

SOLVING THE PROBLEM OF CRIMINALIZING THE MENTALLY ILL: THE MIAMI MODEL

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INTRODUCTION

It does not seem plausible that a Harvard-educated psychiatrist and the former head of psychiatry at Jackson Memorial hospital in Miami-Dade County would be homeless and continually cycling through the criminal justice system. However, this was exactly the situation that faced Judge Steven Leifman, a county court judge in Miami-Dade County, Florida in 2000.¹ Early in his career, Judge Leifman met with parents who asked if he could help their son who was scheduled to appear before Judge Leifman in court that day.² They explained that their son was a Harvard-educated psychiatrist and the former head of psychiatry at Jackson Memorial hospital in Miami-Dade County.³ Further, they explained that he was suffering from late-onset schizophrenia, was homeless, and had been arrested numerous times on minor offenses.⁴ As a result, he had been in and out of the county jail system for years.⁵ Although Judge Leifman had not previously dealt with a similar situation, he assured the parents that he would help their son.⁶

The accused man had been arrested on a second-degree misdemeanor for stealing a shopping cart.⁷ As Judge Leifman began to speak to him, the accused man had a psychotic episode in the courtroom.⁸ This caused Judge Leifman to order a mental competency examination for him.⁹ After the examination, it was determined that he was “incompetent to proceed” in court due to his mental illness and

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1. Ines Novacic, *Treatment or Lockup? Criminal Justice System Grapples with Mentally Ill*, CBS News (July 21, 2015, 5:36 AM), <http://www.cbsnews.com/news/treatment-or-lockup-criminal-justice-system-grapples-with-mentally-ill/>. See Concept Professional Training & CE (Forensic Mental Health), *IAFMHS 2013 Keynote by Judge Steven Leifman*, YOUTUBE (July 13, 2013), <https://www.youtube.com/watch?v=ky8byo3PTYA>.

2. Concept Professional Training & CE, *supra* note 1.

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. See *id.* (“It was some ridiculous minor offense.”)

8. See *id.* (“[C]learly whatever I said triggered a crisis right before my eyes.”)

9. *Id.*

should be involuntarily committed to a facility where he could receive mental-health treatment and be restored to competency.¹⁰ However, Florida law, like the laws of many other states and jurisdictions, did not allow for the involuntary commitment of defendants in misdemeanor cases.¹¹ As a result, he was released from jail without receiving mental health treatment, only to repeat the cycle of being arrested again and going through the same process without any treatment.¹²

Judge Leifman's experience is not uncommon for those in the criminal justice system. It is generally and most commonly described as the "criminalization of mental illness."¹³ The criminalization of mental illness is the process of directing those with mental illnesses, who usually commit minor offenses, through the criminal justice system and then treating their mental illnesses in our jails and prisons.¹⁴ The criminalization of mental illness has become a significant problem in the United States. According to statistics from the National Sheriff's Association, Treatment Advocacy Center, and the Department of Justice, in 2012 there were over ten times as many people with severe mental illnesses in jails and prisons in the United States as there were in all state psychiatric hospitals combined.¹⁵ Twenty percent of all jail detainees experience a severe mental illness.¹⁶ There are nearly 1.5 million individuals with severe mental illnesses who are arrested annually.¹⁷ On any given day there are 360,000 people with severe mental illnesses in jails and prisons throughout the country and over 760,000 people with severe mental illnesses are on community control or probation.¹⁸ People with mental illnesses are on probation or parole two to four times longer than that of the general population on community control or probation.¹⁹ In South Florida, people with mental illnesses remain incarcerated eight times longer than people without mental illnesses for the exact same charge and at seven times the cost.²⁰

10. *Id.*

11. *Id.*

12. *See id.*

13. *See* RISDON N. SLATE ET AL., *THE CRIMINALIZATION OF MENTAL ILLNESS* 42-43 (2d ed. 2013) (summarizing how U.S. society moved away from "its rehabilitative ideals to a more retributive, punitive stance" toward those with mental illnesses).

14. *Id.*

15. The statistics mentioned most likely include all individuals whether they have committed minor or major offenses. E. FULLER TORREY ET AL., *THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY* 6 (2014), <http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>.

16. *See id.* (finding twenty percent as a "reasonable and possibly overly conservative" estimate).

17. Telephone Interview with Steven Leifman, Associate Administrative Judge, Eleventh Judicial Circuit of Florida (Oct. 19, 2017).

18. *Id.*

19. Jillian Peterson, *Mental Illness Not Usually Linked To Crime, Research Finds*, AM. PSYCHOL. ASS'N (Apr. 21, 2014), <http://www.apa.org/news/press/releases/2014/04/mental-illness-crime.aspx>.

20. MIAMI-DADE COUNTY, OFFICE OF THE MAYOR, *MIAMI-DADE COUNTY MAYOR'S MENTAL HEALTH TASK FORCE* 16 (2007).

When Judge Leifman initially confronted this problem, South Florida had the highest percentage of individuals suffering from mental illnesses in the nation in its population.²¹ In Miami-Dade County, nine percent of the total population suffered from severe mental illness, which is two to three times the national average.²² At this same time, in the Dade County Jail there were up to 1,200 inmates suffering from mental illnesses that occupied three floors of the jail.²³ In contrast, in 1985 there were only 80 inmates suffering from mental illnesses in the county jail.²⁴ Of the 114,000 bookings in the county jail, 20,000 were for individuals suffering from mental illnesses.²⁵ Therefore, the Dade County jail served as the largest psychiatric institution in Florida.²⁶

During this same time period, Miami-Dade County spent millions of dollars yearly on its mental health crisis. Miami-Dade County spent over one million dollars a year on psychotropic medications.²⁷ In addition, it spent eighteen dollars per day to house inmates at its jail.²⁸ The cost for housing inmates suffering from a mental illness was \$125 per day.²⁹ The total cost to house those suffering from mental illnesses was \$218,000 per day and \$80 million annually.³⁰

Judge Leifman recognized the significance of the criminalization of mental illness first hand due to his experiences as a judge in the criminal justice system. He considered it a crisis situation.³¹ This led him to help develop, with other community leaders, the Eleventh Judicial Circuit Criminal Mental Health Project (“CMHP”) in 2000. Now, more than fifteen years later, the CMHP is referred to as the Miami Model.³² The CMHP or Miami Model is a mental health diversion program that consists of a number of distinct parts that have helped eliminate the

21. KATHERINE RUNDLE & DON L. HORN, FINAL REPORT OF THE MIAMI-DADE GRAND JURY: SPRING TERM 2004 6 (Jan. 11, 2005).

22. John K. Iglehart, *Decriminalizing Mental Illness—The Miami Model*, 374 NEW ENG. J. MED. 1701, 1703 (2016).

23. RUNDLE & HORN, *supra* note 21, at 6.

24. *Id.* *Mentally Ill Criminals in Dade County, Florida: A Report On The Problem And How To Deal With It*, Citizens’ Crime Commission Report Program at pg. 17, 41 and 51 (March, 1985). http://passthrough.fw-notify.net/download/563748/http://dcjhistory.com/uploads/1985_Mentally_Ill_Criminals_in_Dade_Cty.pdf.

25. MIAMI-DADE COUNTY ELEVENTH JUDICIAL CIRCUIT, CRIMINAL MENTAL HEALTH PROJECT (CMHP), <https://perma.cc/L77V-VHLT> [hereinafter CMHP A].

26. *Id.*

27. RUNDLE & HORN, *supra* note 21, at 7.

28. *Id.*

29. *Id.*

30. CMHP A, *supra* note 25.

31. See Novacic, *supra* note 1, (“We apply a criminal justice model to a public health problem and it doesn’t work. It’s a disaster.”).

32. Iglehart, *supra* note 22.

criminalization of mental illness in Miami-Dade County.³³ The success of the CMHP has been nationally recognized through numerous awards and the CMHP has become a national model of excellence in dealing with mental illness in the criminal justice system.³⁴

This article, which is divided into six parts, seeks to examine the success of the Miami Model or the CMHP. Part I describes the history of deinstitutionalization, which has contributed to the criminalization of mental illness. Part II describes the concept and problems associated with the criminalization of mental illness. Part III discusses the problems Miami-Dade County faces in its mental health crisis, the institution of the CMHP, and the success of the CMHP. Part IV describes the experiences of other jurisdictions throughout the United States that have implemented programs patterned after or adopted key parts of the CMHP. Part V describes the weaknesses of programs like the CMHP including the need for more legislation and funding to assist courts and communities in combating the criminalization of mental illness. Part VI discusses the success of judicial and community intervention in dealing with mental health issues in the criminal justice system. Finally, this article concludes that the CMHP has been successful and is a model for other jurisdictions to follow in their struggles against the criminalization of mental illness.

