Grant Proposal

T SOCW 533 B: Integrative Practice II

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- **<u>Introduction</u>: Write a brief summary of what this report is about. Include your problem definition, description, and analysis.**

The vicious circle of institutional transfer of individuals from the Criminal justice system to psychiatric hospitals has long-term negative impacts on the well-being of the individual. The rate of patient transfer from the criminal justice system (CJS) to psychiatric hospitals for competency restoration in the U.S. varies significantly due to resource constraints, state policies, and legal precedents. Generally, patients found incompetent to stand trial (IST) are transferred to state psychiatric hospitals or other facilities for competency restoration treatment. There has been a request for evaluation for competency and restoration to stand trial for defendants due to the 1960 Supreme Court ruling "Dusky vs United States. So, since the early '60s, there has been a steady increase from approximately 25,000 to 36,000 annually to 50,000 to 60,000 in recent years, and competency to stand trial is the most common form of forensic evaluation or admission and continues growing in number (Melton et al., 2018; Seaman & Johnson, 2008; Danzer et al., 2019). The "Dusky vs United States determines the standard for competency to stand trial for any defendant. This standard protects the defendant's due process right afforded by the Constitution (Winick, 1985).

According to Colwell and Colwell (2011), competency-to-stand trial evaluations occur in 2 to 8 percent of all felony cases, which concerns public defenders as about 10 to 15 percent of their cases require competency restoration (CR). However, some jurisdictions are experiencing extended delays due to a lack of available beds in psychiatric hospitals, with defendants spending weeks or months in jails awaiting transfer. This describes a recurring cycle where individuals with mental health challenges oscillate between incarceration in the criminal justice system (CJS) and admission to psychiatric hospitals (Deng, 2023). However, according to Akram et al. (2020), the "vicious circle of institutional transfer" is a multifaceted issue that impacts patients, families, broader society, and healthcare systems. Unlike general medical readmissions, psychiatric readmissions from CJS are often prompted by mental health and legal necessities, complicating the process. The dual nature of psychiatric hospital readmission triggers bureaucratic and time-sensitiveness because psychiatric hospitals are not only treating patients based on medical urgency but also navigating legal obligations, making the admission process more bureaucratic and time-sensitive, which makes limited flexibility in treatment decisions even if a patient is stabilized, their legal status may require them to remain in a psychiatric facility until a judge determines their fitness to stand trial. This can lead to more extended hospital stays for forensic patients than necessary from a purely clinical perspective.

Moreover, according to Zambrano et al. (2016), several variables are considered consistent risk factors across studies in predicting court-mandated rehospitalization (readmission), which include younger age, diagnosis of schizophrenia, personality disorder diagnosis, history of previous psychiatric admission, and single marital status. According to Rosca et al. (2006), lack of social support from family and social isolation is the constellation that might explain more prolonged cumulative hospital stays for young and single patients. Rosca et al. recommend emphasizing the importance of developing assertive community programs that will enhance social networks and social supports in an effort to diminish social isolation and to reduce the

impact of the factors of young and single marital status on psychiatric hospital readmission. Furthermore, to a lesser extent, non-adherence to medication and not engaging in outpatient therapy were predictors of readmission. Though psychiatric hospital readmission has gained significant attention over the past two decades due to its contentious attributes (demographic, clinical, social, and systemic), some see it as an indicator of the quality of psychiatric hospital care, while others view it as a significant increase in healthcare costs (Kocakulah et al., 2019). Competency restoration also has critical financial implications, which are multiplied when defendants require repeat admissions. Even though this might appear to be a positive thing as more people are receiving access to psychiatric services and treatment, there is a negative side to the readmission of people in the psychiatric hospital. High readmission in these psychiatric hospitals can be seen as a lack of complete evaluations, a lack of awareness among families, patients, and providers regarding alternatives, and multiple other factors. This problem is complex, rooted in various social, economic, and structural issues, and has significant implications for public safety, community resources, and the well-being of both individuals with mental illness and the broader population. For example, social issues like stigma and discrimination, lack of social support, and criminalization of mental illness all contribute to a cycle of hospitalizations for individuals with severe mental illness between jails and psychiatric hospitals. Given the impact on defendants' due process rights and the financial burden associated with repeat restoration treatment, understanding factors related to repeated admissions is critical to know as people (social workers) who are driven by a deep-seated commitment to addressing social issues (Cabeldue et al., 2020). Addressing this "vicious circle of institutional transfer" should be a multifaceted approach, with a focus on improved post-discharge support, community mental health services, policy reform, and collaborative reintegration programs, which is essential for mitigating this cycle of readmission and supporting individuals' recovery and community safety (McDermott et al., 2019)

- **What have been some of the major shifts in our understanding of the problem and population?**

