Incarceration Prevention Reduction Task Force
Behavioral Health Ad Hoc Committee Meeting

December 10, 2015
Whatcom Alliance for Health Advancement
3:00 – 5:00pm

AGENDA

Time	Topic	Purpose	Responsible	Attachment
3:00 5 minutes	**1. Welcome and Introductions**		Veronica	
3:05 15 minutes	**2. Vision: What does Success Look Like?**	Discussion	Veronica	
3:20 40 minutes	**3. Discuss Draft Statement of Work** • Review and revise goals • Review and revise scope • Set deadlines	Discussion and Decision	Veronica	Statement of Work
4:00 10 Minutes	**4. Subject Matter Expertise** • Whom do we need to hear from or have at the table?	Discussion	Veronica	
4:10 45 Minutes	**5. Sequential Intercept Model** • Begin mapping • What additional information do we need?		ALL	Sequential Intercept Model GAINS Center
4:55	**6. Meeting Schedule** •	Set schedule through Jan, 2016		
10:.30	**7. Adjourn**			

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whatcom alliance for health advancement

Incarceration Prevention and Reduction Task Force

Behavioral Health Programs and Services Ad Hoc Committee

DRAFT Statement of Work

Statement of Purpose

The purpose of the Incarceration Prevention and Reduction Task Force is to continually review Whatcom County's criminal justice and behavioral health programs and make specific recommendations to safely and effectively reduce incarceration of individuals struggling with mental illness and chemical dependency, and minimize jail utilization by pretrial defendants who can safely be released. (Ord. 2015-037; Ord. 2015-025; County Code 2.46.020).

The purpose of the Behavioral Health Programs and Services Ad Hoc Committee is to develop recommendations for new, or enhancement of existing, programs designed along a continuum that effectively reduces incarceration of individuals struggling with mental illness and chemical dependency (Ord. 2015-037).

Recommendations will be based on local needs, recognized best practices and the work of the other two Ad Hoc Committees.

Goals

- Minimize jail utilization by pretrial defendants who can be safely released
- Identify new or enhancement of existing programs designed along a continuum that effectively reduces incarceration of individuals struggling with mental illness and chemical dependency.
- Improve the continuum of alternatives to incarceration and jail diversion programs.
- Identify and implement programs and services that are effective alternatives to incarceration
- Benchmark Whatcom County behavioral health programs and services against nationally recognized best practices
- Provide comprehensive discharge planning to ensure citizens are connected to and engaged in available programs and services upon their return to the community (warm hand-offs)

Scope (Project Tasks)

- Assemble information about existing program and services
    - Services offered
    - Financial resources
    - Budgets and expenses
    - Number of people served
    - Demographics of people served
    - Effectiveness in reducing or preventing incarceration
- Map existing programs and services in the Sequential Intercept Model
- Identify gaps in existing programs and services
    - Consider pre-intercept One programs and services that may reduce incarceration
- Identify nationally recognized best practices for programs and services that are known to reduce incarceration
- Create comparison with Whatcom County based programs
- Identify appropriate resources and supports for client departures from facility (warm hand-offs)
- Recommend improvements to existing programs and services
- Recommend additional or modified programs and services

Deliverables

- Progress report for Phase One deliverable date

- Recommendations for improvements to existing programs and services
- Recommendations for additional or modified programs and services

Schedule of Work

- Workgroup meeting schedule
    - December 7, 2015
    -
    -
    -
- Phase One Progress Report: February 09, 2016
- Sequential Intercept Model mapping completed by:
- Benchmarking completed by:
- Recommendations to the Task Force regarding available alternatives to incarceration: September, 2016

Measures of Success

Consistent with established deadlines, deliver to the Task Force a body of clear and specific recommendations for enhancements to behavioral health programs and services that can be implemented in Whatcom County.

Identified Best Practices

Incorporate as appropriate for our work and any appropriate additional best practices that meet nationally recognized standards.

- Substance Abuse and Mental Health Services Administration, GAINS Center
- The VERA Institute of Justice
- National Association of Counties, the Stepping Up Initiative
- Council of State Governments Justice Center
- Other national standards

Other Ad Hoc Committees

The purpose of the Triage Facility and Facility Programming Ad Hoc Committee is to make recommendations to Task Force regarding the construction and operation of a new or expanded multi-purpose crisis triage facility to assist with jail and hospital diversion of individuals struggling with mental illness and/or chemical dependency**.**

The purpose of the Legal System Ad Hoc Committee is to make recommendations to the Task Force regarding programs and services that have the potential to prevent or reduce incarceration. Current, enhanced and new programs and services are under consideration. Behavioral health programs and services are the purview of a different Ad Hoc Committee.