I. DEINSTITUTIONALIZATION: A HISTORICAL PERSPECTIVE

The criminalization of mental illness is not a recent concept. In the early years of our country, jails and prisons were commonly used to house people suffering from mental illnesses because there were no psychiatric hospitals in existence at that time.³⁵ It is estimated that twenty percent of the jail population during this time period included those suffering from severe mental illnesses.³⁶ In the early 1800s, Reverend Louis Dwight, a Yale graduate and Congregationalist minister, while delivering bibles to local jails in Massachusetts, noticed how poorly people suffering from mental illnesses were being treated in these jails.³⁷ As a result, he lobbied the Commonwealth of Massachusetts for better treatment of the mentally ill.³⁸ This led to the creation of the first publicly funded psychiatric hospital, which was opened in Massachusetts in 1833.³⁹

33. CMHP A, *supra* note 25.

34. *Id.*

35. SUP. CT. OF FLA., MENTAL HEALTH: TRANSFORMING FLORIDA'S MENTAL HEALTH SYSTEM 9 (2007) http://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf.

36. E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 13 (2010).

37. E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS (1997), as reprinted in Frontline, *Deinstitutionalization: A Psychiatric "Titanic,"* PBS (May 10, 2005), <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html>.

38. *Id.*

39. *Id.*

The most notable activist in this area was Dorothy Dix. She also lobbied for better treatment of people suffering from mental illnesses that were being housed in jails.⁴⁰ Her advocacy led to the creation of numerous publicly funded psychiatric hospitals.⁴¹ In fact, by 1880, there were more than seventy-five publicly-funded hospitals in the United States.⁴²

Efforts by activists such as Dwight and Dix led the United States government in 1880 to perform a census of people suffering from mental illnesses.⁴³ The census located roughly 90,000 individuals suffering from mental illnesses in the United States.⁴⁴ There were 58,609 prisoners in local jails and prisons but only 397 of those were classified as having severe mental illnesses.⁴⁵ Thus, persons with severe mental illnesses made up only 0.7% of the prison and jail populations at that time.⁴⁶

By the mid-1900s, there were nearly 350 state psychiatric hospitals across the United States.⁴⁷ In addition, there were nearly 560,000 mentally ill patients in the nation's psychiatric hospitals.⁴⁸ As the numbers of patients in psychiatric hospitals began to rise, the level of care began to decline.⁴⁹ Further, the cost to run the institutions was increasingly rising and these hospitals were becoming inefficient to operate.⁵⁰

In 1955, the drug Thorazine began to be used to control the symptoms of psychosis associated with mental illness. The mental health community proposed that mental health patients could receive better treatment in their local communities with the use of Thorazine.⁵¹ It was believed that with proper medication and humane treatment, those suffering from mental illnesses would be treated more humanely and effectively in their own community.⁵² Thus, the policy of the deinstitutionalization of people with mental illnesses began.

Deinstitutionalization is the name given to the policy of moving severely mentally ill individuals out of state hospitals and back into their communities where they received community-based treatment.⁵³ The result of this would ultimately lead to the closing of all or part of the state-run institutions.⁵⁴ This idea was

40. *Id.*

41. *Id.*; see also *Module 2: A Brief History of Mental Illness and the U.S. Mental Health Care System*, Unite For Sight 1, <http://www.uniteforsight.org/mental-health/module2>.

42. TORREY, *supra* note 37.

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

47. SUP. CT. OF FLA., *supra* note 35, at 16.

48. *Module 2*, *supra* note 41, at 2.

49. *Id.* at 1.

50. *Id.*

51. See, e.g., TORREY, *supra* note 37.

52. SUP. CT. FLA., *supra* note 35, at 16–17.

53. See TORREY, *supra* note 37.

54. *Id.* See also SUP. CT. OF FLA., *supra* note 35, at 17.

accepted by the federal government which led to the enactment of the Community Mental Health Centers Act in 1963.⁵⁵

The Community Mental Health Centers Act “was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services.”⁵⁶ “In what would be his last public bill signing, President Kennedy signed a \$3 billion authorization to support this movement from institutional to community-based treatment.”⁵⁷ However, President Kennedy was assassinated, and with the distraction of the Vietnam War, none of the \$3 billion was ever appropriated.⁵⁸

After the passage of the act, a number of federal tort and class action lawsuits were filed against the states.⁵⁹ As the courts ruled against the state-run facilities, the judgments led to the closing of the institutions or the release of patients with mental illnesses.⁶⁰ These closings contributed to the deinstitutionalization of people with mental illnesses because there was no organized or adequate network of community mental health centers to receive the released patients.⁶¹

One of the landmark cases that contributed to deinstitutionalization was *Wyatt v. Stickney*.⁶² In *Wyatt*, a challenge was made to the conditions and treatment provided to the patients at Bryce Hospital in Alabama.⁶³ The challenges were prompted when funding for mental health services was decreased statewide and about 100 employees’ employment was terminated at the hospital.⁶⁴ Bryce Hospital serviced primarily patients who were involuntarily committed due to their mental illness.⁶⁵

The court held that individuals involuntarily committed through the civil commitment process had a constitutional right to adequate and effective treatment that would allow them the opportunity to be cured or improve their mental condition.⁶⁶ In its reasoning, the court stated:

55. See SUP. CT. OF FLA., *supra* note 35, at 17.

56. *Id.*

57. *Id.* It is thought that President Kennedy had a personal motivation behind signing this bill because his sister Rosemary Kennedy, while suffering from a severe mental illness, received a botched lobotomy that left her permanently mentally and physically incapacitated. *Reflecting on JFK’s Legacy of Community-based Care, Substance Abuse and Mental Health Services Administration* (Apr. 19, 2016), <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/jfk%E2%80%99s-legacy-community-based-care>.

58. See SUP. CT. OF FLA., *supra* note 35, at 17.

59. See *id.* at 19.

60. See Daniel Yohanna, *Deinstitutionalization of People with Mental Illness: Causes and Consequences*, 15 AMA J. OF ETHICS 886, 887 (2013).

61. See *id.* at 888.

62. 325 F. Supp. 781 (M.D. Ala. 1971).

63. *Id.*

64. *Id.* at 783.

65. *Id.* at 784.

66. *Id.*

The patients at Bryce Hospital, for the most part, were involuntarily committed through noncriminal procedures and without the constitutional protections that are afforded defendants in criminal proceedings. When patients are so committed for treatment purposes they unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition. . . . Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed into a penitentiary where one could be held indefinitely for no convicted offense. The purpose of involuntary hospitalization for treatment purposes is *treatment* and not mere custodial care or punishment. This is the only justification, from a constitutional standpoint, that allows civil commitments to mental institutions such as Bryce.⁶⁷

As a result, the court held that even though the failure to provide adequate treatment was due to a lack of operating funds resulting in a lack of staff and facilities, this could not be used to justify not providing suitable and adequate care to people with mental illnesses.⁶⁸ According to the court, this failure to provide the adequate and suitable care was a violation of the individual's due process rights.⁶⁹

The court gave the defendants six months to establish treatment plans and implement a compliant treatment program.⁷⁰ In doing so, the court outlined three fundamental conditions for adequate and effective treatment programs in public mental institutions. "These three fundamental conditions [were]: (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment, and (3) individualized treatment plans."⁷¹ As a result, if the state could not meet these standards, then the patients were to be released.⁷²

These factors of compliance became known as the "Wyatt Standards."⁷³ Relying on these standards, similar litigation began in numerous other states. Many states were unable to meet these requirements.⁷⁴ As a result, patients with mental illnesses were rapidly released from hospitals all over the country.⁷⁵

Several other "court cases . . . further defined the legal requirements for admission to or retention in a hospital setting" and contributed to deinstitutionalization.⁷⁶ For example, the District of Columbia Court of Appeals in 1966 "requir[ed] hospitals to discharge patients to an environment less restrictive than a hospital if at all

67. *Wyatt*, 325 F. Supp. at 784 (internal quotation marks omitted) (emphasis in original).

68. *Id.*

69. *Id.* at 785.

70. *Wyatt v. Stickney*, 334 F. Supp. 1341, 1342 (M.D. Ala. 1971).

71. *Id.* at 1343.

72. *Id.*

73. See Comment on *Wyatt v. Stickney* 25 F. Supp 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd in part, rev'd in part sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974), MENTAL ILLNESS POL'Y ORG., <https://mentalillnesspolicy.org/legal/wyatt-stickney-right-treatment.html> (last visited Sept. 6, 2018).

74. *Id.*

75. *Id.*

76. See Yohanna, *supra* note 60, at 887.

possible,” and the burden was placed on the government to find alternative courses of treatment.⁷⁷ Also, in 1975, the United States Supreme Court held that “a finding of ‘mental illness’ alone cannot justify a state confining a person against his will and holding him indefinitely in simple custodial confinement.”⁷⁸ The Court held further that a state cannot constitutionally confine a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends solely because he suffers from a mental illness.⁷⁹ Finally, in 1999, the Court held that a mental illness could be defined as a disability, and thus could be covered under the Americans with Disabilities Act.⁸⁰ Thereafter, all governmental agencies, not just state hospitals, would be required to make “reasonabl[e] accommodat[i]ons” to move people with mental illnesses into community-based treatment to end unnecessary institutionalization.⁸¹ However, many states and communities lacked adequate community-based treatment and this led to further deinstitutionalization.

