technical Assistance and Policy Analysis (TAPA) Center. The Center will provide information and assistance to the 10 grantees and other communities implementing the jail diversion and will oversee the evaluation of all programs.

¹ Steadman, H.J., Deane-Williams, M., Morissey, J.P., Westcott, M.L., Salasin, S., & Shapiro, S. (1999). A SAMHSA Research Initiative Assessing the Effectiveness of Jail Diversion Programs for Mentally Ill Persons, *Psychiatric Services*, 50(1) 1620-1623.

² Steadman, H.J., Morris, S.M., & Dennis, D.L. (1995). The diversion of mentally ill persons from jails to community-based services: A profile of programs. *American Journal of Public Health*, 85(12), 1630-1635.

PROGRAM MISSION AND GOALS

The mission of the Hawai'i County Post-Booking Jail Diversion Program (HCJDP) is to provide time-limited mental health and substance abuse treatment services for persons with SPMI with or without a substance abuse disorder. The intent of the service is to reduce criminal recidivism by diverting eligible, non-dangerous mentally ill arrestees from incarceration and into the appropriate level of community behavioral health services. The Program strives to balance the individual service needs of the arrestee, the legal requirements of the courts, and the safety needs of the community.

The specific goals of the HCJDP are to:

1. Systematically identify individuals with SPMI prior to arraignment, through prompt screening and evaluation;
2. Develop and formalize with representatives from the judicial systems and mental health/substance abuse systems a coordinated service plan to manage critical aspects of interagency cooperation and thus maximize effective and safe alternatives to incarceration;
3. Provide aggressive crisis support services and intensive case management models of care to individuals with a SPMI diverted from the criminal justice system to community-based mental health and substance abuse programs and supported programs;
4. Provide support to diverted individuals through community housing, release planning, referral, monitoring of any outstanding legal responsibilities, monitoring of release conditions and time-limited services for a minimum of six months;
5. Improve quality, accessibility, and availability of mental health and other services delivery to forensic populations³;
6. Build system infrastructure to support expansion and coordination of services for forensic populations;
7. Refer persons with ineligible legal and/or clinical status to appropriate community treatment services;
8. Reduce the number of incarcerated mentally ill persons in Hawai'i County;
9. Provide tracking for one year for evaluation purposes.

³ Individuals with a mental illness involved in the criminal justice system.

THE HAWAII COUNTY JAIL DIVERSION PROJECT VS. PROGRAM

The Hawai'i County Jail Diversion Program is overseen by members of the Hawai'i County Jail Diversion Project. The members include:

- **Project Director:** Florence Dunn-O'Neal, RN, MPH, Service Area Administrator, Hawai'i County, Adult Mental Health Division, Department of Health, State of Hawai'i
- **Co-Project Director & Project Evaluator:** Annette S. Crisanti, Ph.D., Mental Health Services Research and Evaluation, Adult Mental Health Division, Department of Health, State of Hawai'i
- **Project Evaluator:** Keith H. Claypoole, Ph.D., Mental Health Services Research and Evaluation, Adult Mental Health Division, Department of Health, State of Hawai'i

The Hawai'i County Jail Diversion Program includes the following positions⁴:

- Jail Diversion Program Coordinator/Boundary Spanner
- Jail Diversion Specialist – East Side
- Jail Diversion Specialist – East Side
- Jail Diversion Specialist – West Side
- Research Coordinator

⁴ In addition to the positions paid from funds from the grant, there is one state position funded by AMHD for a case manager on the west side who will provide back up to the Intensive Case Manager and the Jail Diversion Specialist.

INTEGRATING CULTURAL COMPETENCE INTO JAIL DIVERSION

Cultural competence has been defined as a set of congruent practices, skills, attitudes, and policies that come together in a system, institution, or agency to assure effective mental health treatment within the context of cultural differences. Given the rich diversity of Hawai`i's populations, it is imperative that mental health services be culturally appropriate, sensitive, and flexible. The resource guide "Towards a Culturally Competent System of Care: Volume I" identified five elements important to attaining cultural competency on an organizational level. These elements are useful constructs for jail diversion programs and staff for integrating cultural competence into service delivery systems. The first element states the need to value and respect the diversity of the population served, which means knowing who lives in the local community. The second element of cultural competence is the capacity for self-assessment: jail diversion stakeholder agencies and staff, for instance, need to be willing to examine the cultural competency of the current system, assessing both areas of strength and areas needing improvement. Thirdly, awareness of the dynamics of cultural interaction is important: various cultures negotiate the world in different ways, and people view the world through different cultural lenses; becoming educated about these differing worldviews can avoid misunderstandings. Fourthly, reliable access to institutionalized cultural knowledge, such as history and values, helps agencies identify treatment strategies that are most effective. Finally, the ability to adapt services to meet the diverse needs of local populations results in creative service development. Ideally, innovative services should be offered by all mental health facilities, and should vary according to the needs of local communities. Organizational self-assessment helps to identify necessary service adaptations.

A recent report by the Surgeon General indicated tremendous disparities in access, availability, and utilization of mental health services by racially and ethnically diverse populations. Increasing the cultural competency of Hawai`i's public mental health and correctional systems will enable clinicians to more effectively engage, treat, and support all populations with mental illnesses. We must ensure that jail diversion screening, assessment, treatment, and evaluation strategies are developed within a culturally competent framework, taking into consideration the unique needs of Hawai`i's diverse consumer population.