The work between Ad Hoc Committees is interrelated and interdependent.

Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness

Mark R. Munetz, M.D.
Patricia A. Griffin, Ph.D.

The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment. (*Psychiatric Services* 57:544–549, 2006)

Over the past several years, Summit County (greater Akron), Ohio has been working to address the problem of overrepresentation, or "criminalization," of people with mental illness in the local criminal justice system (1,2). As part of that effort, the Summit County Alcohol, Drug Addiction, and Mental Health Services Board obtained technical assistance consultation from the National GAINS Center for People with Co-occurring Disorders in the Justice System. From that collaboration, a conceptual model based on public health principles has emerged to address the interface between the criminal justice and mental health systems. We believe that this model—Sequential Intercept Model—can help other localities systematically develop initiatives to reduce the criminalization of people with mental illness in their community.

The Sequential Intercept Model: ideals and description

We start with the ideal that people with mental disorders should not "penetrate" the criminal justice system at a greater frequency than people in the same community without mental disorders (personal communication, Steadman H, Feb 23, 2001). Although the nature of mental illness makes it likely that people with symptomatic illness will have contact with law enforcement and the courts, the presence of mental illness should not result in unnecessary arrest or incarceration. People with mental illness who commit crimes with criminal intent that are unrelated to symptomatic mental illness should be held accountable for their actions, as anyone else would be. However, people with mental illness should not be arrested or incarcerated simply because of their mental disorder or lack of access to appropriate treatment—nor should such people be detained in jails or prisons longer than others simply because of their illness.

With both this ideal and current realities in mind, we envision a series of "points of interception" or opportunities for an intervention to prevent individuals with mental illness from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points. Each point of interception can be considered a filter (Figure 1). In communities with poorly developed mental health systems and no active collaboration between the mental health and criminal justice systems, the filters will be porous. Few will be intercepted early, and more people with mental illness will move through all levels of the criminal justice system. As systems and collaboration develop, the filter will become more

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finely meshed, and fewer individuals will move past each intercept point.

The Sequential Intercept Model complements the work of Landsberg and colleagues (3) who developed an action blueprint for addressing system change for people with mental illness who are involved in the New York City criminal justice system. The Sequential Intercept Model expands that work by addressing Steadman's (4) observation that people with mental illness often cycle repeatedly between the criminal justice system and community services. The model addresses his key question of how we can prevent such recycling by showing the ways in which people typically move through the criminal justice system and prompting considerations about how to intercept those with mental illness, who often have co-occurring substance use disorders.

Interception has several objectives (4,5): preventing initial involvement in the criminal justice system, decreasing admissions to jail, engaging individuals in treatment as soon as possible, minimizing time spent moving through the criminal justice system, linking individuals to community treatment upon release from incarceration, and decreasing the rate of return to the criminal justice system.

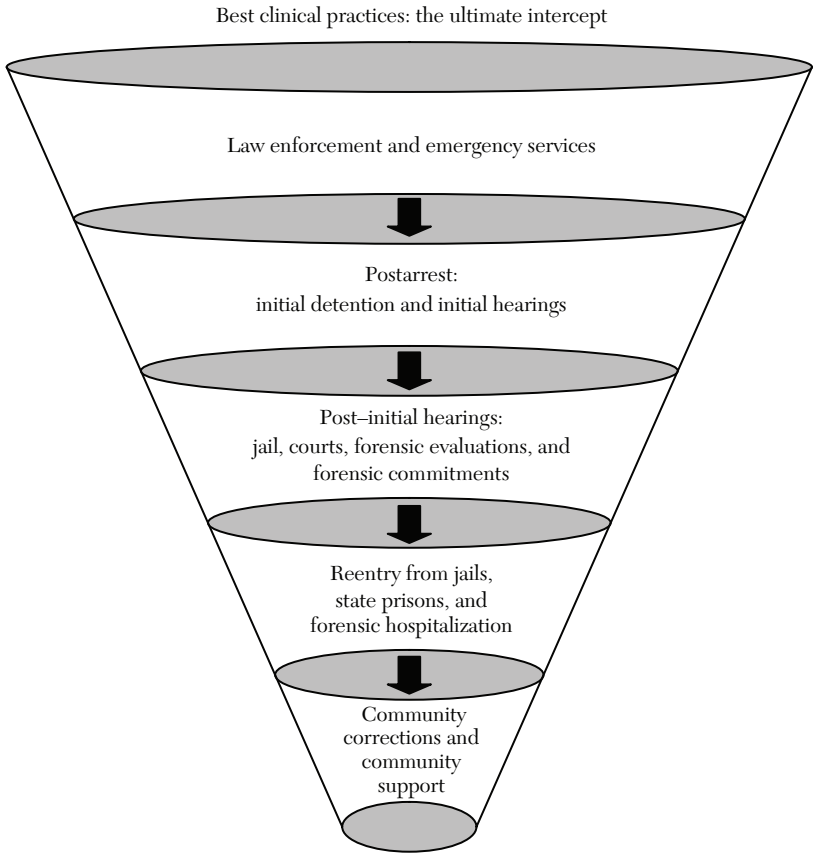
In contrast to the six critical intervention points identified in Landsberg's conceptual roadmap (3), we have specified the following five intercept points to more closely reflect the flow of individuals through the criminal justice system and the interactive nature of mental health and criminal justice systems (Figure 2):