As deinstitutionalization began, the number of patients in state mental hospitals began to decline. From 1955 until 1995, the number of patients in state hospitals fell from approximately 560,000 to 72,000 patients, which was a decrease of over 90 percent.⁸² Further, in 2009, with the onset of the Great Recession, states spent less money on mental health facilities by cutting spending by \$4.35 billion.⁸³ This led to an even greater decrease in facilities for those suffering from mental illnesses.⁸⁴ As a result, in 2010, there were only 43,000 beds in psychiatric facilities available for use in the United States.⁸⁵ This was fourteen beds for every 100,000 people.⁸⁶ This was the same ratio that existed in 1850 before the work of activists Dix and Dwight.⁸⁷

Deinstitutionalization was meant to help those suffering from mental illnesses. Individuals suffering from severe mental illnesses were supposed to be freed from the confines of state mental hospitals and receive treatment back in their communities through a community-based health system. However, because of the lack of funding for community-based health systems, the vast majority of these individuals were left with no way of being ensured that they would receive proper medication or treatment. Further, there are now very few psychiatric hospitals left in the

77. Yohanna, *supra* note 60, at 887; *Lake v. Cameron*, 364 F.2d 657, 660-661 (D.C. Cir. 1966).

78. *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

79. *Id.*

80. *Olmsted v. L.C.*, 527 U.S. 581, 597-598 (1999).

81. *Id.* at 607.

82. Brief for the Am. Psychiatric Ass'n et al. as Amici Curiae Supporting Respondents at 21 n.5, *Olmstead v. L.C.*, 527 U.S. 563 (1999) (No. 98-536).

83. Deanna Pan, *Timeline: Deinstitutionalization and Its Consequences*, MOTHER JONES (April 29, 2013, 10:00 AM), <http://www.motherjones.com/politics/2013/04/timeline-mental-health-america>.

84. *See id.*

85. *Id.*

86. *Id.*

87. *Id.*

country and even fewer beds in the remaining hospitals for those who suffer from mental illnesses. This has led many to call deinstitutionalization the major cause of the mental health crisis in the United States.⁸⁸

II. THE CONCEPT OF THE CRIMINALIZATION OF MENTAL ILLNESS

Deinstitutionalization contributed significantly to the criminalization of mental illness. As people with mental illnesses left the psychiatric hospitals, they were turned out into the communities at large. However, since there was inadequate funding for the community-based programs, those with mental illnesses suffered from a lack of adequate treatment. As a result, many ended up in local jails and state prisons. This is likely the reason why, “over the next four decades [as the patients in the state psychiatric hospitals] decreased by 90 percent, the prison population grew by 400 percent.”⁸⁹

The term criminalization of mental illness was coined by Dr. Marc F. Abramson as he noticed the large rise of those suffering from mental illnesses in the prison population after the start of deinstitutionalization.⁹⁰ Criminalization of mental illness is used to describe people with mental illnesses who are arrested and prosecuted, with or without jail detention, for minor offenses rather than being placed in the mental health system.⁹¹ Some scholars in the area include in this term individuals who commit serious offenses, but the overwhelming majority of experts in this area apply the term to minor offenses only.⁹² The difference between minor offenses and serious offenses is important.⁹³ Those who commit serious offenses are normally directed to the criminal justice system and housed in forensic state institutions. Alternatively, those who commit minor offenses will be directed to a civil facility if there is adequate space available.⁹⁴ Due to the closing of the psychiatric hospitals and the lack of community-based programs, those who have committed minor offenses are released, only to be re-arrested for the same or similar offenses.⁹⁵ As a result, they continually cycle in and out of state and local jail facilities.⁹⁶

According to recent data collected by the Department of Justice, Bureau of Justice Statistics, there are more than 1.2 million people with some type of reported

88. TORREY, *supra* note 37.

89. RUNDLE & HORN, *supra* note 21, at 5.

90. SLATE ET AL., *supra* note 13, at 43.

91. *Id.*; see also H. Richard Lamb and Linda E. Weinberger, *Persons With Severe Mental Illness in Jails and Prisons: A Review*, 49 PSYCHIATRIC SERVS. 483, 484 (1998)483 (arguing term “criminalization” should be applied to mentally ill persons arrested for minor, but not serious, offenses).

92. Telephone Interview with Steven Leifman, Associate Administrative Judge, Eleventh Judicial Circuit of Florida (Oct. 19, 2017).

93. Lamb & Weinberger, *supra* note 91.

94. *Id.*

95. *Id.* at 490 (arguing that insufficiency of community treatment can result in later reincarceration of patients).

96. *Id.*

mental illness incarcerated in jails and prisons throughout the United States.⁹⁷ Of these, people with mental illnesses are on probation or parole two to four times more often than the general population.⁹⁸ On any given day there are about 360,000 people with severe mental illnesses in jails and prisons throughout the country and over 760,000 people with severe mental illnesses are on community control or probation.⁹⁹ There are also roughly 35,000 individuals with severe mental illnesses in state psychiatric hospitals.¹⁰⁰ Most of these individuals are in the hospitals in response to court orders in criminal cases.¹⁰¹ “In forty-four of the fifty states and the District of Columbia, a single prison or county jail in that state holds more people with severe mental illnesses than the largest remaining . . . psychiatric hospital” in that state.¹⁰² Thus, the number of those with severe mental illnesses in prisons and jails is nearly ten times the number remaining in state hospitals.¹⁰³

“The United States ranks number one in the world in [both] the number of people suffering from mental illnesses . . . [and the] number of untreated cases of mental illnesses.”¹⁰⁴ “Further, nearly half the inmates with mental illnesses in state or federal custody in the United States are incarcerated for committing a nonviolent crime.”¹⁰⁵ According to recent statistics by the United States Department of Justice (“DOJ”), nearly 20 percent of all jail detainees experience severe mental illnesses and are incarcerated four to eight times longer than people without mental illnesses for the exact same charge.¹⁰⁶

According to the DOJ, \$15 billion is spent annually on housing those with mental illnesses in prisons and jails throughout the country.¹⁰⁷ State prisons spend \$5

97. Jillian Peterson, *Mental Illness Not Usually Linked To Crime, Research Finds*, AM. PSYCHOL. ASS'N (April 21, 2014), <http://www.apa.org/news/press/releases/2014/04/mental-illness-crime.aspx>; see also DORRIS J. JAMES AND LAUREN E. GLA, BUREAU OF JUST. STATISTICS, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (September 2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> (estimating that in 2005 1.2 million inmates of state prisons, federal prisons, and local jails had a mental health problem). As explained earlier the term criminalization of mental illness is traditionally applied to those who commit minor offenses. The 1.2 million individuals documented by the Department of Justice most likely include all individuals whether they have committed minor or major offenses.

98. Peterson, *supra* note 97.

99. Telephone Interview with Steven Leifman, Associate Administrative Judge, Eleventh Judicial Circuit of Florida (Oct. 19, 2017); see also TORREY ET AL., *supra* note 15, at 6 (estimating 356,268 inmates with severe mental illness in 2012).

100. TORREY ET AL. *supra* note 15, at 6.

101. *Id.* at 23.

102. *Id.* at 7.

103. *Id.* at 6.

104. RUNDLE & HORN, *supra* note 21, at 5.

105. *Id.*

106. MIAMI-DADE CNTY. MAYOR'S MENTAL HEALTH TASK FORCE, *supra* note 20, at 16.

107. E. Fuller Torrey, *Criminalization of Individuals with Severe Psychiatric Disorders*, MENTAL ILLNESS POL'Y ORG., <https://mentalillnesspolicy.org/consequences/criminalization.html> (last visited Sept. 6, 2018).

billion annually to house non-violent inmates with mental illnesses.¹⁰⁸ On average it costs more to house those with mental illnesses than those without.¹⁰⁹

Although this is a national problem, each state has its own unique challenges. For example, in Texas it costs \$22,000 a year to house an inmate without mental illness, but those with mental illnesses cost the state \$30,000 to \$50,000 a year.¹¹⁰ In some areas of Florida, it costs the state \$80 per day to house inmates, but those with mental illnesses cost the state \$130 a day.¹¹¹ In Cook County, Illinois, it costs \$143 a day on average to house an inmate but costs twice that amount if the individual has severe mental illnesses.¹¹² In Arkansas, the cost to process an individual through the court system and keep them incarcerated is \$6,300 per year, but the cost for an individual with mental illness is \$30,000 a year.¹¹³ These are just a few of the examples of the nationwide consequences of the criminalization of mental illness.

In regard to the State of Florida, Judge Leifman, who is the chair of the Florida Supreme Court Task Force on Substance Abuse and Mental Issues, recently presented a study before the Subcommittee on the Oversight and Investigations of the Energy and Commerce Committee of the United States House of Representatives.¹¹⁴ According to his study, the prison population in Florida has increased by fifty-six percent since 1996.¹¹⁵ By contrast, the number of inmates receiving mental health treatment has increased by 160%.¹¹⁶ The total cost to house people with mental illnesses in Florida's prisons and forensic treatment facilities is \$625 million annually and an additional \$400 million is spent housing people with mental illnesses in local jails.¹¹⁷ State expenditures are expected to increase as much as one billion dollars annually over the next decade.¹¹⁸

These costs to house those suffering from mental illnesses are higher because of the costs associated with special care that is needed for these inmates. This

108. Allen Frances, *Prison or Treatment for the Mentally Ill*, HUFF POST (May 11, 2013) https://www.huffingtonpost.com/allen-frances/prison-prison-population-_b_2811448.html.