Over the past few decades, significant shifts have emerged in how the challenges and populations involved in competency restoration and mental health care within the criminal justice system are understood. These shifts reflect evolving perspectives on mental health, justice, and systemic shortcomings. First, recognition of the scope of mental illness in CJ Populations; about two in five people who are incarcerated in America have a history of mental illness; of these, 37% are in state and federal prisons, and 44% are held in local jails, which is twice the rate of mental illness in the overall adult population. Due to this prevalence, America's jails and prisons have become de-facto mental health providers through competency restoration, which is a great cost to the well-being of people with mental health conditions (National Alliance on Mental Illness, n.d.). This significant understanding of the "vicious circle of institutional transfer" as a result of increasing data collection helps to highlight the rate at which individuals with mental illnesses are disproportionately arrested and detained, often for minor or nonviolent offenses, because of systemic gaps in behavioral health services (Patterson, 2018b). Second, awareness of systemic failures: mental health care systems' inadequacies have resulted in jails and prisons functioning as de facto psychiatric facilities. This shift recognizes that incarceration exacerbates mental

health issues rather than addressing them, which has resulted in high-profile cases like Trueblood in Washington. This case underscored the systemic delays in evaluations and treatments that lead to legal and ethical scrutiny of competency restoration by the Department of Social and Health Services (DSHS) (Washington Fined Over $100 Million for Delays in Competency Evaluations and Restoration (Prison Legal News, n.d.; Ways & Means Committee 2023 et al., 2023; Inslee Signs Trueblood Fix to Improve Competency Services | Governor Jay Inslee, 2023). Third, the integration of community-based solutions. The introduction of outpatient competency restoration (OCR) programs reflects a growing emphasis on treating individuals in less restrictive settings when possible. These programs aim to reduce the need for inpatient transfers while maintaining public safety. According to Gowensmith et al.. (2016), diversion programs and outpatient treatment models reduce reliance on hospitalizations when effectively implemented. Diversion programs, such as mental health courts and crisis response units, are increasingly seen as essential to preventing unnecessary incarceration and improving long-term outcomes ("Rediversion in Two Postbooking Jail Diversion Programs in Florida," n.d..). Fourth, there is a recognition of the trauma-incarceration cycle. Recent studies have highlighted the compounding effects of incarceration on mental health, showing how prolonged detention exacerbates psychiatric conditions, particularly for individuals awaiting competency restoration. There is a growing understanding of the bidirectional relationship between mental health crises and criminal justice involvement, emphasizing the need for early intervention and support systems (*Fact Sheet: Incarceration and Mental Health | Weill Cornell Medicine Psychiatry*, n.d.-a). Also, the role of institutional design and perception has helped with understanding institutionalization, which has shifted from viewing it merely as confinement to recognizing the psychological and social impacts on individuals. Efforts to reduce institutional dependency now include improving physical and therapeutic environments in psychiatric facilities, as well as promoting adaptive behaviors for reintegration into the community (Chow & Priebe, 2013). Fifth, focus on workforce and infrastructure challenges. Staffing shortages and insufficient forensic bed capacity have been identified as critical barriers to timely competency restoration. Efforts to expand capacity, improve workforce retention, and build new facilities are ongoing but remain behind demand. These shifts demonstrate a growing awareness that addressing the mental health needs of CJ populations requires systemic reform, from expanding community resources to reevaluating the role of incarceration in responding to behavioral health crises.

- **What are some of the theoretical frameworks for understanding social problems?**

Several theoretical frameworks have been proposed to understand the intersection of mental health issues and involvement in the criminal justice system. These frameworks provide different lenses through which to analyze and address the challenges faced by individuals with mental health disorders within this context. The most popular of these theoretical frameworks are the biopsychosocial model uses an integrative framework that considers the interplay of biological, psychological, and social factors in understanding mental health issues and criminal behavior. It helps identify underlying causes of mental health challenges and design holistic interventions that address individual and environmental factors. The criminalization theory suggests that societal and systemic factors, such as the deinstitutionalization of psychiatric care and lack of community-based mental health resources, have led to increased criminal justice involvement

among individuals with mental illness. It argues for policies that address these systemic shortcomings to reduce incarceration rates. The recovery-oriented framework approaches focus on the potential for individuals with mental illnesses to recover and reintegrate into society. Recovery-oriented models emphasize the importance of individualized care plans, access to supportive housing, employment opportunities, and community-based mental health services to reduce recidivism (Fradella, 2011; Winick, 1995). The collaboration frameworks Lamberti's conceptual framework emphasizes collaboration between mental health and criminal justice systems to improve outcomes for shared clients. This includes shared goals, joint service plans, and coordination to bridge gaps between systems, ultimately reducing the risk of repeated justice involvement. The ecological systems theory examines how interactions between individuals and their environments influence behavior. It highlights the role of systemic factors, such as poverty, discrimination, and inadequate mental health services, in exacerbating the challenges faced by justice-involved individuals with mental illnesses (Johnston, 2019; Kamin et al., 2022; "The Impact of Mental Health on Criminal Behavior," n.d.). Reflecting on these theories, each framework highlights the need for a multi-faceted approach to address the complex interplay between mental health and criminal justice. They collectively argue for systemic reforms, inter-agency collaboration, and community-based support to improve outcomes for this vulnerable population. So, these theoretical frameworks can help improve coordination of care, reduce recidivism, and ensure individuals with mental health disorders receive appropriate treatment by sharing data between forensic psychiatric hospitals and jail system, a notable example is the California jail joining other service providers to develop the health information exchanges (HIEs) in 2001 (Butler, 2014). I believe integrating these theoretical frameworks into data-sharing practices can help shift the focus from punishment to treatment and rehabilitation, ultimately improving mental health outcomes and reducing recidivism for individuals with mental illness in the criminal justice system.