- Law enforcement and emergency services
- Initial detention and initial hearings
- Jail, courts, forensic evaluations, and forensic commitments
- Reentry from jails, state prisons, and forensic hospitalization
- Community corrections and community support services

In the next sections we describe the points of interception and illustrate them with examples of relevant interventions from the research and practice literature.

Figure 1

The Sequential Intercept Model viewed as a series of filters



An accessible mental health system: the ultimate intercept

An accessible, comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders is undoubtedly the most effective means of preventing the criminalization of people with mental illness. The system should have an effective base of services that includes competent, supportive clinicians; community support services, such as case management; medications; vocational and other role supports; safe and affordable housing; and crisis services. These services must be available and easily accessible to people in need. Unfortunately, few communities in the United States have this level of services (6).

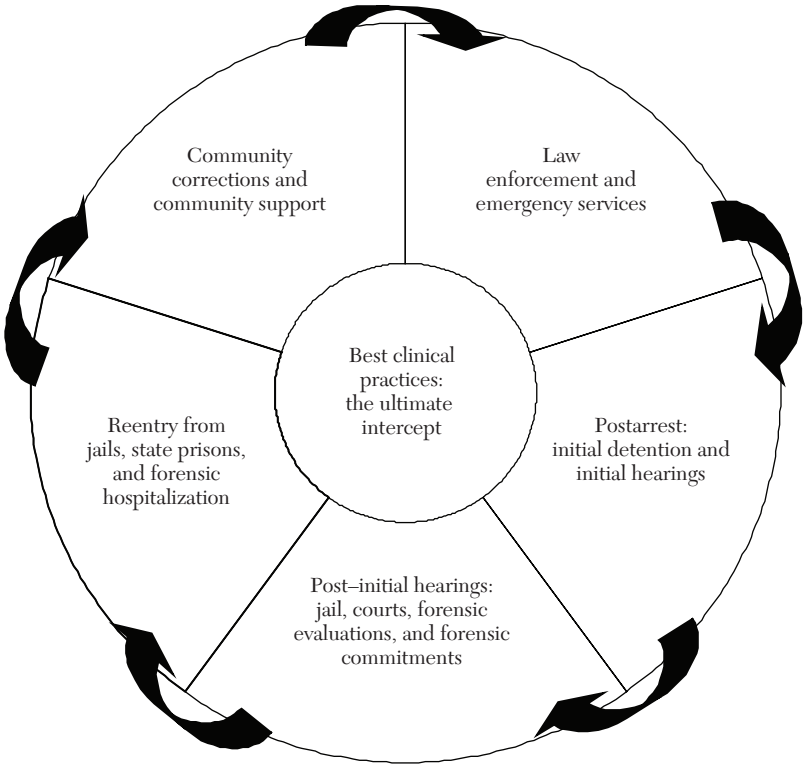
In addition to accessible and comprehensive services, it is increasingly clear that clinicians and treatment systems need to use treatment interventions for which there is evidence of efficacy and effectiveness (7,8). In many systems, evidence-based treatments are not delivered consistently (9). Examples of such interventions include access to and use of second-generation antipsychotic medications, including clozapine (10); family psychoeducation programs (11); assertive community treatment teams (12); and integrated substance abuse and mental health treatment (13). Integrated treatment is especially critical, given the fact that approximately three-quarters of incarcerated persons with serious mental illness have a comorbid substance use disorder (14,15).