DEFINITIONS

Jail Diversion: Herein, use of the term “diversion” employs the definition spelled out in the Diversion Standards of the National Association of Pretrial Services Agencies⁵. A dispositional practice is considered diversion if:

1. It offers persons charged with criminal offenses alternatives to traditional criminal justice proceedings;
2. It permits participation by the accused only on a voluntary basis;
3. It occurs no sooner than the filing of formal charges and no later than a final adjudication of guilt; and
4. It results in a dismissal of charges, or its equivalent, if the arrestee successfully completes the diversion process.

A defendant considering diversion needs to be informed of the specific:

1. Program requirements;
2. Length of the program; and
3. Sanctions for noncompliance.

Severe and Persistent Mental Illness: Severe and persistent mental illnesses (SPMI) are included diagnoses identified later in this manual that result in emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with one’s capacity to remain in the community without treatment, psychosocial rehabilitation services, and other community supports of a long-term or indefinite period. The mental disability is severe and persistent if it results in long-term limitations in one’s functional capacities for even the primary activities of daily living, such as interpersonal relationships, self-care, homemaking, employment and recreation.

⁵ National Association of Pretrial Service Agencies, Performance Standards and Goals for Pretrial Release and Diversion, August 1995, p. 1.

Crisis Support Services: An array of services, including Crisis Emergency and Urgent Care mental health services and triage, link the individual with other crisis services, as appropriate. Time-limited support and intervention services provide an individual with opportunity to stabilize and to secure supports necessary to comply with legal requirements to remain in the community; and for jail diversion staff to explore immediate service options in the community.

Intensive Case Management: Intensive Case Management provides treatment and restorative interventions to assist participants in gaining access to necessary medical and rehabilitative services that reduce psychiatric and addiction symptoms and develop optimal community living skills. Goals include to: 1) actualize vocational and personal goals of participants; 2) lessen/eliminate debilitating symptoms of mental illness and to minimize or prevent recurrent acute episodes of the illness through rehabilitation and progressive treatment interventions; 3) ensure that participants have the basic needs and skills for sustaining community living and enhancing the quality of life; 4) improve/establish new linkages with a variety of community services and mobilize the involvement of the consumer's support network; 5) maintain consumer engagement in treatment; and 6) promote harm reduction and encourage substance use reduction, abstinence, and recovery for participants with co-occurring substance abuse/addiction by providing substance abuse services.

Community Housing Services: These services encompass an array of housing options based on least-restrictive-environment concepts, beginning with:

- Interim Housing - licensed group home residential services for consumers who are being diverted from jail/prison, or are awaiting eligibility assessment, or are at-risk for losing a Conditional Release and those who, without twenty-four-hour care, would further decompensate and increase their likelihood of hospitalization or reoffending;
- 24-Hour Group Home - supervised 24/7 for participants who continue to need supervision and linkage to community activities (including clubhouses, psychosocial rehabilitation programs, jobs, etc.) and to social/recreational activities during the days/evenings/weekends;

- 8- to 16-Hour Group Home - with supportive staff on-site between eight and sixteen hours-per-day, seven days-per-week. Staff provides in-vivo life skills training and participants are encouraged to share the responsibility for the daily upkeep of the group home or apartment.

ELIGIBILITY STANDARDS

In general, the program will serve adults ages 18 years and older. Individual entry into the program will be reviewed on a case-by-case basis. Participation in the program is voluntary but first, clients need to meet: (a) clinical diagnostic and functional impairment criteria for SPMI; and (b) legal criteria for petty misdemeanor or misdemeanor nonviolent offense. The general eligibility, clinical diagnostic, and legal criteria are listed in more detail below.

I. General Eligibility Criteria

- Adult (18 years of age or over)
- Voluntary

II. Clinical Diagnostic Criteria

A. Eligible DSM-IV-TR Diagnoses: According to the diagnostic eligibility criteria outlined in the recent AMHD pilot Policy and Procedures (60.X00X)⁶, adults eighteen years or older with functional impairment in one or more life areas who do not have access to other appropriate mental health services are eligible for AMHD Category I Continuing Services with the following SPMI diagnoses:

1. Schizophrenia and Other Psychotic Disorders

	<u>DSM-IV-TR</u>
• Paranoid Type	295.30
• Disorganized Type	295.10
• Catatonic Type	295.20
• Undifferentiated Type	295.90
• Residual Type	295.60
• Schizoaffective Disorder	295.70
• Delusional Disorder	295.1
• Schizophreniform Disorder	295.40

⁶ AMHD Policy # not yet available.