- **Interventions: What Micro, Mezzo, and Macro-level evidence-based interventions have been identified in your literature search as effective? What is missing from these interventions that still needs to be addressed?**

Based on the literature search for this assignment, evidence-based interventions at the micro, mezzo, and macro levels have demonstrated varying levels of effectiveness in addressing the mental health needs of justice-involved populations.

There was an individual-focused strategy at a micro-level intervention that targeted direct behavioral health and competency needs. Trauma-focused CBT is particularly effective for individuals with co-occurring PTSD and substance use disorders, and peer support navigators or support groups help individuals engage with treatment and reentry programs while reducing stigma (Eboreime et al., 2022). Medications for severe mental illnesses (e.g., antipsychotics, mood stabilizers) are standard evidence-based practice, with regular follow-ups in correctional or outpatient settings proving to be critical (Johnston, 2019). Cognitive-behavioral therapy (CBT) has also shown effectiveness in addressing cognitive distortions, impulse control, and maladaptive behaviors among justice-involved individuals with mental illness (Kamin et al., 2022). While interventions targeting cognitive distortions, impulse control, and maladaptive

behaviors are used for justice-involved individuals, they often require modifications for those awaiting competence restoration. Psychiatric stabilization, legal education, and behavioral therapy are typically needed to help these individuals regain competency and proceed with their cases. However, some of the gaps at the micro level are weak continuity of care after release, leading to high rates of recidivism or treatment discontinuation, and cultural competence and language accessibility in therapies are often insufficient for non-English speakers and noncitizens.

At the mezzo level, intervention, community-focused strategies, and collaborative care frameworks. Like mental health courts, which divert individuals with mental illnesses away from incarceration and into treatment programs, improving treatment engagement and reducing recidivism (Prison Legal News, n.d.; Ways & Means Committee 2023 et al., 2023; Inslee Signs Trueblood Fix to Improve Competency Services | Governor Jay Inslee, 2023; Johnston, 2019). Outpatient competency restoration (OCR) programs allow individuals to remain in their communities while receiving treatment and education on court procedures, reducing the need for inpatient care. Reentry and diversion programs, housing, employment assistance, and case management during reentry have effectively reduced reincarceration and improved stability (Johnston, 2019; Kamin et al., 2022). However, gaps at the mezzo level are housing instability and homelessness, which are persistent barriers that these interventions do not always address comprehensively. Coordination between community-based organizations and justice systems also remains limited.

As for the macro level of intervention, which is policy and advocacy efforts, legislation like Senate Bill 5440 and "Trueblood Settlement" mandate timelines for competency restoration and mental health evaluations to address systemic delays; these policies also invest in forensic beds and staffing, which help expand forensic mental health facilities and address workforce shortages in psychiatry and social work. These are ongoing systemic efforts to reduce wait times for competency restoration (Prison Legal News, n.d.; Ways & Means Committee 2023 et al., 2023; Inslee Signs Trueblood Fix to Improve Competency Services | Governor Jay Inslee, 2023; Johnston, 2019). However, gaps at the macro level of intervention and insufficient funding for preventative mental health services perpetuate reliance on the justice system as a safety net. Structural inequities, such as racism and poverty, remain largely unaddressed in macro-level reforms.

Answering the question of what is missing across all levels of intervention, these will be the answers: few preventative measures that interventions target the root causes of justice involvement, such as poverty, early trauma, or systemic inequities in education and healthcare access. Cultural competence and inclusion programs often fail to adequately address the unique needs of marginalized populations, including LGBTQ+ individuals, non-native English speakers, and those from diverse cultural backgrounds. Due to fragmented data systems, data integration and accountability hinder collaboration between the justice, healthcare, and social service sectors, limiting the ability to track outcomes and identify best practices and sustainability, as many interventions rely on short-term grants and pilot programs, which can lead to inconsistent implementation and scaling challenges. Therefore, addressing these gaps will require systemic

investments in community mental health infrastructure, interagency collaboration, and policies prioritizing equity and sustainability.

What did your stakeholders identify as important considerations for addressing the problem? You can use the summaries from the templates created for the stakeholder interviews for this section.

Of the three stakeholders I interviewed, though they have different views of addressing the issues, the most important considerations for addressing the vicious circle of institutional transfer of individuals from the Criminal justice system to psychiatric hospitals the three most common important consideration that came across were;

- ✓ Policy reformation for mental health
- ✓ Funding for mental Health
- ✓ Record management/digitalization and unification of records.