109. *Serious Mental Illness Prevalence in Jails and Prisons*, TREATMENT ADVOC. CTR. (Sept. 2016), <http://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3695>.

110. TORREY, *supra* note 37, at 10.

111. *Id.* at 9-10.

112. Deborah L. Shelton, *How Sending the Mentally Ill to Jail Is a Cost to Us All*, TAKEPART (May 15, 2015), <http://www.takepart.com/article/2015/05/18/when-sickness-crime> (defining severe as having "a psychiatric condition and require[ing] a doctor's care, medication, and extra security").

113. *Report: Incarcerating the Mentally Ill 20 Times More Costly Than Treatment*, ARK. NEWS (June 18, 2015), <http://www.arkansasnews.com/news/arkansas/report-incarcerating-mentally-ill-people-20-times-more-costly-treatment>.

114. *Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 113th Cong. 74-77 (2014) (testimony of Judge Steve Leifman, Chair, Supreme Court of Florida Task Force on Substance Abuse and Mental Health Issues in the Courts).

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.*

includes special medical treatment, costs for special medication, i.e., psychotropic drugs, and additional supervision costs. For example, the Los Angeles County Jail spends ten million dollars per year on psychiatric medications.¹¹⁹ In the Oklahoma prison system, the number of psychiatric drugs prescribed increased almost fifty percent over a five-year period from 1996 to 2001.¹²⁰ In Portland, Oregon, the local county jail spends half of its medication budget on psychiatric drugs for those suffering from mental illness.¹²¹

In addition, inmates with mental illnesses spend, on average, a longer amount of time in jail. This increased jail stay results in higher costs for inmates suffering from mental illnesses compared to those without mental illnesses. For example, in Florida, inmates in the Orange County Jail stay for a period of twenty-one days, but inmates suffering from mental illnesses are there for an average of fifty-one days.¹²² Further, in New York, inmates in Riker's Island stay for an average of forty-two days, but those with mental illnesses stay for an average of 215 days.¹²³ In Denver, Colorado, inmates suffering from mental illnesses stay in jail five-and-one-half times longer than other inmates.¹²⁴

Furthermore, the costs associated with lawsuits from injuries sustained relating to inmates suffering from mental illnesses while in jail facilities are not usually included in the costs of housing them.¹²⁵ However, these costs can be substantial. For example, in a recent six-year period, the State of Washington spent over \$1.2 million in judgments from lawsuits involving the care of inmates with mental illnesses.¹²⁶ Monetary amounts are not available in most instances due to confidential settlements, but one only has to read the numerous accounts of negligence to know how costly these lawsuits can be to the states and local jurisdictions.¹²⁷

As a result of deinstitutionalization, jails have become the new mental hospitals.¹²⁸ Not only do jails house people with mental illnesses that are accused of committing crimes, they also house those not accused of committing crimes. In a

119. Torrey, *supra* note 107.

120. *Id.*

121. Matt Davis, *The Criminalization of Mental Illness: Why Are Oregon's Jails the Biggest Providers of Mental Health Services?*, PORTLAND MERCURY (Jan. 14, 2010), <http://www.portlandmercury.com/portland/the-criminalization-of-mental-illness/Content?oid=2090110>.

122. Stephanie Mencimer, *There Are 10 Times More Mentally Ill People Behind Bars Than in State Hospitals*, MOTHER JONES (April 8, 2014, 10:00 AM), <http://www.motherjones.com/mojo/2014/04/record-numbers-mentally-ill-prisons-and-jails>.

123. *Id.*

124. Sidney M. Wolfe, *Criminalizing the Seriously Mentally Ill: Two Decades Later*, 27 PUB. CITIZEN 1, 1 (July 2011).

125. Mencimer, *supra* note 122.

126. CHAD KINSELLA, THE COUNCIL OF ST. GOV'TS, CORRECTIONS HEALTH CARE COSTS 3, (Jan. 2004), <https://www.prisonpolicy.org/scans/csg/Corrections+Health+Care+Costs+1-21-04.pdf>.

127. Mencimer, *supra* note 122 (explaining how a schizophrenic man housed in a Texas state prison gouged out his eye and ate it, while another man in a Florida prison cut open his abdomen and repeatedly vomited into the open wound).

128. TORREY ET AL., *supra* note 15, at 12.

1992 study, it was found that twenty-nine percent of jails nationwide housed those suffering from mental illnesses that were not accused of committing crimes.¹²⁹ These individuals not accused of crimes are housed while they await mental health evaluations pursuant to civil commitment proceedings.¹³⁰ Jails have to house these individuals because they have become the only receiving facilities for civil commitments in these areas.¹³¹ These numbers are not decreasing. In fact, Public Citizen's Health Research Group and the National Alliance for the Mentally Ill reviewed these statistics over a twenty-year period and found that the numbers increased for this period.¹³²

A major problem caused by deinstitutionalization is that prisons, and especially local jails, are ill-equipped to deal with inmates suffering from mental illnesses.¹³³ Jails and prisons are not prepared to provide adequate psychiatric and medical treatment for people suffering from mental illnesses.¹³⁴ Jail staffs are often not adequately trained in handling those suffering from mental illnesses.¹³⁵ In addition, inmates suffering from mental illnesses are more likely to physically attack correctional staff and other inmates and also are subject to victimization by other inmates in disproportionate numbers.¹³⁶ Finally, deterioration of their psychiatric condition occurs when they are denied adequate treatment, which often leads to a disproportionate number of suicides.¹³⁷

The criminalization of mental illness is a major problem in this country. As jails and prisons have become the main holding facilities for those suffering from mental illnesses, the results for society include significant financial costs to the taxpayers and inadequate care and treatment for people suffering from mental illnesses. There was and is a great need for a solution to this problem.

III. A SOLUTION TO THE CRIMINALIZATION OF MENTAL ILLNESS: THE MIAMI MODEL

A. *Miami-Dade County's Problem*

In the early 2000s, south Florida had the highest number of people in its population suffering from mental illnesses in the country.¹³⁸ In Miami-Dade County, nine percent of the population suffered from mental illnesses which is two to three times

129. AZZA ABUDAGGA ET AL., PUB. CITIZENS' HEALTH RES. GROUP AND TREATMENT ADVOC. CTR., INDIVIDUALS WITH SERIOUS MENTAL ILLNESSES IN COUNTY JAILS: A SURVEY OF JAIL STAFF'S PERSPECTIVES 3 (2016), <http://www.citizen.org/documents/2330.pdf>.

130. *Id.*

131. *See id.* (explaining that the individuals are those being held for involuntary examinations based on civil commitment statutes in the differing states).

132. *Id.*

133. TORREY ET AL., *supra* note 15, at 7.

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. RUNDLE & HORN, *supra* note 21, at 6.

the national average.¹³⁹ However, Florida ranked 48th in the nation in state funding for mental health services.¹⁴⁰ Miami-Dade County had the largest percentage of mental illness among large U.S. communities.¹⁴¹ In the Dade County Jail, there were up to 1,200 inmates suffering from mental illnesses and they took up three floors of the jail.¹⁴² Contrast this with 1985 when there were only eighty inmates suffering from severe mental illnesses in the county jail.¹⁴³ Of the 114,000 bookings in the county jail, 20,000 were for individuals suffering from mental illnesses.¹⁴⁴ Thus, the Dade County jail served as the largest psychiatric institution in Florida.¹⁴⁵

During this time period, Miami-Dade County spent over one million dollars a year on psychotropic medications.¹⁴⁶ Miami-Dade County spent \$18 per day to house inmates without mental illnesses at its jail.¹⁴⁷ However, the cost for housing inmates with mental illnesses was \$125 a day.¹⁴⁸ The total cost to house those with mental illnesses was \$218,000 a day and \$80 million annually.¹⁴⁹ People suffering from mental illnesses were incarcerated eight times longer than those without and at seven times the cost.¹⁵⁰

B. The Solution: The Creation of the CMHP

These were the issues facing Judge Leifman. He saw the problem of the criminalization of mental illness firsthand. This led him to help develop the Eleventh Judicial Circuit Criminal Mental Health Project (“CMHP”) in 2000. Fifteen years later, it is called the Miami Model.¹⁵¹ The Miami Model contains a number of distinct parts that have helped to substantially eliminate the criminalization of mental illness in Miami-Dade County.

Certain core elements are necessary to ensure that any mental health diversion project is successful.¹⁵² These core elements are included in the CMHP and make up the essential system of care that is necessary for any program to be successful and provide the proper treatment.¹⁵³ According to Tim Coffey, the Eleventh Judicial Circuit’s project coordinator, “it’s not about following or using the exact

139. Iglehart, *supra* note 22, at 1701–03.

140. *Id.*

141. *Id.*

142. RUNDLE & HORN, *supra* note 21, at 6.

143. *Id.*

144. CMHP A, *supra* note 25, at 2.

145. *Id.*

146. RUNDLE & HORN, *supra* note 21, at 7.

147. *Id.*

148. *Id.*

149. CMHP A, *supra* note 25, at 2.

150. MAYOR’S MENTAL HEALTH TASK FORCE, *supra* note 20, at 16.

151. Iglehart, *supra* note 21, at 1703.

152. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Nov. 23, 2016).