2. *Mood Disorders: Depressive Disorders*

- | | <u>DSM-IV-TR</u> |
|-------------------------------|------------------|
| • Major Depression, Recurrent | 296.3x |

3. *Mood Disorders: Bipolar Disorders*

- | | <u>DSM-IV-TR</u> |
|-----------------------------------|------------------|
| • Single Manic Episode | 296.0x |
| • Most Recent Episode Hypomanic | 296.40 |
| • Most recent Episode Manic | 296.4x |
| • Most Recent Episode Mixed | 296.6x |
| • Most Recent Episode Depressed | 296.5x |
| • Most Recent Episode Unspecified | 296.7 |
| • Bipolar Disorder II | 296.89 |

4. *Anxiety Disorders*

- | | <u>DSM-IV-TR</u> |
|-----------------------------------|------------------|
| • Panic Disorder With Agoraphobia | 300.21 |
| • Obsessive Compulsive Disorder | 300.3 |
| • Posttraumatic Stress Disorder | 309.81 |

5. *Dissociative Disorders*

- | | <u>DSM-IV-TR</u> |
|----------------------------------|------------------|
| • Dissociative Amnesia | 300.12 |
| • Dissociative Fugue | 300.13 |
| • Dissociative Identity Disorder | 300.14 |
| • Depersonalization Disorders | 300.6 |
| • Dissociative Disorders NOS | 300.15 |

6. *Personality Disorders*

- | | <u>DSM-IV-TR</u> |
|-----------------------------------|------------------|
| • Borderline Personality Disorder | 301.83 |

7. *Substance Induced Psychotic Disorders (that do not resolve in 30 days with onset during withdrawal only)*

- | | <u>DSM-IV-TR</u> |
|--------------------------------------------------------------|------------------|
| • Alcohol-Induced Psychotic Disorder With Delusions | 291.5 |
| • Alcohol-Induced Psychotic Disorder With Hallucinations | 291.3 |
| • Amphetamine-Induced Psychotic Disorder With Delusions | 292.11 |
| • Amphetamine-Induced Psychotic Disorder With Hallucinations | 292.12 |
| • Cannabis-Induced Psychotic Disorder With Delusions | 292.11 |

• Cannabis-Induced Psychotic Disorder With Hallucinations	292.12
• Cocaine-Induced Psychotic Disorder With Delusions	292.11
• Cocaine-Induced Psychotic Disorder With Hallucinations	292.12
• Hallucinogen-Induced Psychotic Disorder With Delusions	292.11
• Hallucinogen-Induced Psychotic Disorder With Hallucinations	292.12
• Inhalant-Induced Psychotic Disorder With Delusions	292.11
• Inhalant-Induced Psychotic Disorder With Hallucinations	292.12
• Opioid-Induced Psychotic Disorder With Delusions	292.11
• Opioid-Induced Psychotic Disorder With Hallucinations	292.12
• Phencyclidine-Induced Psychotic Disorder With Delusions	292.11
• Phencyclidine-Induced Psychotic Disorder With Hallucinations	292.12
• Sedative, Hypnotic, or Anxiolytic-Induced Psychotic Disorder With Delusions	292.11
• Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder With Hallucinations	292.12
• Other (Or Unknown) Substance-Induced Psychotic Disorder With Delusions	292.11
• Other (Or Unknown) Substance-Induced Psychotic Disorder With Hallucinations	292.12

B. Functional Impairment: In addition to the above diagnoses, the person’s SPMI will or has resulted in functional impairment that seriously interferes with the person’s ability to function independently in an appropriate and effective manner in one or more areas of life functioning.

C. Co-occurring Substance Abuse Disorders: Persons with one or more of the above SPMI eligible diagnoses and who additionally have a substance abuse disorder are eligible for AMHD Category I Continuing Services for both the SPMI and the substance abuse disorder. Consumers with a primary diagnosis of a substance-induced psychotic disorder that does not resolve within 30 days of first assessment are eligible for AMHD Category I Continuing Services.

D. Co-occurring Developmental Disability: Persons with a DSM-IV-TR diagnosis of Mild Mental Retardation (317) in addition to an SPMI eligible diagnoses are eligible for AMHD Category I Continuing Services. Other developmental disability and mental retardation diagnoses are excluded from eligibility.

E. Excluded Diagnoses: Unless an included diagnosis listed above is also present, individuals with the following disorders are excluded from eligibility for AMHD Category I Continuing

Services. If a specific DSM-IV-TR diagnosis is not noted in the list below, the entire DSM category of diagnoses is excluded. The excluded diagnostic categories and diagnoses are as follows:

- Diagnoses Usually First Diagnosed in Infancy, Childhood, or Adolescence
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Substance-Related Disorders, except Substance-Induced Psychosis as noted above.
- Acute Stress Disorder (308.30)
- Panic Disorder without Agoraphobia (300.01)
- Specific Phobia (300.29)
- Social Phobia (300.23)
- Personality Disorders, except Borderline Personality Disorder as noted above.
- Major Depression, single episode (296.2x)
- Brief Psychotic Disorder (298.80)
- Sexual and Gender Identity Disorders
- Eating Disorders
- Sleeping Disorders
- Somatoform Disorders
- Factitious Disorders
- Impulse Disorders Not Elsewhere Classified
- Adjustment Disorders
- Other Conditions That May Be a Focus of Clinical Attention
- Mental Disorders Due to a General Medical Condition
- Shared Psychotic Disorders (297.3)
- Psychotic Disorders NOS (298.9)⁷
- Dysthymic Disorder (300.4)
- Depressive Disorder NOS (311)
- Cyclothymic Disorder (301.13)
- Bipolar Disorder NOS (296.80)
- Mood Disorder NOS (296.90)
- Agoraphobia without History of Panic Disorder (300.22)
- Generalized Anxiety Disorder (293.84)
- Anxiety Disorder NOS (300.00)

F. Other Exclusions – Clinically Related:

- Offenders who are acutely intoxicated and require substance detoxification or other medical treatment will not be eligible for immediate enrollment but may be considered

⁷ Individuals with Psychotic Disorders NOS may be admitted into the Jail Diversion Program if the Judge grants admission to Jail Diversion and there is no current SPMI diagnosis in the AMHD Behavioral Health Information System (BHIS); or there is no current SPMI diagnosis from a mental health provider in the community; or the client was not actively receiving treatment from the AMHD or other community provider during the past year.

for the Jail Diversion Program after completion of detox and/or residential substance abuse treatment.