According to Dr. Sidhu, "….man, if we can have a digital record of all the services and support and everything about every patient, it will be much helpful for their treatment."

- **<u>Resources</u>: Summarize the resources available for your population's needs using the resource map as appropriate.**

In summarizing the resources available to help address the need for my population target, Western State Hospital (WSH), Enhanced Services Facilities (ESF), Residential Treatment Facilities (RTFs), and Adult Family Homes (AFHs) provide critical services for individuals with serious mental illnesses or co-occurring disorders within the criminal justice system or at risk of justice involvement.

The first is the WSH, a state-operated psychiatric hospital in Washington that provides acute, long-term, and forensic mental health services. It primarily serves individuals referred through the civil commitment process or criminal courts, including those requiring competency restoration. WSH addresses the most acute psychiatric needs, often serving as a facility for individuals deemed incompetent to stand trial. The hospital plays a key role in stabilizing patients and preparing them for community reintegration or trial participation. However, the challenges are limited bed capacity and workforce shortages, which have contributed to significant delays in service access, as highlighted by legal cases like Trueblood v. DSHS.

Second, the ESFs provide higher care for individuals who cannot be served in traditional residential settings due to complex medical or behavioral needs. These facilities are designed for those transitioning out of psychiatric hospitals or who might otherwise require institutional care. The ESFs serve as a step-down resource for patients leaving WSH, offering a more integrated setting while maintaining a high level of care and supervision. They help reduce recidivism in acute care settings by stabilizing individuals in the community. However, this resource has limitations, such as the lack of widespread availability and variability in service quality across facilities.

Third, the RTFs provide structured residential care with therapeutic services for individuals with chronic mental health or substance use disorders. Services include counseling, medication management, and life-skills training. RTFs are key resources for individuals who no longer need hospital-level care but still require intensive support. They often work as a bridge to independent living or lower levels of care. However, the main gaps of some of these RTFs are that they are not equipped to manage individuals with severe behavioral disturbances or legal involvement.

Finally, the AFHs offer community-based living with care and supervision for small groups of residents, often accommodating individuals with mental illnesses, developmental disabilities, or age-related needs. These AFHs settings are particularly valuable for individuals needing stable housing and basic supervision without the intensive services of hospitals or RTFs. They provide a more normalized environment and are integral to reducing homelessness and recidivism among justice-involved individuals. However, these resources always come with challenges, like funding constraints and limited training for staff in handling complex psychiatric or forensic cases.

In summary, these resources collectively address a continuum of care needs, from acute inpatient services at WSH to community reintegration through ESFs, RTFs, and AFHs. However, key challenges include limited capacity at all levels, leading to bottlenecks. Workforce shortages, particularly in specialized psychiatric and forensic care, and systemic gaps in addressing housing instability, cultural competence, and community-based preventive services. Therefore, addressing these challenges requires increased investment in infrastructure, staff training, and expanded service availability tailored to the justice-involved population's unique needs.

Beginning needs statement and potential intervention:

- **Based on the data you've collected (annotated literature review, resource mapping, and stakeholder interviews), what ideas do you have for addressing the problem (interventions)?**

Policy reform, increased funding for mental health services, and advancements in record management and digitalization can significantly enhance interventions to address "the vicious circle of institutional transfer of individuals from the Criminal justice system to psychiatric hospitals has long-term negative impacts on the well-being of the individual." Each of these can be leveraged in diverse ways. Some programs divert individuals with mental health issues away from incarceration and into treatment, reduce the criminalization of mental health conditions, enforce timelines for competency restoration, and promote collaboration between criminal justice, healthcare, and community-based services. Reforms target disparities in treatment access to ensure marginalized populations (e.g., racial minorities and low-income groups) receive equitable care, as seen in the Trueblood Settlement and Senate Bill 5440. So, my Intervention in terms of policy reforms is to have policy reform for mental health through the expansion of preventive care policies and legal protections for individuals with mental health to reduce stigma and discrimination against individuals with mental illness. As for increased funding for mental health, since it can expand the availability of mental health services, such as more forensic beds,

outpatient competency restoration programs, crisis stabilization, technologically innovative programs (e.g., telepsychiatry in correctional settings) as we sow it during the height of covid-19, longitudinal research that will ensure interventions remain evidence-based, investments in supportive housing, case management, and community-based mental health services reduce reliance on incarceration as a default response. In this light, my intervention will be sustainable and equitable distribution of funds across urban and rural settings and financial support for smaller, community-based organizations often closest to underserved populations. Finally, in the area of record management and digitalization, which is the main intervention idea I am considering for my project, this digitalized record system is the case for insurance and private healthcare systems. This will ensure that health information is accessible across systems, facilitating seamless transitions from incarceration to community care; it helps integrate criminal justice, healthcare, and social services data, enabling better coordination and accountability; it tracks individual outcomes, treatment, and medication history, helping identify gaps in services, and reduce errors and streamline processes, such as competency evaluations and treatment referrals. So, my intended intervention will be privacy protection to safeguard individuals' sensitive health data to prevent misuse or discrimination. Interoperability systems that will be compatible across agencies and jurisdictions with equitable access to support underfunded organizations to be effective.