Intercept 1: law enforcement and emergency services

Prearrest diversion programs are the first point of interception. Even in the best of mental health systems, some people with serious mental disorders will come to the attention of the police. Lamb and associates' (16) review of the police and mental health systems noted that since deinstitutionalization "law enforcement agencies have played an increasingly important

Figure 2

The Sequential Intercept Model from a revolving-door perspective with best practices at the core



role in the management of persons who are experiencing psychiatric crises." The police are often the first called to deal with persons with mental health emergencies. Law enforcement experts estimate that as many as 7 to 10 percent of patrol officer encounters involve persons with mental disorders (17,18). Accordingly, law enforcement is a crucial point of interception to divert people with mental illness from the criminal justice system.

Historically, mental health systems and law enforcement agencies have not worked closely together. There has been little joint planning, cross training, or planned collaboration in the field. Police officers have considerable discretion in resolving interactions with people who have mental disorders (19). Arrest is often the option of last resort, but when officers lack knowledge of alternatives and cannot gain access to them, they may see arrest as the only available disposition for people who clearly cannot be left on the street.

Lamb and colleagues (16) described several strategies used by police departments, with or without the participation of local mental health systems, to more effectively deal with persons with mental illness who are in crisis in the community: mobile crisis teams of mental health professionals, mental health workers employed by the police to provide on-site and telephone consultation to officers in the field, teaming of specially trained police officers with mental health workers from the public mental health system to address crises in the field, and creation of a team of police officers who have received specialized mental health training and who then respond to calls thought to involve people with mental disorders. The prototype of the specialized police officer approach is the Memphis Crisis Intervention Team (CIT) (20,21), which is based on collaboration between law enforcement, the local community mental health system, and other key stakeholders. A comparison of three police-based diversion models (22) found the Memphis CIT program to have the lowest arrest rate, high utilization by patrol officers, rapid response time, and frequent referrals to treatment.

Intercept 2: initial hearings and initial detention

Postarrest diversion programs are the next point of interception. Even when optimal mental health service systems and effective prearrest diversion programs are in place, some individuals with serious mental disorders will nevertheless be arrested. On the basis of the nature of the crime, such individuals may be appropriate for diversion to treatment, either as an alternative to prosecution or as an alternative to incarceration. In communities with poorly developed treatment systems that lack prearrest diversion programs, the prototypical candidate for postarrest diversion may have committed a nonviolent, low-level misdemeanor as a result of symptomatic mental illness.

If there is no prearrest or police-level diversion, people who commit less serious crimes will be candidates for postarrest diversion at intercept 2. In communities with strong intercept 1 programs, postarrest diversion candidates are likely to be charged with more serious acts. In such cases, although diversion at the initial hearing stage is an option and treatment in lieu of adjudication may be a viable alternative, some courts and prosecutors may look only at postconviction (intercept 3) interventions.

Postarrest diversion procedures may include having the court employ mental health workers to assess individuals after arrest in the jail or the courthouse and advise the court about the possible presence of mental illness and options for assessment and treatment, which could include diversion alternatives or treatment as a condition of probation. Alternatively, courts may develop collaborative relationships with the public mental health system, which would provide staff to conduct assessments and facilitate links to community services.

Examples of programs that intercept at the initial detention or initial

hearing stage include the statewide diversion program found in Connecticut (23) and the local diversion programs found in Phoenix (24) and Miami (25). Although Connecticut detains initially at the local courthouse for initial hearings and the Phoenix and Miami systems detain initially at local jails, all three programs target diversion intervention at the point of the initial court hearing. A survey of pretrial release and deferred prosecution programs throughout the country identified only 12 jurisdictions out of 203 that attempt to offer the same opportunities for pretrial release and deferred prosecution for defendants with mental illness as any other defendant (26).