153. *Id.*

model of the Eleventh Judicial Circuit. The success of the program has been due to implementation or following of certain core elements which any community can follow.”¹⁵⁴

These core elements are described by the National Leadership Forum on Behavioral Health/Criminal Justice Services to include “forensic intensive case management, supportive housing, peer support, accessible and appropriated medication, . . . integrated dual diagnosis treatment, . . . supported employment, . . . assertive community treatment/ forensic assertive community treatment . . . and cognitive-behavioral interventions targeted to risk factors.”¹⁵⁵ In addition, Coffey stated:

Judge Leifman identified the following other elements that would be essential to a successful program and they include: proper diagnosis and treatment for both mental illnesses and co-occurring substance use disorders; trauma related services; meaningful day activities (e.g., clubhouses, drop-in centers) that can provide opportunities for development of social and employment skills; coordinated criminal justice responses (e.g., problem solving courts, diversion programs, and Crisis Intervention Training); and use of advances in information technology to reduce system fragmentation and enhance care coordination.¹⁵⁶

The CMHP was established with the primary goal of diverting individuals with serious mental illnesses (“SMI”) or co-occurring serious mental illnesses and substance use disorders out of the criminal justice system and into comprehensive community-based treatment and support services.¹⁵⁷ The object was to establish a solution to the problem of the criminalization of mental illness by providing essential services to those in need and bridging a gap between the community partners and stakeholders who had an interest in eliminating or reducing the problem of criminalization of mental illness.¹⁵⁸ The short-term goals were to reduce the number of individuals with SMI in county jails and provide sufficient help with housing, treatment, and other essential medical services so that those re-entering the community would not reoffend and would have the proper treatment for a successful mental health recovery.¹⁵⁹ The program’s long term goals included: “reduced demand for costly acute care services in jails, prisons, forensic mental health treatment facilities, emergency rooms, and other crisis settings; decreased crime and improved public safety; improved public health; decreased injuries to law enforcement officers and people with mental illnesses; and decreased rates of chronic

154. *Id.*

155. NAT’L LEADERSHIP F. ON BEHAV. HEALTH/CRIM. JUST. SERVS., ENDING AN AMERICAN TRAGEDY: ADDRESSING THE NEEDS OF JUSTICE-INVOLVED PEOPLE WITH MENTAL ILLNESSES AND CO-OCCURRING DISORDERS (Sept. 2009).

156. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Dec. 13, 2016).

157. CMHP A, *supra* note 25.

158. *Id.*

159. *Id.*

homelessness.”¹⁶⁰ Most important, the CMHP’s main goal was “to close the revolving door which results in the devastation of families and the community, the breakdown of the criminal justice system, and wasteful government spending.”¹⁶¹

The CMHP has been in operation for eighteen years. It functions to divert nonviolent misdemeanor defendants suffering from SMI or those with SMI who commit less serious felonies, or those with co-occurring SMI and substance use disorders, from the criminal justice system into community-based treatment and support services.¹⁶² The program has two main components. First, there is a pre-booking process that relies heavily on crisis intervention training (“CIT”) with law enforcement officers.¹⁶³ Second, there is a post-booking diversion program that seeks to divert those arrested and awaiting adjudication out of the criminal justice system.¹⁶⁴ Both components seek to divert the individuals out of the criminal justice system and place them in community-based treatment and support programs.¹⁶⁵

The success of the CMHP depends on the participation and cooperation of community stakeholders.¹⁶⁶ Without the support of the community stakeholders, the CMHP would have no chance of success.¹⁶⁷ The community stakeholders for the CMHP include: “the State Attorney’s Office, the Public Defender’s Office, the Miami-Dade County Department of Corrections and Rehabilitation, the Florida Department of Children and Families, the Social Security Administration, public and private community mental health providers, Jackson Memorial Hospital-Public Health Trust, law enforcement agencies, family members, and mental health consumers.”¹⁶⁸ These community leaders have a vested interest in making sure each of the following programs is successful in order to help alleviate the societal problems associated with the criminalization of mental illness.

1. Pre-Booking Diversion

CIT is the key component of the pre-booking diversion. CIT was modeled after training developed in Memphis, Tennessee, in the 1980s and is currently known as the Memphis Model.¹⁶⁹ The basis of CIT is to equip and train law enforcement officers to appropriately deal with those suffering from mental illnesses.¹⁷⁰ Law enforcement officers on a regular basis are the first responders to deal with those suffering from mental illnesses. Thus, proper training is essential.

160. *Id.* at 1.

161. *Id.*

162. CMHP A, *supra* note 25.

163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.*

168. *Id.* at 2.

169. *Id.* at 3.

170. *Id.*

CIT requires that officers receive “40 hours of specialized training in psychiatric diagnoses, suicide intervention, substance abuse issues, behavioral de-escalation techniques, the role of the family in the care of a person with a mental illness, mental health and substance abuse laws, and local resources for those in crisis.”¹⁷¹ “The training is designed to educate and prepare officers to recognize the signs and symptoms of mental illnesses, and to respond more effectively and appropriately to individuals in crisis.”¹⁷² CIT officers are trained and have expertise in de-escalating crises involving people suffering from mental illnesses and provide an understanding and compassion in dealing with those with SMI in difficult situations.¹⁷³ As a result, officers dealing with those suffering from SMI can often divert them to proper mental health services rather than taking them to jail.¹⁷⁴

This training is important because it can divert individuals with SMI out of the criminal justice system and into programs that are designed to address their needs.¹⁷⁵ For example, an individual with SMI may habitually trespass at a convenience store. An officer with CIT can ascertain that the individual’s conduct is based on his SMI and divert him to a proper mental health facility. In this way, the officer can provide services that may help alleviate the problem rather than to arrest the individual and continue the cycle of the individual being repeatedly incarcerated because of the mental illness.

The CMHP has been very successful in its CIT. Through the history of the program the CMHP has provided training free of charge to over 4,600 law enforcement officers and to all thirty-six local municipalities in Miami-Dade County, as well as to Miami-Dade Public Schools and the Department of Corrections and Rehabilitation.¹⁷⁶ Between 2006 and 2010, these officers from the Miami-Dade Police Department and City of Miami Police Department who have received CIT “have responded to nearly 38,000 mental health crisis calls resulting in over 9,000 diversions to crisis units and just 85 arrests.”¹⁷⁷ “Last year alone, [2016] CIT officers from the Miami-Dade Police Department and City of Miami Police Department responded to more than 11,000 calls, resulting in nearly 1,700 diversions to crisis units and just 19 arrests. Since 2010, these two agencies have responded to nearly 72,000 mental health crisis calls resulting

171. *Id.*

172. *Id.*

173. *Id.*

174. *Id.*

175. *See id.* (“Last year alone, CIT officers from the Miami-Dade Police Department and City of Miami Police Department responded to more than 10,000 calls, resulting in over 1,200 diversions to crisis units and just 9 arrests.”)

176. *Id.*; *see also* MIAMI-DADE COUNTY ELEVENTH JUDICIAL CIRCUIT, CRIMINAL MENTAL HEALTH PROJECT (CMHP): CRIM. JUST./MENTAL HEALTH STAT. AND PROJECT OUTCOMES (JUNE 8, 2016), available at <https://perma.cc/BT65-A2GX> [hereinafter CMHP STATISTICS AND OUTCOMES]; *see also* Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017).

177. CMHP A, *supra* note 25, at 3; *see also* Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017).

Table 1: Results of Annual CIT Calls¹⁸⁵

	Annual Calls	Arrests	Diversions from Jail	Crisis Center Placements
2010	7,779	4	1,940	3,307
2011	9,399	45	3,563	4,642
2012	10,404	27	2,118	5,527
2013	10,626	9	1,215	3,946
2014	11,042	24	1,871	5,155
2015	10,579	10	1,633	7,417
2016	11,799	19	1,694	8,303
Total	71,628	138	14,034	38,297
		0.20%	19.60%	53.50%

in 38,000 diversions to crisis units and 138 arrests.”¹⁷⁸ Statistically, this is one arrest per every 519 calls for service dealing with people with mental illnesses, one diversion for every five calls, and one transport for treatment for every 1.8 calls.¹⁷⁹ As a result of CIT, the average daily population in the county jail system has dropped from 7800 to 4,800 inmates and the county has closed one entire jail facility.¹⁸⁰ This has produced a savings to the taxpayers of \$12 million per year.¹⁸¹ There has also been a reduction in fatal shootings and injuries of people with mental illnesses by police officers.¹⁸² From 1999 through 2005, there were nineteen persons with mental illnesses who died as the result of incidents with law enforcement officers in Miami-Dade County.¹⁸³ Since 2005, this figure has dropped significantly.¹⁸⁴ The following statistics indicate the success of the CIT program.

178. MIAMI-DADE COUNTY ELEVENTH JUDICIAL CIRCUIT, CRIMINAL MENTAL HEALTH PROJECT (CMHP), <https://perma.cc/5H3U-ZF83> [hereinafter CMHP B].

179. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017).

180. CMHP A, *supra* note 25, at 3.

181. *Id.*

182. *Id.*

183. *Id.*

184. *Id.*

185. CMHP STATISTICS AND OUTCOMES, *supra* note 176; *see also* Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017).