- **When considering potential interventions, what challenges/gaps need to be resolved or considered)? What supports exist for your intervention? What questions still need to be answered to develop an intervention?**

To effectively implement interventions for addressing mental health challenges within the criminal justice system, it is critical to recognize the challenges/gaps, existing supports, and unanswered questions, which include systemic barriers like fragmentation and workforce Shortages; Resource limitations like resource limitations and underfunded community services; equity issues, and Digital infrastructure which are hindered by privacy concerns, interoperability challenges, and the uneven ability of smaller organizations to implement new systems. Moreover, as for existing supports, policy frameworks (willing to make new policies), Mental health diversion programs that have reduced recidivism and improved access to care, there are funding opportunities like federal grants for substance Abuse and Mental Health Services Administration (SAMHSA), technological innovations, community-based organizations like nonprofits and advocacy groups provide critical services and support for justice-involved individuals with mental health needs. There are collaborative efforts between government agencies and private organizations that foster innovative solutions like integrated crisis response teams. However, the questions that need to be answered for this intervention are as follows:

- ✓ Data and Outcomes: How can systems better collect and analyze data to measure the long-term impact of interventions? What metrics should be used to evaluate success in reducing recidivism, improving mental health outcomes, and achieving equity?
- ✓ Scalability and Sustainability: How can successful pilot programs (e.g., outpatient competency restoration) be scaled while maintaining quality and sustainability?

- ✓ Equity and Access: What strategies can be implemented to ensure equitable access to interventions for marginalized groups?
- ✓ Workforce Development: What incentives can attract and retain skilled professionals in forensic psychiatry and mental health services?
- ✓ Cross-Sector Collaboration: What models of collaboration across justice, healthcare, and community systems are most effective, and how can they be standardized?

Description of project

Project Location: This project will be implemented in a metropolitan area with high rates of justice-involved individuals experiencing mental illness, preferably Western State Hospital and all the Jails that the Hospital services in the Washington State. Moreover, after the pilot and implementation phase, it will slowly be implemented at the Eastern State Hospitals, community mental health clinics (like Greater Lakes), and social service organizations DSHS/BHA to ensure comprehensive coverage and smooth implementation.

Target Population: This project will specifically serve justice-involved individuals with mental health disorders awaiting competence restoration, individuals transitioning from forensic hospitals, and those seeking mental health treatment in communities. Additionally, the project will benefit mental health professionals, correctional staff, policymakers, and community service providers by fostering collaboration and improving access to shared data.

Project Activities: The project will employ these key activities;

- **System Development: Shear digital databases like Epic/Mychart in medicine.** Creating a secure, interoperable system for sharing health, legal, and social service data between jails, forensic hospitals, and community providers.
- **Stakeholder Training and Collaboration:** Conducting training for law enforcement, mental health professionals, and social workers on data-sharing best practices, HIPAA compliance, and continuity of care strategies.
- **Competence Restoration and Reentry Support:** Using shared data to facilitate better transitions from jails and hospitals to community-based treatment, supportive housing, and employment opportunities.
- **Evaluation and Policy Advocacy:** Monitoring key indicators such as recidivism rates, treatment adherence, and health outcomes to inform future policy recommendations.

Advertising and Outreach: In the area of informing the target population and stakeholders, the project will employ the following:

- Community Outreach Events in collaboration with mental health advocacy organizations like the National Alliance for Mental Illness (NAMI) and Substance Abuse and Mental Health Services Administration (SAMHSA).
- Public Awareness Campaigns through social media, local news outlets, and informational brochures in jails and Wester State Hospitals.
- Stakeholder Engagement Meetings with correctional facilities, healthcare providers, and policymakers.

- Referral Networks where legal representatives, probation officers, and social workers inform eligible individuals about the program.

Potential Barriers and Strategies

A. **Data Privacy and Legal Concerns:** Strict HIPAA regulations and confidentiality concerns may limit data-sharing efforts.

    a. **Strategy:** Develop clear data-sharing agreements, ensure legal compliance, and provide training on secure data usage.

B. **Technological and Infrastructure Gaps:** Agencies may use incompatible systems, hindering integration.

    b. **Strategy**: Use interoperable software and provide technical assistance to partner organizations.

C. **Resistance from Stakeholders**: Some justice and healthcare professionals may resist changing established procedures.

    c. **Strategy***:* Engage in early stakeholder involvement, highlight the benefits of collaboration, and offer incentives for participation.

D. **Limited Funding**: Implementing a large-scale data-sharing initiative requires financial support.

    d. **Strategy**: Seek grant funding, partner with government agencies, and demonstrate cost-effectiveness through pilot programs.