- A negative clinical assessment of SPMI as defined in the mental illness eligibility criteria.

III. Legal Criteria

A. Inclusion Criteria:

- Within the jurisdiction of the Third Judicial Circuit.
- Individual on pre-arraignment status who is arrested and charged with an eligible misdemeanor(s) or petty misdemeanor(s) where a primary factor in the offender's criminal behavior is an underlying mental illness or mental illness and co-occurring substance abuse disorder.
- Nonviolent offender, meaning a person who:
 1. Is not presently charged with or convicted of an offense during the commission of which:
 - a. The person carried, possessed, or used a firearm or other dangerous weapon;
or
 - b. The person used force against another person; or
 - c. Death or serious bodily injury occurred to any person, without regard to whether any of the circumstances described above is an element of the offense or conduct for which the person is charged or convicted; or
 2. Current charge can include 707-712 (Assault in the Third Degree), 707-717 (Terroristic Threatening in the Second Degree) and 586-11 (Violation of Protection of Order) where there is no physical contact.
 3. Prior convictions can include 707-712, 707-717, and 586-11 in which convictions are at least two years old and the offender is not on status for a violent conviction at the time of arrest.
 4. Does not have a prior conviction for a felony crime of violence involving the use or attempted use of force against a person with the intent to cause death or serious bodily injury.
- Entry of the offender into the HCJDP is supported by Jail Diversion Case Managers (JDCMs) and Intake Service Center (ISC) staff, agreed upon by the prosecution and defense, and accepted by the judge.

B. Exclusion Criteria: Any of the following would disqualify the offender:

- Person has a prior conviction during the past five years of causing the death of another person and/or causing serious or substantial bodily injury.
- Person has a prior conviction during the past five years of felony assault, violent or sexual crimes.
- Excessive restitution.
- The offender is arraigned to a mandatory minimum term of incarceration.
- Person is adjudicated under Chapter 704 due to legal concerns regarding defendant's competency to stand trial, need for immediate psychiatric inpatient hospitalization or criminal responsibility for an offense.

ENTRY PROCESS

Figure 1, which follows this section, provides a schematic overview of this process.

I. Arrested and Booked

1. An individual is arrested and booked at the holding cell.
2. For each defendant who does not post bail, ISC staff will screen defendants for mental health concerns and will complete a mental health referral form for possible diversion candidates in the holding cell prior to 9am (see Appendix B).
3. The JDCM arrives at the holding cell around 7:45am and/or meets at the court after arrestees have been transported, and communicates with ISC staff regarding defendants who during the screening process were identified as possible diversion candidates.
4. The JDCM approaches defendants identified during the screening process and explains the Jail Diversion Program (see handout about jail diversion, Appendix C), including the eligibility criteria and the process to determine eligibility. If the defendant consents to participate in the Program, the JDCM obtains a written consent (see Appendix D) and conducts an assessment for diagnostic eligibility only if:
 - a. There is no current SPMI diagnosis in the AMHD Behavioral Health Information system (BHIS); or
 - b. There is no current SPMI diagnosis from a mental health provider in the community; or
 - c. The client was not actively receiving treatment from the AMHD or other community provider during the past year.
5. For those defendants who are not known to the mental health system (AMHD or community provider), the JDCM conducts a Level I Assessment (see Appendix E describing Level I Assessment) to assess for an SPMI diagnosis and functional impairment.
6. If a defendant is known to the mental health system, a review of the defendant's current situation is conducted with a structured interview by the HCJDP Level I assessment.
7. Those defendants who refuse to participate in the Jail Diversion Program will continue through the normal course of legal proceedings.

8. The JDCM prepares a diversion plan specific to the SPMI client's needs which will specify appropriate mental health and substance abuse treatment and other treatment needs (e.g., housing status), so that the client may remain in the community under supervised release and return to Court on the next scheduled date.
9. In cases where Jail Diversion is recommended, the JDCM will fax a written referral sheet (Appendix F) to the Prosecutor's Office and the Prosecutor's Office will contact the victim for input. The Prosecutor's Office requires that the fax referral be sent in the morning as soon as possible.
10. The JDCM communicates with ISC staff to notify them of the client's confirmed or conditional eligibility regarding clinical diagnostic and legal criteria. This notification needs to take place prior to ISC writing the bail report for court.
11. ISC staff and the JDCM communicate with defense and prosecution regarding eligible clients and the proposed plans for the clients if admitted into the Jail Diversion Program.
12. The defendant is brought before court within time limits, and at arraignment the prosecutor informs the public defender or private counsel that the defendant appears to be eligible for the Jail Diversion Program.
13. Defense counsel consults with the defendant regarding the Jail Diversion Program option.
14. The JDCM and ISC staff attend arraignment and negotiate with defense and prosecution regarding the conditions and duration of defendant's supervised release and jail diversion case management treatment.
15. Jail diversion is recommended to the Judge after negotiations are conducted among defendant, defense, prosecution, ISC and the JDCM.
16. Defendant's counsel consults with the defendant on availability of JD Program and specifically clarifies the following:
 - (a) Waiver of speedy trial and Rule 48;
 - (b) Process of jury-waived trial on termination of program and preservation of right to file constitutionally based pretrial motions.