Intercept 3: jails and courts

Ideally, a majority of offenders with mental illness who meet criteria for diversion will have been filtered out of the criminal justice system in intercepts 1 and 2 and will avoid incarceration. In reality, however, it is clear that both local jails and state prisons house substantial numbers of individuals with mental illnesses. In addition, studies in local jurisdictions have found that jail inmates with severe mental illness are likely to spend significantly more time in jail than other inmates who have the same charges but who do not have severe mental illness (27,28). As a result, prompt access to high-quality treatment in local correctional settings is critical to stabilization and successful eventual transition to the community

An intercept 3 intervention that is currently receiving considerable attention is the establishment of a separate docket or court program specifically to address the needs of individuals with mental illness who come before the criminal court, so-called mental health courts (29–32). These special-jurisdiction courts limit punishment and instead focus on problem-solving strategies and linkage to community treatment to avoid further involvement in the criminal justice system of the defendants who come before them. The National GAINS Center estimates that there are now 114 mental health courts for adults in the United States (33).

Intercept 4: reentry from jails, prisons, and hospitals

There is little continuity of care between corrections and community mental health systems for individuals with mental illness who leave correctional settings (34). Typically, communication between the two systems is limited, and the public mental health system may be unaware when clients are incarcerated. Mental health systems rarely systematically follow their clients once they have been incarcerated. In a recent survey of jails in New Jersey, only three jails reported providing release plans for a majority of their inmates with mental illness, and only two reported routinely providing transitional psychotropic medications upon release to the community (35).

Nationally, the issue of facilitating continuity of care and reentry from correctional settings is receiving increasing attention. In part these efforts are fueled by class action litigation against local corrections and mental health systems for failing to provide aftercare linkages, such as the successful *Brad H* case against the New York City jail system (36). In addition, pressure is increasing on corrections and mental health systems to stop the cycle of recidivism frequently associated with people with severe mental illness who become involved in the criminal justice system (37–39). The APIC model for transitional planning from local jails that has been proposed by Osher and colleagues (40) breaks new ground with its focus on assessing, planning, identifying, and coordinating transitional care. Massachusetts has implemented a forensic transitional program for offenders with mental illness who are reentering the community from correctional settings (41). The program provides "in-reach" into correctional settings three months before release and follows individuals for three months after release to provide assistance in making a successful transition back to the community.

Intercept 5: community corrections and community support services

Individuals under continuing supervision in the community by the criminal justice system—probation or parole—are another important large group to consider. At the end of 2003, an estimated 4.8 million adults were under federal, state, or local probation or parole jurisdiction (42). Compliance with mental health treatment is a frequent condition of probation or parole. Failure to attend treatment appointments often results in revocation of probation and return to incarceration. Promising recent research by Skeem and colleagues (43) has begun to closely examine how probation officers implement requirements to participate in mandated psychiatric treatment and what approaches appear to be most effective.

Other research by Solomon and associates (44) has examined probationers' involvement in various types of mental health services and their relationship to technical violations of probation and incarceration. Similar to mental health courts, a variety of jurisdictions use designated probation or parole officers who have specialized caseloads of probationers with mental illness. The probation and parole committee of the Ohio Supreme Court advisory committee on mentally ill in the courts (45,46) has developed a mental health training curriculum for parole and probation officers.

Discussion

Some people may argue that the basic building blocks of an effective mental health system are lacking in many communities, and therefore efforts to reduce the overrepresentation of people with mental illness in the criminal justice system are futile. This argument is not persuasive. Even the most underfunded mental health systems can work to improve services to individuals with the greatest need, including the group of people with serious and persistent mental disorders who have frequent interaction with the criminal justice system. Such efforts require close collaboration between the mental health and criminal justice systems.

The Sequential Intercept Model provides a framework for communities to consider as they address concerns about criminalization of people with mental illness in their jurisdiction. It can help communities un-

derstand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time. Different communities can choose to begin at different intercept levels, although the model suggests more "bang for the buck" with interventions that are earlier in the sequence.

Five southeastern counties in Pennsylvania (Bucks, Chester, Delaware, Montgomery, and Philadelphia) used the Sequential Intercept Model as a tool to organize their work in a forensic task force charged with planning coordinated regional initiatives (47). As a result of that year-long effort, Bucks County staff organized a countywide effort to improve the local continuum of interactions and services of the mental health and criminal justice systems (48), and Philadelphia County started a forensic task force that uses the model as an organizing and planning framework. The model is also being used in a cross-training curriculum for community change to improve services for people with co-occurring disorders in the justice system (49).

Conclusions

Although many communities are interested in addressing the overrepresentation of people with mental illness in local courts and jails, the task can seem daunting and the various program options confusing. The Sequential Intercept Model provides a workable framework for collaboration between criminal justice and treatment systems to systematically address and reduce the criminalization of people with mental illness in their community.