Table 2: Reduction in Fatal Shootings and Injuries¹⁸⁶

	Annual Calls	Use of Force	Officer Injuries	Consumer Injuries
2010	7,779	29	-	-
2011	9,399	75	-	-
2012	10,404	72	-	-
2013	10,626	59	11	127
2014	11,042	79	21	262
2015	10,579	69	26	211
2016	11,799	58	12	203
Total	71,628	441	70	803
		0.60%	0.10%	1.10%

2. Post-Booking Jail Diversion Program

The CMHP was created to divert non-violent misdemeanor offenders with SMI and co-occurring substance abuse disorders out of the criminal justice system and into community-based treatment and service programs.¹⁸⁷ In 2008, the program was expanded to address certain non-violent felony offenses in the diversion program.¹⁸⁸ On average, 500 individuals annually are diverted out of the criminal justice system.¹⁸⁹ However, that number has increased as the program has developed over the years. For example, in 2015, there were 831 referrals.¹⁹⁰ Over the past ten years, roughly 4,000 individuals have been diverted out of county jails and into community-based programs and services for treating mental illnesses.¹⁹¹ The misdemeanor and felony jail diversion programs are the main parts of the Post-Booking Jail Diversion program.

186. CMHP STATISTICS AND OUTCOMES, *supra* note 176. See also Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017).

187. CMHP A, *supra* note 25.

188. *Id.*

189. CMHP A, *supra* note 25, at 3.

190. CMHP STATISTICS AND OUTCOMES, *supra* note 176.

191. CMHP A, *supra* note 25, at 3.

a. Misdemeanor Jail Diversion Program

The misdemeanor diversion program has 300 referrals annually.¹⁹² The post-booking diversion program requires that defendants who are booked into the jail are screened for signs and symptoms of mental illnesses by correctional officers.¹⁹³ Defendants charged with misdemeanors and who satisfy the program admission criteria are transferred from the jail to a community-based crisis stabilization unit within twenty-four to forty-eight hours of booking.¹⁹⁴ Once the defendant is stabilized, the criminal charges may be dismissed or modified according to the type of further treatment that is needed.¹⁹⁵ If further treatment is needed, then defendants who agree to further services are assisted by matching them with a comprehensive array of community-based treatment, support, and housing services that are essential for successful community re-entry and recovery outcomes.¹⁹⁶ “Program participants are monitored by the CMHP for up to one year following community re-entry” to ensure that they are continuing with their treatment and are in contact with necessary supports and services.¹⁹⁷

Seventy-five to eighty percent of the defendants in the misdemeanor diversion program are homeless at the time of arrest.¹⁹⁸ In addition, they tend to be those who suffer from the most severe forms of mental illnesses and also have co-occurring substance abuse issues.¹⁹⁹ The program has been very successful as the recidivism rates among program participants have decreased from about seventy-five percent to twenty percent annually.²⁰⁰

b. Felony Jail Diversion Program

There are roughly 200 defendants that are referred to the felony diversion program each year.²⁰¹ The defendants in the felony jail diversion program are referred to the CMHP through a number of community sources “including the Public Defender’s Office, the State Attorney’s Office, private attorneys, judges, corrections health services, and family members.”²⁰² The defendants must meet mental health diagnostic criteria to qualify to enter the program.²⁰³ They must also meet the legal criteria of entering the program with a third-degree felony and cannot

192. *Id.* at 4. That number has been growing each year as the program has grown.

193. CMHP A, *supra* note 25, at 4.

194. *Id.*

195. *Id.*

196. *Id.*

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

201. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017).

202. CMHP A, *supra* note 25, at 4.

203. *Id.*

have more than three prior felony convictions.²⁰⁴ In addition, they must be eligible to apply for entitlement benefits such as Supplemental Security Income (“SSI”), Social Security Disability Insurance (“SSDI”), and Medicaid.²⁰⁵

Once the person is accepted into the felony jail diversion program, the assistant state attorney prosecuting the case will inform the court of the plea offer to the defendant and any subsequent plea conditions that will be offered contingent upon successful program completion.²⁰⁶ Similar to the misdemeanor program, legal charges may be dismissed or modified based on treatment engagement.²⁰⁷ All defendants are assisted in accessing community-based services and supports, and their progress is monitored and reported back to the court by CMHP staff.²⁰⁸

Of those participating in the felony diversion program, sixty-five percent complete the program.²⁰⁹ While those who completed and did not complete the program both demonstrated improvements in criminal justice outcomes, those who completed it did much better.²¹⁰ Recidivism rates were twenty-five percent for completers and seventy-three percent for non-completers within one year of finishing or leaving the program. Within two years of leaving the program, recidivism rates were thirty-five percent for completers and seventy-nine percent for non-completers.²¹¹ Non-completers of the program returned to jail twice as often as those who completed the program.²¹² Those who completed the program demonstrated an eighty-two percent reduction in jail bookings and a ninety percent reduction in jail days within one year.²¹³ For every 100 completers of the program, there was over \$750,000 dollars in cost avoidance to the jail in the year following admission.²¹⁴ “Since 2008, the felony jail program alone is estimated to have saved the county over 15,000 days of housing costs in the county jail,” which is more than thirty-five years of costly jail time.²¹⁵ Overall, participants in the program demonstrated continued reductions in criminal justice involvement during the two years following discharge from the program.²¹⁶

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

208. *Id.*

209. Telephone interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017).

210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.*

215. CMHP A, *supra* note 25, at 4.

216. Telephone interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017).

3. Forensic Hospital Diversion Program

In 2009, the CMHP implemented a pilot project funded by the State of Florida to develop the Miami-Dade Forensic Alternative Center (“MD-FAC”). The MD-FAC is a ten-bed receiving facility which was implemented to “demonstrate the feasibility of establishing a program to divert individuals with mental illnesses committed to the Florida Department of Children and Families from placement in state forensic hospitals to placement in community-based treatment and forensic services.”²¹⁷ Individuals participating in the program are those that have been charged with second and third degree felonies but who do not have significant histories of violent felony offenses.²¹⁸ In addition, they must not be likely to face incarceration if convicted of their alleged offenses.²¹⁹ Finally, they must have been adjudicated incompetent to proceed to trial or not guilty by reason of insanity.²²⁰ Individuals meeting these requirements qualify for the community-based treatment program.²²¹

“The community-based treatment provider for the pilot project is responsible for providing a full array of residential treatment and community re-entry services including crisis stabilization, competency restoration, development of community living skills, assistance with community re-entry, and community monitoring to ensure ongoing treatment following discharge.”²²² In addition, the treatment provider will help individuals in accessing “entitlement benefits and other means of economic self-sufficiency to ensure ongoing and timely access to services and supports after re-entering the community.”²²³ Unlike individuals admitted to state hospitals, individuals served by MD-FAC are not returned to jail upon restoration of competency.²²⁴ This is an advantage because, unlike state facilities, the program is able to keep individuals whose competency has been restored in the program rather than in jail while awaiting trial.²²⁵ As a result, this decreases the burdens on the jail and eliminates the possibility that a person may decompensate while in jail and lose his ability to maintain normal psychological functioning and be declared incompetent to proceed again.²²⁶

To date, the project has demonstrated a

more cost effective delivery of forensic mental health services, reduced burdens on the county jail system in terms of housing and transporting defendants with forensic mental health needs, and [has provided a] more effective

217. FLA. SENATE INTERIM REP., THE FORENSIC MENTAL HEALTH SYSTEM, 2012-108, at 3 (2011).

218. CMHP A, *supra* note 25, at 4.

219. *Id.*

220. *Id.*

221. *See id.*

222. *Id.* at 4–5.

223. *Id.* at 5.

224. *Id.*

225. *Id.*

226. *Id.*

community re-entry and monitoring of individuals who, historically, have been at high risk for recidivism to the justice system and other acute care settings.²²⁷

Additionally, “[i]ndividuals admitted to the MD-FAC program are identified as ready for discharge from forensic commitment an average of fifty-two days (thirty-five percent) sooner than individuals who complete competency restoration services in forensic treatment facilities, and spend an average of thirty-one fewer days (eighteen percent) under forensic commitment.”²²⁸ And “[t]he average cost to provide services in the MD-FAC program is roughly thirty-two percent less expensive than services provided in state forensic treatment facilities.”²²⁹

4. Access to Entitlement Benefits

Stakeholders in the criminal justice and behavioral health communities consistently identify lack of access to public entitlement benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid as among the most significant and persistent barriers to successful community re-integration and recovery for individuals who experience serious mental illnesses and co-occurring substance use disorders.²³⁰

The majority of individuals involved in the CMHP programs do not receive any entitlement benefits at the time they enter a CMHP program.²³¹ As a result, many of the participants do not have sufficient funds to obtain “adequate housing, treatment, or support services in the community.”²³²

In order to address this barrier and maximize limited resources, the CMHP developed an innovative plan to improve the ability to transition individuals from the criminal justice system to the community.²³³ Funding is essential to the success of the program. Therefore, “all participants in the program who are eligible to apply for Social Security benefits are provided with assistance utilizing a best practice model referred to as SOAR (SSI/SSDI, Outreach, Access and Recovery).”²³⁴ SOAR is an approach that was developed as a federal technical assistance initiative to expedite access to social security entitlement benefits for individuals with mental illnesses who are homeless.²³⁵ The result of obtaining SSI and/or SSDI for the program participants is essential in that it provides a “steady income and health care coverage which enables individuals to access basic needs including housing,