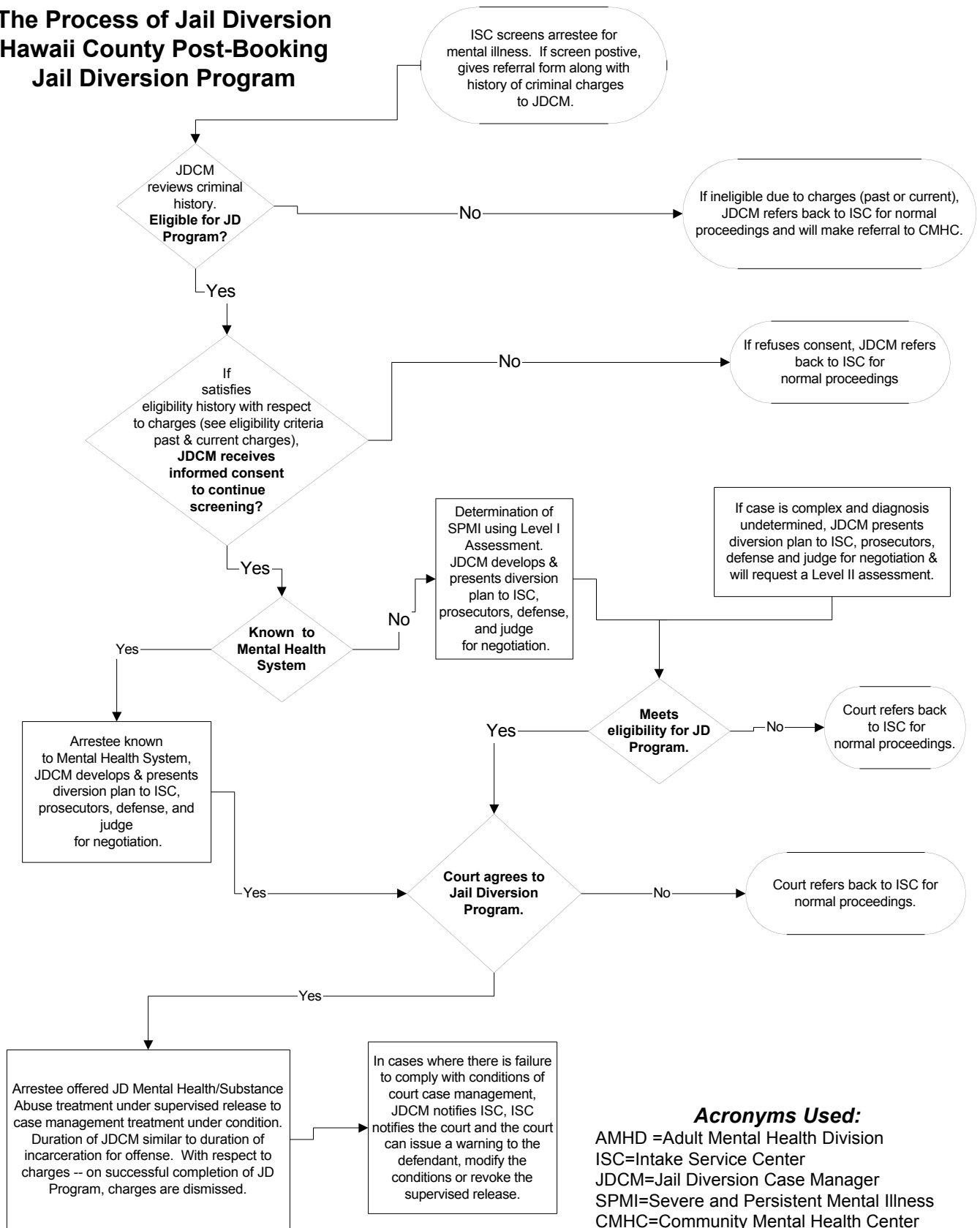
II. Arrested, Booked, and Charged

1. If defendant is determined to be eligible on legal and diagnostic criteria for the HCJDP, then it will be recommended that the defendant be placed on supervised release with specified conditions and duration under the supervision of the ISC and the HCJDP.
2. The Judge will order the conditions of the supervised release, and the court will agree to dismiss the charge(s) if the conditions of the supervised release are met for the duration of the specified supervised release.
3. Intake Service Center (ISC) will prepare the Order of Supervised Release.
4. A status hearing will be scheduled at 1 month, or as otherwise ordered by the Court, to review the case. Proof of compliance or status hearings to be set by the Court.
5. If the defendant elects not to initially participate in the jail diversion program, then legal procedures resume their regular course.