Acknowledgments

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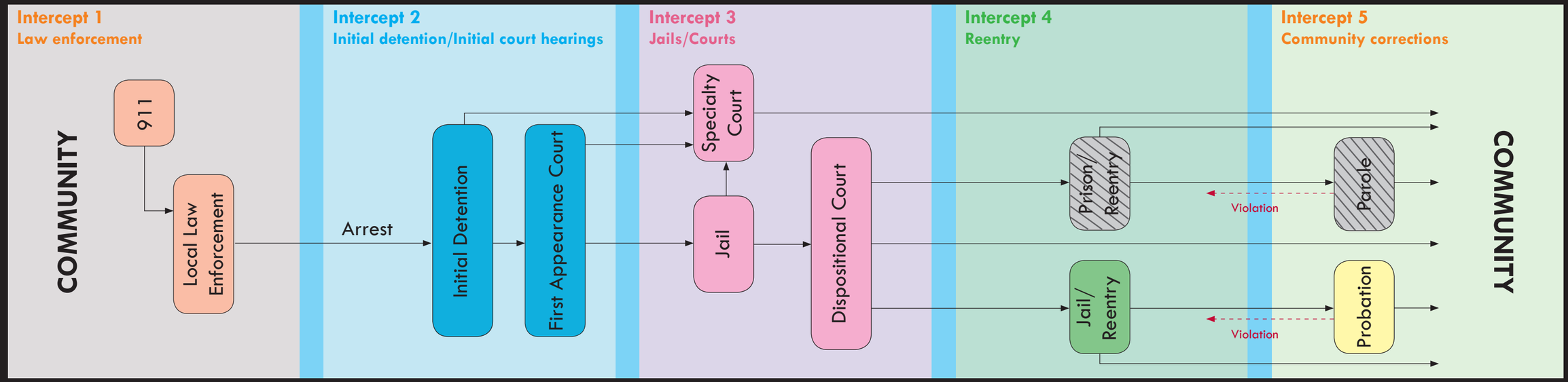
Sequential Intercepts for Developing CJ–MH Partnerships

Action for System-Level Change

- Develop a comprehensive state plan for mental health/criminal justice collaboration
- Legislate task forces/commissions comprising mental health, substance abuse, criminal justice, and other stakeholders to legitimize addressing the issues
- Encourage and support collaboration among stakeholders through joint projects, blended funding, information sharing, and cross-training
- Institute statewide crisis intervention services, bringing together stakeholders from mental health, substance abuse, and criminal justice to prevent inappropriate involvement of persons with mental illness in the criminal justice system
- Take legislative action establishing jail diversion programs for people with mental illness
- Improve access to benefits through state-level change; allow retention of Medicaid/SSI by suspending rather than terminating benefits during incarceration; help people who lack benefits apply for same prior to release
- Make housing for persons with mental illness and criminal justice involvement a priority; remove constraints that exclude persons formerly incarcerated from housing or services
- Expand access to treatment; provide comprehensive and evidence-based services; integrate treatment of mental illness and substance use disorders
- Expand supportive services to sustain recovery efforts, such as supported housing, education and training, supportive employment, and peer advocacy
- Ensure constitutionally adequate services in jails and prisons for physical and mental health; individualize transition plans to support individuals in the community
- Ensure all systems and services are culturally competent, gender specific, and trauma informed – with specific interventions for women, men, and veterans



Action Steps for Service-Level Change at Each Intercept

- ***911:*** Train dispatchers to identify calls involving persons with mental illness and refer to designated, trained respondents
- ***Police:*** Train officers to respond to calls where mental illness may be a factor
- ***Documentation:*** Document police contacts with persons with mental illness
- ***Emergency/Crisis Response:*** Provide police-friendly drop off at local hospital, crisis unit, or triage center
- ***Follow Up:*** Provide service linkages and follow-up services to individuals who are not hospitalized and those leaving the hospital
- ***Evaluation:*** Monitor and evaluate services through regular stakeholder meetings for continuous quality improvement

- ***Screening:*** Screen for mental illness at earliest opportunity; initiate process that identifies those eligible for diversion or needing treatment in jail; use validated, simple instrument or matching management information systems; screen at jail or at court by prosecution, defense, judge/court staff or service providers
- ***Pre-trial Diversion:*** Maximize opportunities for pretrial release and assist defendants with mental illness in complying with conditions of pretrial diversion
- ***Service Linkage:*** Link to comprehensive services, including care coordination, access to medication, integrated dual disorder treatment (IDDT) as appropriate, prompt access to benefits, health care, and housing; IDDT is an essential evidence-based practice (EBP)