227. *Id.*

228. *Id.*

229. *Id.*

230. *Id.*

231. *Id.*

232. *Id.*

233. *Id.*

234. *Id.*

235. *Id.*

food, medical care, and psychiatric treatment.”²³⁶ “This significantly reduces recidivism to the criminal justice system, prevents homelessness, and is an essential element in the process of recovery” for the CMHP participants.²³⁷

The CMHP has developed a good working relationship with the Social Security Administration, which helps expedite and ensure approvals for entitlement benefits in the shortest time possible.²³⁸ The process begins when all CMHP participants are initially screened for eligibility for federal entitlement benefits, with CMHP staff initiating applications as early as possible utilizing the SOAR model.²³⁹ Program data demonstrates that ninety percent of the individuals are approved on the initial application.²⁴⁰ By contrast, the national average across all disability groups for approval on initial application is twenty-nine percent.²⁴¹ In addition, the average time until approval for CMHP participants is forty days.²⁴² This quick turnaround time is remarkable when compared to the ordinary approval process, which typically takes between nine and twelve months.²⁴³

Based on the success of the CMHP, Miami-Dade County was awarded a three-year, \$1.2 million grant from the State of Florida in 2010.²⁴⁴ The grant was for the purpose of implementing and expanding applications for access to entitlement benefit services to include individuals with SMI re-entering the community after completing jail sentences.²⁴⁵ This would be done by implementing a specialized entitlement benefits unit utilizing the SOAR model to expedite access to Social Security and Medicaid benefits for individuals served by the CMHP programs.²⁴⁶

5. Recovery Peer Specialists

Recovery Peer Specialists are another essential element of the CMHP. Recovery Peer Specialists are individuals who suffered from mental illnesses and have recovered or are in recovery and who work as members of the jail diversion team.²⁴⁷ Based on their life experiences, they are able to better relate in some instances and provide invaluable help to those they are serving. “The primary function of the Recovery Peer Specialist is to assist jail diversion program participants

236. *Id.*

237. *Id.*

238. *Id.*

239. *Id.* at 6.

240. *Id.*

241. CMHP B, *supra* note 178.

242. *Id.*

243. *Id.*

244. *Id.*

245. *Id.*

246. *Id.*

247. *Id.*; see also *The Florida Certification Board, Available Certifications*, <http://flcertificationboard.org/certifications/certified-recovery-peer-specialist-adult-family-or-veteran>. One can receive a certificate of training as a Recovery Peer Specialist from the State of Florida.

with community re-entry and engagement in continuing treatment and services.”²⁴⁸ “This is accomplished by working with participants, caregivers, family members, and other sources of support to minimize barriers to treatment engagement and to model and facilitate the development of adaptive coping skills and behaviors.”²⁴⁹ Recovery Peer Specialists also serve as consultants and faculty to the CMHP’s CIT training program.²⁵⁰

6. *Bristol-Myers Squibb Foundation Project*

The South Florida Behavioral Health Network, with coordination from CMHP, “which is contracted by the Florida Department of Children and Families to manage the substance abuse and mental health system of care in Miami-Dade and Monroe counties, was awarded a three-year, \$1.2 million grant from the Bristol-Myers Squibb Foundation.”²⁵¹ The purpose of the grant is to develop and implement a “first-of-its-kind coordinated system of care,” targeting the needs of individuals with serious mental illnesses who are at highest risk for involvement in the criminal justice system and other institutional settings.²⁵² The project coordinates and works with CMHP’s Misdemeanor and Felony Jail Diversion programs.²⁵³ “A primary goal of the project is to ensure timely and efficient access to a comprehensive array of services based on enhanced, individualized assessment of clinical and criminogenic needs and risk factors.”²⁵⁴ The services are to be delivered by a “coordinated network of community-based treatment providers and justice system stakeholders involved in cross-systems and cross-disciplinary treatment planning, service coordination, and information sharing.”²⁵⁵ Although in its infancy, the project will be evaluated by comparisons of behavioral health and criminal justice outcomes among individuals enrolled in the new program versus individuals participating in traditional community-based services.²⁵⁶

7. *Mental Health Diversion Facility*

Another important aspect of the CMHP is its development of a dedicated mental health diversion facility. Since 2006, the courts and stakeholders from Miami-Dade County have worked on a capital improvement project to develop a mental health diversion and treatment facility. Currently, the county has begun building a dedicated mental health diversion facility, which will cost taxpayers over \$42

248. CMHP B, *supra* note 178, at 6.

249. *Id.*

250. *Id.*

251. CMHP A, *supra* note 25, at 6.

252. *Id.*

253. *Id.*

254. *Id.*

255. *Id.*

256. *Id.*

million.²⁵⁷ The facility will service individuals who are diverted from the county jail system into a “seamless continuum of comprehensive community-based treatment programs that leverage local, state, and federal resources.”²⁵⁸ The project’s main goal is to “build on the successful work of the CMHP with the goal of creating an effective and cost efficient alternative treatment setting to which individuals awaiting trial may be diverted.”²⁵⁹

“The diversion facility will be housed in a former state forensic hospital which . . . is in the process of being renovated to include programs operated by community-based treatment and social services providers.”²⁶⁰ The services offered at the facility will include “crisis stabilization, short-term residential treatment, day treatment and day activities programs, intensive case management, outpatient behavioral health and primary care treatment services, and vocational rehabilitation/supportive employment services.”²⁶¹ The facility will also include “space for the courts and for social service agencies such as housing providers, legal services, and immigration services so that the comprehensive needs of individuals can be served.”²⁶²

The goal for the mental health diversion facility and expansion of the CMHP’s diversion programs is to “create a centralized, coordinated, and seamless continuum of care for individuals who are diverted from the criminal justice system either pre-booking or post-booking.”²⁶³ By providing a comprehensive array of services and supports in one facility, it is likely that “individuals who are currently recycling through the criminal justice system will be more likely to engage treatment and recovery services.”²⁶⁴ The new facility will also allow individuals who spend extended amounts of time in the county jail to move more quickly and seamlessly into residential treatment programs and supervised outpatient services.²⁶⁵

It is estimated that the new diversion facility will save \$8.2 million each year.²⁶⁶ In addition, it is estimated that there will be a reduction in almost 1,200 jail

257. Telephone interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017); see also David Ovalle, *In Miami-Dade, hope, help for offenders with mental illness*, MIAMI HERALD (Sept. 29, 2014, 10:31 PM), <http://www.miamiherald.com/news/local/community/miami-dade/article2319144.html>

258. CMHP B, *supra* note 178, at 6.

259. *Id.*

260. *Id.*

261. *Id.*

262. *Id.*

263. *Id.*

264. *Id.* at 7.

265. *Id.*

266. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Oct. 25, 2017); see also MENTAL HEALTH DIVERSION FACILITY, SERVICE AND FISCAL IMPACT ESTIMATES (Jun. 9, 2016).

bookings each year.²⁶⁷ Further, it is estimated that the county will save over 36,000 annual jail days, which is equivalent to more than ninety beds every year.²⁶⁸

8. *Typical or Troubled? Program*

Recently, the CMHP partnered with the American Psychiatric Foundation (“APF”) and Miami-Dade County Public Schools (“MDCPS”) to implement the *Typical or Troubled? School Mental Health Education Program* for all public junior high and high schools in the Miami-Dade County school system.²⁶⁹ “The program will train over 500 teachers, school psychologists, social workers and guidance counselors on early identification of potential mental health problems, will educate and engage parents, and will ultimately link students with mental health services when needed.”²⁷⁰ The program “helps school personnel distinguish between typical teenage behavior and evidence of mental health warning signs that would warrant intervention.”²⁷¹ The goal will be to proactively confront mental health in the school system “through partnerships and targeted training” that identify and provide “effective treatment of mental health problems before those problems manifest through increased truancy, substance abuse,” criminal activity, violence, or tragedy.²⁷²

C. *CMHP: A Model of Success*

The success of the CMHP has been immense in the fight against the criminalization of mental illness. “The CMHP has demonstrated substantial gains in the effort to reverse the criminalization of people with mental illnesses.”²⁷³ This is accomplished because “the CMHP offers the promise of hope and recovery for individuals with SMI [who] have often been misunderstood and discriminated against” through a wide variety of services and programs that are absent from most communities.²⁷⁴ Once a person is “engaged in [the proper] treatment and community support services,” the individual has “the opportunity to achieve successful recovery” and community integration, as well as reduce his recidivism to jail.²⁷⁵

The success of the CMHP has been nationally recognized and is a national model of excellence in dealing with mental illness in the criminal justice system.²⁷⁶

267. *Id.*

268. *Id.*

269. John Schuster, *Miami-Dade County Public Schools and American Psychiatric Foundation Bring Early-Intervention Mental Health Program to Schools*, AM. PSYCHOL. FOUND. (Jan. 23, 2013), <http://www.americanpsychiatricfoundation.org/what-we-do/public-education/typical-or-troubled>.