III. Admission to the Jail Diversion Program and Program Evaluation

1. The JDCM will obtain a consent form for treatment for those diverted to the HCJDP (Appendix G).
2. The JDCM will then introduce the evaluation component of the Jail Diversion Program. The client will be told his/her participation in the evaluation of the outcomes of jail diversion is voluntary, and that (s)he will continue to receive case management services, regardless of his/her decision to participate or not in the jail diversion evaluation outcome process. If the client consents to participate in the evaluation of the Jail Diversion Program, the JDCM will either schedule the baseline evaluation interview or contact the research coordinator, who will be responsible for scheduling and conducting the baseline evaluation interview.

The Process of Jail Diversion Hawaii County Post-Booking Jail Diversion Program



Acronyms Used:

- AMHD =Adult Mental Health Division
- ISC=Intake Service Center
- JDCM=Jail Diversion Case Manager
- SPMI=Severe and Persistent Mental Illness
- CMHC=Community Mental Health Center

**Note: The goal for the consumer is dismissal of charges.
The goal of the program is to reduce recidivism.**

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HAWAII COUNTY JAIL DIVERSION PROGRAM SERVICES

I. Intake Service Center: The ISC staff collaborate with the Jail Diversion Program staff in the initial mental health screening and identification of clients appropriate for diversion, and in subsequent supervision of those who are determined eligible and admitted to the Jail Diversion Program. The screening takes place at the holding cell, both in Kona and Hilo (see Appendix B for a copy of the Referral Form); supervision takes place after the defendant is released into the community. Defendants identified as probable or definite SPMI individuals during the screening will be referred to the JDCM.

II. Jail Diversion Case Management Services: The JDCM will determine whether the client meets legal criteria, and if so, further inquiry into the client's diagnostic and treatment history is conducted. The JDCM communicates findings of assessment to ISC in efforts to develop an appropriate case management treatment plan for presentation to the court. Upon a client's acceptance into the HCJDP, the Program staff shall review and gather additional material forms and consents as required. The Program staff shall meet with the client and provide orientation, which includes performance expectations related to supervision and treatment, limits of confidentiality, and the client's rights to treatment. The Program staff shall provide supervision and case management of the client as determined by the HCJDP and the AMHD's policies and procedures. Initially, the JDCM level of care will be designated at an Intensive Case Management (ICM) level (LOCUS Level 3)⁸. When a client is transferred to Community Mental Health Center (CMHC) case management services, the level of care shall be determined by an assessment of the treatment phase, progress and problems indicated by the case, and other related factors. Additional assessments will be scheduled, as appropriate, to provide mental health treatment, housing, food, basic necessities and diagnostic clarification from Level II Assessment.

⁸ Level of Care Utilization System for Psychiatric and Addiction Services Adult Version 2000 (Sowers, W. and Benacci, R). In Locus there are seven levels of care: six are actually service levels. The seventh is a basic service package that is available to everyone in the population being served whether or not they need mental health care at the moment. Basic services focus on prevention and health maintenance issues. Clients at LOCUS Level Three require high intensity community based services.

Case management shall include service plans that balance treatment, prognosis, and criminal risk and provide coordination of other community-based services that may be needed by the client. In addition, the Program staff shall have monthly meetings with the ISC team and the courts regarding the client's compliance with the conditions of supervised release. The Program staff shall also provide regular progress reports to ISC with recommendations on effective sanctions for noncompliance or termination from the program.

HAWAII COUNTY JAIL DIVERSION PROGRAM SUPERVISION

I. Duties and Functions Prior to Client Being Accepted into Program

1. Obtain authorization to release/obtain confidential information.
2. Review history of convictions and current charges to determine eligibility.
3. Conduct mental health screening and Level I Assessment to determine eligibility.
4. Facilitate communication among ISC staff, prosecution, and defense.
5. Obtain consent for JD Program participation.

II. Duties and Functions Once A Client is Admitted into Program

1. Each case is assigned by the Jail Diversion Program Coordinator to a JDCM. In most instances, the client will be assigned to the JDCM who completed the initial interview. Geographic considerations and caseload are two of the factors considered in the assignment process.
2. The JDCM will assure all mandatory agreements and required consent and other forms are completed.
3. The JDCM will review all documents, including prior mental health and substance abuse treatment and diagnoses, assessment findings and treatment recommendations. Should any disqualifying factor or overlooked pertinent information arise, the Program Coordinator shall be notified immediately.

In addition the JDCM will:

4. Meet with the client to develop the treatment or service plan that includes conditions of release after comprehensive assessment of client's service needs. Continue to assess and modify the plan to ensure that it meets the client's evolving treatment and social service needs.
5. Attend all team staff meetings, court status hearings, and other support agency meetings concerning the client's welfare.
6. Provide ongoing coordination of the care plan through regular contacts with treatment provider and through utilization of community-based services such as physical health, mental health, substance abuse treatment services, housing, entitlements, education, vocational

training, job skills training, and other placements to provide a strong foundation for recovery. Provide jail diversion client progress reports to ISC and court.

