SCOPE OF THE PROBLEM THAT THE PROGRAM WAS CREATED TO ADDRESS

Mentally ill men and women are constantly recycled through the criminal justice system, often being continually incarcerated and receiving little, if any, treatment. Dubuque law enforcement officials realized these individuals do not necessarily need to be incarcerated, but alternatives were limited. The Dubuque County Jail Diversion Program was established to provide alternatives to incarceration for persons with mental health disorders to break the cycle of repeated entry into the criminal justice system. The program strives to increase attendance in an appropriate treatment program, decrease the number of police contacts and arrests, and improve the overall quality of life for its participants.

A University of Iowa Public Health report estimated that 17.5% of the Iowa prison population has a psychiatric diagnosis. The Department of Correctional Services in Dubuque averages 650 offenders under its supervision each month, including pre-trial, probation, and parole. When the program began in 2002, 1,026 offenders were under supervision, 486 of whom were categorized as moderate- to high-risk. Within this subgroup, 82% (400 of 486) were identified as having mental health issues. (This did not include the other 560 offenders that fall within the low-risk level who were not assessed regarding mental health issues.)

According to City of Dubuque Police records, mental illness commitments totaled 215 per year, or 18 per month, over a three-year period (1998-2001). During the same time period, substance abuse commitments averaged 27 per year. Total commitments averaged 242 per year, or more than 20 per month.

The Dubuque Sheriff's Office averages 380 bookings per month and, using the University of Iowa estimate of 17.5%, on average, 67 of those offenders have a psychiatric diagnosis. Additionally, the police and sheriff's office answer many "HB" (handled by police) calls in which no crime has been committed but involve a mental health problem. The estimated number of HB calls is 20-30 per

month. This combination of police and sheriff bookings results in a total estimate of 105-120 people per month who need some type of assistance or intervention rather than incarceration.

The existing system was basically a "revolving door" of persons with mental illness or co-occurring substance abuse disorders who had consistent, repetitive, nonviolent violations of the law resulting in arrests and potential bookings. Often, the law enforcement personnel were not adequately trained in making appropriate mental health assessments or they had very few options: charge the person with a crime or, if the person posed a danger to his/herself or others, take him/her to the hospital emergency room in an attempt to make a "commitment" to the mental ward.

The system was not effective, and the costs of not implementing a jail diversion program were high. Clearly, there was a need for a better method of handling these emergency situations, a need for a protocol to handle crisis incidents involving mentally ill people, a need for a respite opportunity rather than a jail cell, and a need for a secure, 24-hour, no-refusal, drop-off location.

MEASURABLE OUTCOME(S)/RESULTS(S) OF THE PROGRAM

The program began in March of 2003. From April 1, 2003, to October 14, 2003, Dubuque Police filed 212 mental health reports, more than one per day. Of those 212 reports, charges could have been filed in 80 of the cases. However, charges were NOT filed in 63 (79%) of the cases and the affected individuals were diverted to mental health treatment through the jail diversion program. First-year expectations for the program of 20 per month were more than doubled.

Additionally, there was significant improvement in communication between the project's 13 partner agencies and organizations. The law enforcement, mental health, and substance abuse components have utilized opportunities presented by the jail diversion program to increase awareness and understanding of each discipline's culture, philosophy, and process. This more unified approach toward dealing with offenders with co-occurring disorders resulted in integrated treatment replacing incarceration as the primary mode of dealing with these offenders. A Mental Health Intervention Team (MHIT) of officers in the Dubuque Police Department was formed, and they received an average of 22

hours of mental health training in the program's first year. A two-day workshop was held in October 2003 with nearly 150 attendees from the professional, advocacy, family, consumer, and general community.

The second year of the program saw less frequent arrests and reduced police contact with the program's target population and Dubuque law enforcement is beginning to see a positive effect upon costs and time involved with civil entities. The year two expectation of providing case management services to and enrolling 50 individuals was met. Expectations regarding the number of individuals diverted each month from jail to treatment were also exceeded. The year one estimate of 20 per month was again more than doubled and, in fact, increased in year two.

LESSONS LEARNED DURING PLANNING, IMPLEMENTATION, AND ANALYSIS

While all parties involved were committed to the goals and outcomes of the jail diversion program, many had different philosophies and approaches, as well as programmatic rules and guidelines that had to be considered as the program developed. Internal communication and some "turf issues" were addressed early in the process.

One major challenge has been the high case load numbers and staff overload. This resulted in some staff stability issues in year one. High stress continues to be a major problem throughout the field and stress reduction practices have been implemented within the jail diversion program staff.

As we begin the third year of the program, we feel that we have taken the initial steps toward program sustainability. We have been approved to receive Targeted Case Management funding through the Iowa Medicaid system and will begin billing soon.

While tremendous progress has been made, there are some areas in which the goals need further work. Regarding the development of service linkages, we have a reached a point where we have defined the players both from the general population as we discover them, and where the service providers exist. We are at a point where integrated treatment is possible, but in all practical purposes, it has not been able to be optimized. Regarding the efforts toward community outreach, we need a

seriously expanded push for distribution of the knowledge of jail diversion. We need to promote the program to be more of a known entity and a chosen resource for the community. Regarding program evaluation, we are at a point where an increase in numbers is the only need for the process. The numbers are steadily increasing, yet we have some frustrations with the early numbers being lower than anticipated.

Secondary issues have arisen regarding discovered needs for the clients themselves. It is a common industry saying that no matter how much help you give a client, it does not matter unless they have a home. We have found this to be true and have struggled to identify housing assistance for our clients. Further efforts need to take place for some expansion of Section 8 Housing funding that may not have been accessed. Secondly, a tremendous need exists for short-term funding for medication. There is often a lapse between the initial referrals for psychiatric service and the ability to fill prescriptions. Sample medications fill the needs of many of the individuals, yet a particular profile of individuals entering the program does not have this access to immediate prescription needs. Third, our community lacks the resources of sufficient representative payees. We have clients receiving funding at the beginning of the month but are without money by the middle to the end of the month because they lack the financial knowledge and experience to manage their funds.

The central theme of this project was to be system changing, to overcome the obstacles and barriers of interagency interaction and establish a comprehensive system of treatment during a mental health crisis and to provide an ongoing system of aftercare and follow up. To this end, coordinating committee members, comprised of many of the mental health service providers, continue to work closely with each other to change and expand internal protocols and establish common terminology and approaches. Through this collective effort, many of the providers have a more cohesive and inclusive approach to the mental health response and aftercare.