Political Climate and Policy Considerations

- **Criminal Justice Reform Policies:** With growing bipartisan support for reducing incarceration rates for individuals with mental illnesses, like the 2020 National Suicide Hotline Designation Act (47 CFR § 52.200 - Designation of 988 for a National Suicide Prevention and Mental Health Crisis Hotline., n.d.) and 2022 Safer Communities Act, policies favoring diversion programs can support this initiative.
- **HIPAA and Data-Sharing Regulations:** Adhering to federal and state privacy laws while advocating for policy adjustments that facilitate responsible data-sharing.
- **Medicaid Expansion and Behavioral Health Funding:** Leveraging federal and state healthcare funding opportunities to support community-based mental health services.
- **Law Enforcement and Mental Health Training Mandates:** Aligning with existing policies that require crisis intervention training for police officers to strengthen cross-sector collaboration.

By addressing these considerations, this project will provide a sustainable, data-driven approach to improving mental health outcomes and reducing recidivism among justice-involved individuals.

Long-Term Goal

The long-term goal of this project is to establish a sustainable, data-driven infrastructure that improves mental health outcomes and reduces recidivism among justice-involved individuals with mental illness. By integrating shared data systems across criminal justice, healthcare, and social service sectors, the project aims to enhance continuity of care, improve treatment accessibility, and inform policy changes that support holistic rehabilitation.

Project Outcomes

Outcome 1: Improved information-sharing between psychiatric hospitals and the criminal justice system.

Outcome 2: Enhanced data-driven decision-making (therapy and medication formulary) by law enforcement and healthcare providers for patients.

1. Within two years, establish a secure, interoperable data-sharing platform between WSH, 59 Jails, and community health providers.
2. 100% of all the new admissions in the two systems have their information in the database.
3. Train at least 200 justice and healthcare professionals in data-sharing best practices and privacy compliance.
4. Increase the number of justice-involved individuals successfully referred to community-based mental health services by 30% within two years.
5. Conduct bi-annual assessments to monitor progress and adjust strategies as needed.

Key Activities

- **Develop and implement a Data-Sharing Platform:** Secure and integrate records across forensic hospitals, jails, and social services.
- **Stakeholder Training & Capacity Building**: Provide training sessions on data-sharing laws, HIPAA compliance, and collaborative case management.
- **Case Management & Reentry Support**: Ensure individuals leaving forensic hospitals or jails receive coordinated mental health treatment, housing, and employment support.
- **Policy & Advocacy Efforts**: Use project data to advocate for policies supporting cross-sector data integration and increased mental health funding.

Indicators of Success & Evaluation Metrics

- **Data Integration:** Successful launch and adoption of the shared data platform by all partner organizations.

- ➢ **Recidivism Reduction:** A measurable decrease in reincarceration rates among project participants.
- ➢ **Service Utilization:** Increased engagement with community mental health services.
- ➢ **Stakeholder Participation:** Number of trained professionals and organizations actively using the system.
- ➢ **Policy Impact:** Legislative or policy changes influenced by project findings.

Measuring Project Success

- ✓ **Quarterly Reports:** Track system usage, referral rates, and participant progress.
- ✓ **Surveys & Interviews:** Gather feedback from stakeholders and justice-involved individuals on program effectiveness.
  Pre-project implementation (What data was used in developing the patient care plan? Where was this data retrieved/sourced? How fast was the patient's care plan developed? What were the means of data/patient information sharing?, How much patient information/data was inputted by MHP and LE? Is the information/data in the shared data system accurate or up to date for every patient? How fast does MHP or LE respond to any data request for a patient?, How has patient case management changed since the inception of the shared data system? How much data is inputted per month, quarter, and year? What is your experience using the system, and what are the recommendations for smooth operations?)
  Post-project Implementation (How helpful is the shared data system in developing patients' care/treatment plans?, Have you noticed any change in patients' mental health outcomes since the start of the data-sharing system?, How can you compare the rate at which patients' care/treatment plans are developed before and after the shared data system?, How do you think has this data shared system helped in reducing patients recidivism rate?)

- ✓ **Data Analysis:** Compare baseline and post-implementation data to assess improvements in service coordination and client outcomes.
- ✓ **Independent Evaluation:** Collaborate with academic institutions or third-party evaluators to assess project impact and sustainability.

Ensuring Responsiveness to Identified Needs

- ❖ **Continuous Stakeholder Engagement:** Regular meetings with justice, healthcare, and social service partners to adapt strategies based on feedback.
- ❖ **Cultural & Linguistic Competence:** Ensure accessibility for diverse populations by providing multilingual resources and culturally responsive training.
- ❖ **Scalability & Policy Integration:** Develop a framework that allows other jurisdictions to replicate the model, ensuring a broader impact beyond the initial pilot area.

Project Timeline

I. **Months 1-6:** Establish partnerships, secure funding, and begin system development.
II. **Months 6-12:** Develop data-sharing protocols, conduct training, and pilot the system.
III. **Months 12-24:** Expand implementation, refine processes based on initial findings, and conduct mid-project evaluations.
IV. **Months 24-36:** Full-scale implementation, policy advocacy, and final impact assessments.
V. **Beyond Year 3:** Sustainability planning, expansion to other jurisdictions, and integration into long-term policy frameworks.