7. Recommend effective sanctions for Program noncompliance, incentives for Program compliance (including the benefits of recovery, communicated by a certified peer mentor/specialist), and recommendations for termination from Program.
8. Enroll clients into the evaluation process with their consent and then contact the research coordinator who will conduct baseline interview. The JDCM will only conduct the baseline interview if necessary.
9. Link jail diversion clients to ongoing CMHC case management, at such time as the participant no longer requires to be in the Jail Diversion Program and no longer requires Intensive Case Management services.
10. Attend workshops, training, and cross-training.
11. Participate in and encourage open communication with all Jail Diversion Program staff and various service providers.
12. Attend monthly meeting with entire Jail Diversion Project staff.

HAWAII COUNTY JAIL DIVERSION TREATMENT PHASES

HCJDP will provide access to a comprehensive continuum of treatment and rehabilitation services. The level and intensity of chosen treatment approaches will vary according to individual needs. After primary treatment interventions are completed, additional support services will be provided to accommodate individuals who have housing, employment or educational needs or dependent-care responsibilities, or to individuals who are noncompliant. Once an individual is screened and accepted into the HCJDP, further evaluation may be conducted to determine treatment needs and to develop a comprehensive individual treatment plan. ISC will monitor all treatment and rehabilitation services.

Individualized treatment will consist of four phases.

A. Phase I - Level I Assessment, Orientation to Jail Diversion Program and Initial Court Appearance:

1. Identification by ISC through the Mental Health Referral Form.
2. Eligibility assessment by JDCM and eligibility for Program determined.
3. Presentation of Program to prospective participant and consents signed.
4. Develop Initial Treatment Plan to present to Court.
5. Discuss Initial Treatment Plan with ISC, defense and prosecution attorneys, prior to court.
6. Appear in court to present testimony as needed for recommendation to Program and details of the Initial Treatment Plan.
7. Ascertain immediate needs, such as housing, food and clothing, detoxification, medical needs, medication. Make appointments and arrange transportation.
8. Review release conditions and Program requirements.
9. If consent is given, contact family members or significant others.
10. Contact Crisis Support Management, if appropriate.
11. Arrange transportation to a stable environment.

Phase I - Completed on day one of initial court appearance.

B. Phase II - Level II Assessment, Evaluation of Treatment Needs, Development of Master Service Plan:

1. If participant is currently receiving services from a mental health or substance abuse provider, the assigned JDCM will contact the provider to review psychiatric evaluation, history, physical condition, medication and treatment plan.
2. If participant is not currently receiving services, a Level II Assessment is scheduled within a designated time frame.
3. JDCM, after all initial assessments and evaluations are complete, schedules participant for a treatment team meeting with private provider or CMHC psychiatrist, and any other providers, to review current food and shelter needs, employment history, family and social support needs, including peer contact/mentoring, if appropriate. A Master Service Plan is developed and a clinical record is opened. The treatment team is composed of, at a minimum, the participant, the JDCM, and either an Advanced Practice Registered Nurse (APRN) or a psychiatrist, licensed to practice in the State of Hawai`i. The APRN or psychiatrist is the head of the treatment team.
4. JDCM assures that all consents are in place, and orients participant to treatment timelines, required meetings with JDCM and ISC, status court dates, and any other information to encourage compliance.
5. JDCM assists the participant to apply for entitlements, vocational rehabilitation, housing and supported education programs, as appropriate.
6. JDCM provides a copy of Master Service Plan to ISC.
7. The JDCM documents all face-to-face participant meetings, telephone contacts with participant or collaterals, family members or significant others, in progress notes.
8. The JDCM documents all interdisciplinary meetings in the Interdisciplinary Team (IDT) notes. Progress reports from other providers are maintained in the clinical chart. All signed consents, including Health Insurance Portability and Accountability Act (HIPAA), are filed in the chart and kept in a locked file.

Phase II - Completed within two weeks of admittance into Jail Diversion Program.

C. Phase III - Case Management, Monitoring and Compliance:

1. JDCM schedules face-to-face meetings with participant a minimum of one time-per-week.
2. JDCM regularly discuss, in weekly meetings, medication compliance, employment needs, family and social support needs, legal responsibilities, education needs, and any other services that may assist with reduced detention with criminal justice system.
3. JDCM provides routine reports to ISC and the courts, if required.
4. JDCM provides reports of noncompliance to ISC, prosecution and defense.
5. JDCM accompanies participant to court, providing oral testimony of compliance with Master Service Plan.
6. JDCM schedules participant for routine treatment meetings.
7. JDCM attends interdisciplinary treatment meetings and reviews each participant's progress at least every two weeks.
8. As the participant's monitoring needs decrease (with compliance and stability), the participant may be moved to a Targeted Case Manager (TCM). The JDCM together with the Program Coordinator will continue to track court dates, ISC appointments, defense appointments and will communicate with the TCM to assure that the participant completes HCJDP.

Phase III - Lasts until the participant completes the legal requirements of the Jail Diversion Program.

D. Phase IV - Follow-up and Evaluation

1. Participants who have volunteered to take part in the Evaluation portion of the Jail Diversion Program will be contacted at 6 months and 12 months to ascertain current status. (See The Evaluation Plan.)
2. If the participant fails to complete the agreed Evaluation Interviews, that failure will not impact the legal status or participation in the treatment Program.

Phase IV – Ends when the final Evaluation Interview has been completed.

ADDITIONAL PROGRAM INFORMATION

Treatment Provider:

All service delivery agencies and providers which provide services to the Jail Diversion Program will be employees of or contracted by the AMHD, or licensed as private providers.