- ***Screening:*** Inform diversion opportunities and need for treatment in jail with screening information from Intercept 2
- ***Court Coordination:*** Maximize potential for diversion in a mental health court or non-specialty court
- ***Service Linkage:*** Link to comprehensive services, including care coordination, access to medication, IDDT as appropriate, prompt access to benefits, health care, and housing
- ***Court Feedback:*** Monitor progress with scheduled appearances (typically directly by court); promote communication and information sharing between non-specialty courts and service providers by establishing clear policies and procedures
- ***Jail-Based Services:*** Provide services consistent with community and public health standards, including appropriate psychiatric medications; coordinate care with community providers

- ***Assess*** clinical and social needs and public safety risks; boundary spanner position (e.g., discharge coordinator, transition planner) can coordinate institutional with community mental health and community supervision agencies
- ***Plan*** for treatment and services that address needs; GAINS Reentry Checklist (available from http://www.gainscenter.samhsa.gov/html/resources/reentry.asp) documents treatment plan and communicates it to community providers and supervision agencies – domains include prompt access to medication, mental health and health services, benefits, and housing
- ***Identify*** required community and correctional programs responsible for post-release services; best practices include reach-in engagement and specialized case management teams
- ***Coordinate*** transition plans to avoid gaps in care with community-based services

- ***Screening:*** Screen all individuals under community supervision for mental illness and co-occurring substance use disorders; link to necessary services
- ***Maintain a Community of Care:*** Connect individuals to employment, including supportive employment; facilitate engagement in IDDT and supportive health services; link to housing; facilitate collaboration between community corrections and service providers; establish policies and procedures that promote communication and information sharing
- ***Implement a Supervision Strategy:*** Concentrate supervision immediately after release; adjust strategies as needs change; implement specialized caseloads and cross-systems training
- ***Graduated Responses & Modification of Conditions of Supervision:*** Ensure a range of options for community corrections officers to reinforce positive behavior and effectively address violations or noncompliance with conditions of release

The Sequential Intercept Model

Developed by Mark R. Munetz, MD, and Patricia A. Griffin, PhD, the Sequential Intercept Model provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with serious mental illness. Within the criminal justice system there are numerous intercept points — opportunities for linkage to services and for prevention of further penetration into the criminal justice system. Munetz and Griffin (2006) state:

> The Sequential Intercept Model … can help communities understand the big picture of interactions between the criminal justice and mental health systems, identify where to intercept individuals with mental illness as they move through the criminal justice system, suggest which populations might be targeted at each point of interception, highlight the likely decision makers who can authorize movement from the criminal justice system, and identify who needs to be at the table to develop interventions at each point of interception. By addressing the problem at the level of each sequential intercept, a community can develop targeted strategies to enhance effectiveness that can evolve over time.

The Sequential Intercept Model has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pre-trial services, courts, jails, community corrections, housing, health, social services, and many others.

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Plan Health & Justice The Intercept

Three Major Responses for Every Community

Three Major Responses Are Needed:

1. **Diversion programs** to keep people with serious mental illness who do not need to be in the criminal justice system in the community.
2. **Institutional services** to provide constitutionally adequate services in correctional facilities for people with serious mental illness who need to be in the criminal justice system because of the severity of the crime.
3. **Reentry transition** programs to link people with serious mental illness to community-based services when they are discharged.

The Sequential Intercept Model has been used by numerous communities to help organize mental health service system transformation to meet the needs of people with mental illness involved with the criminal justice system. The model helps to assess where diversion activities may be developed, how institutions can better meet treatment needs, and when to begin activities to facilitate re-entry.

The GAINS Center

The CMHS National GAINS Center, a part of the CMHS Transformation Center, serves as a resource and technical assistance center for policy, planning, and coordination among the mental health, substance abuse, and criminal justice systems. The Center's initiatives focus on the transformation of local and state systems, jail diversion policy, and the documentation and promotion of evidence-based and promising practices in program development. The GAINS Center is funded by the Center for Mental Health Services and is operated by Policy Research Associates, Inc., of Delmar, NY.

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Developing a Comprehensive for Mental Criminal Collaboration: Sequential Model