Following this structured approach, the project will create a sustainable, evidence-based model for bridging gaps between mental health and criminal justice systems, ensuring lasting care coordination and outcome improvements.

Share Data Share Solution: Unified Approach to Mental Health and Criminal Justice Budget.

Bah's Capstone Annual Budget						Notes
Revenue						
Individual Contributions						
Private Grants					$ -	
Grant 1						
Grant 2						
Government Grants					$ 250,000	
Grant A		DSHS	150000			Department of Social and Health Services
Grant B		BHA	100000			Behavioral Health Administration
Program Fees						
In-Kind						
Other						
TOTAL REVENUE					**$ 250,000**	
Personnell Expenses	**FTE**	**Hrly Wage**	**Annual Wage**	**Taxes & Benefit**	**Cost to Program**	
Program Specialst	1.0	$ 50.00	104,000	31,200	$ 135,200	
Position 2			-	-	$ -	
Position 3			-	-	$ -	
Total Personnell Expenses					**$ 135,200**	
Non-Personell Expenses						
Space						
Communications					$ 704	$117.33 per month for the mobile phone used by the Program specialist.
Supplies					$ 22,004	Office equipment and supplies for the new office created for the program
Travel					$ 298	IRS mileage rate is 65.5 67s per mile; 430 miles per month
Equipment					$ 40,000	Payment for the development of Behavioral Health Electronic Record (BHER) and Operationalizing
Client Support					$ 2,329	Incentives (Token) for patients in their participation of Per and Post system launching survey/Interview
General Operating					$ 26,738	Training of Mental Health Providers and Law enforcement officers in the use of BHER
In-kind					$ -	
Other Expenses					$ -	
Subttl Non-Personell Expenses					**$ 92,073**	
Subtotal All Expenses					**$ 227,273**	
Admin/Indirect Costs					$ 22,727	10% Admin/Indirect
TOTAL EXPENSES					**$ 250,000**	
Net Revenue (Deficit)					$ (0)	

Reference

An act relating to providing timely competency evaluations and restoration services to persons suffering from behavioral health disorders within the framework of the forensic mental health care system consistent with the requirements agreed to in the Trueblood settlement agreement. (2023). In *Senate Bill Report* (Report SB 5440; pp. 1–3). https://apps.leg.wa.gov/documents/billdocs/2023-24/pdf/bill%20reports/Senate/5440%20SBR%20WM%20OC%2023.pdf

Bonczar, T. P., U.S. Department of Justice, Office of Justice Programs, & Bureau of Justice Statistics. (2003). *Prevalence of imprisonment in the U.S. population, 1974-2001* (Report NCJ 197976). U.S. Department of Justice. https://bjs.ojp.gov/content/pub/pdf/piusp01.pdf

Butler, B. (2014). Health information exchange between jails and their communities: a bridge that is needed under healthcare reform. *PubMed*, *11*, 1b. https://pubmed.ncbi.nlm.nih.gov/24808809

Chow, W. S., & Priebe, S. (2013). Understanding psychiatric institutionalization: a conceptual review. In *BMC Psychiatry*. https://spriebe.smd.qmul.ac.uk/publications/Peer-reviewed%20full%20text%20for%20upload/2013/2013%20-%20Chow%20-%20Understanding%20psychiatric%20institutionalization%20-%20BMC%20Psych.pdf

Colwell, L. H., & Colwell, K. (2011). Assessing feigned cognitive impairment in defendants hospitalized for competency restoration: Further validation of the TOMI. *Journal of Forensic Psychology Practice*, *11*(4), 293–310. https://doi.org/10.1080/15228932.2011.562804

Deng, G. (2023). Washington faces steep path closing mental health bed gap for jailed defendants. In *Washington State Standard*.

https://www.courts.wa.gov/content/publicupload/eclips/2023%2010%2017%20Washington%20faces%20steep%20path%20closing%20mental%20health%20bed%20gap%20for%20jailed%20defendants.pdf

Danzer, G. S., Wheeler, E. M. A., Alexander, A. A., & Wasser, T. D. (2019). Competency restoration for adult defendants in different treatment environments. *PubMed*, *47*(1), 68–81. https://doi.org/10.29158/jaapl.003819-19

Eboreime, E., Shalaby, R., Mao, W., Owusu, E., Vuong, W., Surood, S., Bales, K., MacMaster, F. P., McNeil, D., Rittenbach, K., Ohinmaa, A., Bremault-Phillips, S., Hilario, C., Greiner, R., Knox, M., Chafe, J., Coulombe, J., Xin-Min, L., McLean, C., . . . Agyapong, V. I. O. (2022). Reducing readmission rates for individuals discharged from acute psychiatric care in Alberta using peer and text message support: Protocol for an innovative supportive program. *BMC Health Services Research*, *22*(1). https://doi.org/10.1186/s12913-022-07510-8