Length of Program:

Minimum length of the program will be six months from the date of acceptance into the Jail Diversion Program.

Supervision:

Arrestee will be supervised by ISC and the assigned JDCM. Status review hearings will be scheduled as needed (depending on a participant's status, compliance, and stability). These may occur at a minimum of once a month, but at shorter regular intervals if necessary.

TERMINATION AND COMPLETION CRITERIA

Termination Criteria:

Failure to cooperate in treatment, or noncompliance with the requirements of the Jail Diversion Program may result in the revocation of the arrestee's supervised release status, leading to termination from the Jail Diversion Program. Revocation of supervised release will be determined on a case-by-case basis. In the event of termination, the individual will return to the Court with a written report from the Jail Diversion Program as to the current mental health status. Each participant will be dealt with individually, and termination is at the sole discretion of the Court.

Completion:

After successful completion of the Jail Diversion Program, the State will dismiss the underlying charge(s), subject to Court approval.

Completion Criteria:

1. Successful completion of Phases I-III.
2. No unexcused absences from scheduled appointments.
3. Compliance with essential elements of the Master Service Plan, (e.g., prescribed medications, supportive counseling sessions with JDCM, consistent attendance in recommended vocational or pre-vocational programs, community volunteerism, and, as assigned, attendance and participation in substance abuse program, anger management or any other program).
4. Extra Credit can be earned if a participant serves as a peer support for another participant in the Jail Diversion Program.

MANAGEMENT INFORMATION SYSTEM PLAN

Two AMHD Management Information Systems (MIS) will be used for this project. One is the state-wide BHIS in which each participant is registered as a client of either the East Hawai`i or West Hawai`i CMHC. Daily service contacts are individually entered in BHIS by data entry persons. The second MIS system is called “e-CURA.” If a service is provided by an AMHD-contracted purchase-of-service (POS) provider, that service is registered in utilization management with the e-CURA software. The e-CURA system allows for service authorizations from and payments made to providers. Security of these databases meets Health Insurance Portability and Accountability Act (HIPAA). Data elements include demographics, diagnosis, treatment team members, legal status, and emergency contact numbers.

THE EVALUATION PLAN

The Government Performance and Results Act of 1993 (Public Law 103-62) requires that all federal agencies, in this case SAMHSA, be accountable for demonstrating the effectiveness of all their programs through performance data. SAMHSA awarded funding to the TAPA Center in New York to ensure that the evaluation of all jail diversion programs is conducted in a standardized way nationwide. The TAPA Center has proposed that the following data (referred to as the “GPRA Client Outcome Measures”) be collected at baseline, 6- and 12-month interviews:

1. demographics;
2. education, employment, and income;
3. drug and alcohol use;
4. family and living conditions;
5. crime and criminal justice status;
6. mental health and physical health problems and treatment ;
7. history of trauma (measured by the Trauma Collaboration Study Violence and Trauma Screening which includes 8 items);
8. perceived coercion (measured by the Perceived Coercion Scale, five items);
9. consumer’s perception of outcome (measured by seven of the 28 items of the Mental Health Statistics Improvement Program (MHSIP) survey); and
10. severity of illness (measured by the Colorado Symptom Index, 15 items).

The TAPA Center also requires that data be collected on service utilization and arrests for one year prior to and following admission into the Program. The Program evaluation will be enhanced in Hawai`i by using the Wisconsin Quality of Life Instrument to measure changes in quality of life, medication compliance, and functional status. In addition, the remaining items of the MHSIP scale will be used to assess satisfaction with services. The MHSIP scale is used annually by AMHD to assess consumers’ perception and experiences with AMHD Community Mental Health Centers (CMHCs). Appendix H includes copies of all instruments and data

collections forms. In order to be able to locate clients for the collection of follow-up data, all individuals participating in the evaluation will be asked to complete a future contact form. A copy of this form is included in Appendix I.

JDCM will recruit clients for the evaluation of outcomes. If the client consents to participate, the JDCM will schedule the baseline interview and then contact the research coordinator. The research coordinator will be responsible for obtaining informed consent (Appendix J) and for conducting the baseline and follow-up interviews. If necessary, the JDCM may conduct the baseline interview and if this is the case, he or she will also be responsible for obtaining informed consent. An introductory script has been developed to facilitate the introduction of the evaluation component of the HCJD (see Appendix K).

Basic information for tracking number of cases referred and entered into the program will be entered into two Microsoft ACCESS-based programs developed by the TAPA Center. Completed interviews (ie., baseline, 6-month and 12-month) will be copied and the original mailed to the TAPA Center monthly. The TAPA Center will be responsible entering all data.

Data will be collected from clients through primary data collection using standardized, valid and reliable instruments. Confidentiality of data will be maintained by employing strategies to manage the data. For example: (a) consent forms will be stored separate from other data; (b) records with personal identifiers will be kept under lock and key; (c) access to confidential information will be restricted to program staff; and (d) an identification number will be assigned to each client, and this number rather than the client's name will be entered into the database. This identification number will be used to access and retrieve all data, and computers will be password-protected. In addition, (a) data will only be presented in aggregate form, and (b) all reports, presentations, and publications of the data will not contain any identifying information.