Fact Sheet: Incarceration and Mental Health | Weill Cornell Medicine Psychiatry. (n.d.). Weill Cornell Medicine. https://psychiatry.weill.cornell.edu/research-institutes/dewitt-wallace-institute-psychiatry/issues-mental-health-policy/fact-sheet-0

Fradella, H. F. (2011). Editor's introduction: Forensic Science and Criminal Justice. *Journal of Contemporary Criminal Justice*, *27*(2), 128–132. https://doi.org/10.1177/1043986211405834

Hegedüs, A., Kozel, B., Richter, D., & Behrens, J. (2020). Effectiveness of Transitional Interventions in Improving patient outcomes and service use after Discharge from Psychiatric inpatient Care: A Systematic Review and Meta-Analysis. *Frontiers in Psychiatry*, *10*. https://doi.org/10.3389/fpsyt.2019.00969

Inslee signs Trueblood fix to improve competency services | Governor Jay Inslee. (2023, May 15). https://governor.wa.gov/news/2023/inslee-signs-trueblood-fix-improve-competency-services

Johnston, E. L. (2019). Reconceptualizing criminal justice reform for offenders with serious mental illness. *Florida Law Review*, *71*(2), 515. https://scholarship.law.ufl.edu/cgi/viewcontent.cgi?article=1897&context=facultypub

Kamin, D., Weisman, R. L., & Lamberti, J. S. (2022). Promoting mental health and criminal justice collaboration through System-Level partnerships. *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.805649

Myers, C. (2024, September 11). *Seeley Lake Lodge*. Rehab.com. https://www.rehab.com/greater-lakes-mental-healthcare-seeley-lake-lodge

National Alliance on Mental Illness. (n.d.). Retrieved December 7, 2024, from https://www.nami.org/advocacy/policy-priorities/improving-health/mental-health-treatment-while-incarcerated/

Orchards highlands & apple tree. (n.d.). Orchards Highlands & Apple Tree. https://orchardshighlands.com/

Patterson, R. F. (2018a). Our part in the evolution of correctional mental health care. *PubMed*, *46*(2), 140–146. https://doi.org/10.29158/jaapl.003740-18

Patterson, R. F. (2018b). Our part in the evolution of correctional mental health care. *PubMed*, *46*(2), 140–146. https://doi.org/10.29158/jaapl.003740-18

Prins, S. J., Skeem, J. L., Mauro, C., & Link, B. G. (2014). Criminogenic factors, psychotic symptoms, and incident arrests among people with serious mental illnesses under

intensive outpatient treatment. *Law And Human Behavior*, *39*(2), 177–188. https://doi.org/10.1037/lhb0000104

Quality Indicators and Outcomes for Persons Discharged from State Psychiatric Hospitals | DSHS. (n.d.). https://www.dshs.wa.gov/ffa/rda/research-reports/quality-indicators-and-outcomes-persons-discharged-state-psychiatric-hospitals

Rediversion in Two Postbooking Jail Diversion Programs in Florida. (n.d.). *Psychiatry Services*. https://doi.org/10.1176/appi.ps.56.7.835

Rosca, P., Bauer, A., Grinshpoon, A., Khawaled, R., Mester, R., & Ponizovsky, A. M. (2006). Rehospitalizations among psychiatric patients whose first admission was involuntary: a 10-year follow-up. The Israel journal of psychiatry and related sciences, 43(1), 57–64.

Supporting clients across Washington. (2019). In *State-Operated Living Alternatives*. SOLA. https://www.dshs.wa.gov/sites/default/files/publications/documents/22-1787.pdf

The Impact of Mental Health on Criminal Behavior. (n.d.). *International Journal of Legal Science and Innovation*, *6*(3). https://doi.org/10.10000/IJLSI.111894

Washington fined over $100 million for delays in competency evaluations and restoration | Prison Legal News. (n.d.). https://www.prisonlegalnews.org/news/2024/feb/1/washington-fined-over-100-million-delays-competency-evaluations-and-restoration/

Washington SB5440 | 2023-2024 | Regular Session. (n.d.). LegiScan. https://legiscan.com/WA/supplement/SB5440/id/298927

Western State Hospital | DSHS. (n.d.). https://www.dshs.wa.gov/bha/division-state-hospitals/western-state-hospital

Ways & Means Committee 2023, Washington State Department of Social and Health Services, Washington State Health Care Authority, & Washington Criminal Justice Training Commission. (2023). *Trueblood Update*.

47 CFR § 52.200 - Designation of 988 for a National Suicide Prevention and Mental Health Crisis Hotline. (n.d.). LII / Legal Information Institute. https://www.law.cornell.edu/cfr/text/47/52.200

APPENDIXIES

Appendix A ………………………………………………... Logic Model

Appendix B………………………………………………... Data Collection

Appendix C……………………………..………Mental Health Providers and Law Enforcement

Appendix D…………………Patients Pre and Post System Implementation Survey and Interview