270. *Id.*

271. *Id.*

272. *Id.*

273. CMHP A, *supra* note 25, at 7.

274. *Id.*

275. *Id.*

276. *Id.*

The CMHP has received numerous recognitions and awards including the 2010 Prudential Davis Productivity Award for implementation of SOAR, 2010 Eli Lilly Reintegration Award for Advocacy, the 2008 Center for Mental Health Services/National GAINS Center Impact Award, the 2007 National Association of Counties Achievement Award, the 2006 United States Department of Housing & Urban Development's HMIS National Visionary Award, the 2006 Prudential Financial Davis Productivity Award, and the 2003 National Association of Counties Distinguished Service Award.²⁷⁷ In addition, for Judge Leifman's incredible work in this area, he was honored in 2015 by the United States Supreme Court when he received the National Center for State Courts' William H. Rehnquist Award for Judicial Excellence.²⁷⁸

"The CMHP provides an effective and cost-efficient solution to a community problem."²⁷⁹ As previously noted, over CMHP's fifteen-year history, "[p]rogram results demonstrate that individualized transition planning to access necessary community based treatment and services upon release from jail will ensure successful community re-entry and recovery for individuals with mental illnesses, and possible co-occurring substance use disorders that are involved in the criminal justice system."²⁸⁰ This truly innovative program has seen incredible results.

The CMHP is estimated to have saved the county millions of dollars since its inception.²⁸¹ Its diversion programs alone save the taxpayers nearly \$6 million a year.²⁸² In addition, the population in the local jails has dropped from 7,800 to 4,800, which allowed for the closing of one of the county jails and has saved the taxpayers \$12 million per year.²⁸³ The savings alone would seem to most to be a success, but the real success is that recidivism rates of those treated and participating in the program dropped from seventy-five percent to twenty percent annually.²⁸⁴ This decline shows that the fight against the criminalization of mental illness is working as individuals suffering from SMI are not being repeatedly recycled through the criminal justice system. In addition, they are receiving the necessary treatments and services to help them lead a productive life.

The Chief Justice of the Florida Supreme Court, Jorge Labarga, summed up the work of Judge Leifman and the CMHP:

Judge Leifman epitomizes judicial excellence: "Troubled by people with mental illnesses cycling through his Miami courtroom, Judge Leifman

277. *Id.*

278. Press Release, National Center for State Courts, Miami Judge Steve Leifman Wins William H. Rehnquist Award, (Aug. 12, 2015), http://www.floridasupremecourt.org/pub_info/documents/pressreleases/2015/08-12-2015_Leifman-Wins-Rehnquist-Award.pdf.

279. CMHP A, *supra* note 25, at 8.

280. *Id.*

281. *Id.* at 3.

282. CMHP STATISTICS AND OUTCOMES, *supra* note 176, at 6.

283. CMHP A, *supra* note 25, at 3.

284. *Id.* at 4.

decided to take action. His unwavering commitment and compassion in the years since that moment have brought astounding results, changing and saving lives, and bringing families back together. He has made our courts more just and our society more humane.”²⁸⁵

IV. DO THE PRINCIPLES OR PARTS OF THE CMHP WORK IN OTHER JURISDICTIONS?

The CMHP has been shown to be an innovative program that helps solve the problem of the criminalization of mental illness. It is clear that the problem of the criminalization of mental illness occurs across the nation. If the problem is so widespread, the question is whether other areas or jurisdictions have adopted the CMHP’s program or similar components of the program. If these areas or jurisdictions have adopted the programs or components of the program, then the question becomes whether these areas or jurisdictions are seeing similar successes.

In making this determination, research was conducted on eighteen different jurisdictions suffering from the effects of the criminalization of mental illness that are utilizing diversionary programs similar to the CMHP.²⁸⁶ Fifteen of these jurisdictions made site visits to Miami, Florida to view the CMHP.²⁸⁷ One jurisdiction worked closely with Judge Leifman and his staff in developing their programs but did not make a site visit.²⁸⁸ Interviews were done with representatives of seventeen of the eighteen jurisdictions.²⁸⁹

A. Site Visits

Fifteen of the eighteen jurisdictions researched made site visits to the CMHP and viewed the CMHP’s programs. One jurisdiction did not make a site visit but has worked closely with the Judge Leifman and the staff of the CMHP in developing its programs.²⁹⁰ Seventy-five percent of the jurisdictions making visits or working directly with Judge Leifman and his staff adopted parts of the CMHP.²⁹¹ None

285. Press Release, National Center for State Courts, *supra* note 278.

286. The jurisdictions researched were as follows: Duval Cnty., Fla.; Shelby Cnty., Tenn.; Broward Cnty., Fla.; Pinellas Cnty., Fla.; 19th Judicial Circuit, Fla.; Franklin Cnty., Ohio; Cook Cnty., Ill.; Orange Cnty., Fla.; 20th Judicial Circuit, Fla.; Bexar County, Tex.; Hillsborough Cnty., Fla.; Alachua Cnty., Fla.; Harris Cnty., Tex.; Cuyahoga Cnty., Ohio; Palm Beach Cnty., Fla.; King Cnty., Wash.; Douglas Cnty., Kan.; Los Angeles Cnty., Cal.

287. Telephone interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017).

288. 19th Judicial Circuit, Fla.; King Cnty., Wash.; and Douglas Cnty., Kan., did not make site visits.

289. Only King Cnty., Wash., was not interviewed. They did not visit the CMHP. Information on their program was gathered by web-based sources.

290. Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017).

291. *See id.*; Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview

of those jurisdictions adopted the entire CMHP program and all cited lack of financial resources as the major reason.²⁹² Twenty-five percent of the jurisdictions did not adopt parts of the program after their visit because they already had similar programs in place. Only one of the sixteen jurisdictions did not adopt any parts of the CMHP because their studies on the subject area showed that their program worked better, although they had some similar components in place.²⁹³ All those that visited the CMHP stated that the visit was valuable and that they gained valuable ideas that could be helpful in the future for solving the problem of the criminalization of mental illness in their jurisdictions.²⁹⁴

B. Main Components

All of the eighteen researched jurisdictions utilize CIT.²⁹⁵ However, only 66 percent of those had a triage or crisis stabilization center similar to that of the CMHP.

with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

292. See Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

293. Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017).

294. See *id.*; Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

295. See Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter

This crisis stabilization center is an important component because it gives CIT officers a place away from the county or local jail to which individuals suffering from SMI can be diverted. A representative of one of the jurisdictions stated, “[i]t is frustrating when CIT has been completed but there is no facility to divert individuals to other than the county jail.”²⁹⁶

In regard to mental health diversion, 66 percent of the jurisdictions had a pre-trial diversion program for those suffering from SMI.²⁹⁷ Eight-three percent of the jurisdictions had a mental health court system in place. Sixty-six percent of the jurisdictions used their pre-trial diversion program as their main diversionary component for people with mental illnesses.²⁹⁸ Twenty-six percent of those operating a mental health court used this court as their main diversionary program for those suffering from SMI.²⁹⁹

Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep’t (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

296. Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

297. *Blueprint for Success: The Bexar County Model, How To Set Up A Jail Diversion Program In Your Community*, <http://passthrough.fw-notify.net/download/318528/http://www.fairfaxcounty.gov/policecommission/subcommittees/materials/jail-diversion-toolkit.pdf>; Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017).

298. See Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep’t (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

299. See Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep’t (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

In regards to the CMHP's other components, only 38 percent were utilizing SOAR.³⁰⁰ Only one jurisdiction had adopted a school program to target those in schools suffering from SMI.³⁰¹ No jurisdiction had developed a dedicated mental health diversion facility.³⁰²

All of the jurisdictions interviewed cited two major problems in limiting the success of their programs. All of the jurisdictions stated that financial resources are the biggest barrier in limiting their success.³⁰³ For example, many interviewed cited the fact that the CMHP was spending \$42 million on a dedicated mental health diversion facility,³⁰⁴ which they would never be able to do in their jurisdiction. Further, all of the jurisdictions cited the need for changes in legislation or new legislation to provide help and tools in the fight against the criminalization of mental illness.³⁰⁵

300. Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017).

301. Times-Union Editorial Board, *JCCI Mental Health Study has produced lasting impact*, FLA. TIMES UNION (Dec. 23, 2016, 6:02 PM), <http://jacksonville.com/opinion/2016-12-23/jcci-mental-health-study-has-produced-lasting-impact>.

302. See Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

303. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

304. Ovale, *supra* note 257.

305. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with

From the visits, all of the representatives of the jurisdictions stated that they gained valuable ideas on how to implement or make their diversion programs better.³⁰⁶ Further, they stated that it helped bring community leaders together.³⁰⁷ For the majority of these jurisdictions, their programs had not been in place long enough to gain valuable statistics as to whether the ideas they implemented had been successful. However, the perception by these representatives was that they had made strides in the right direction and that their programs were going to be successful.³⁰⁸

C. Examples and Models

It is clear from the interviews and web-based resources that areas and jurisdictions that suffer from the criminalization of mental illness have attempted to solve their problem by adopting parts of the CMHP's programs or by adopting similar components. Some have been very successful. Others have just started to implement programs so that there are no concrete numbers with which to measure success. Most have financial restrictions but are using creative methods to craft

Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

306. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

307. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017); Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017); Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017); Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017); Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017); Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017); Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts, (July 31, 2017); Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017); Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017); Telephone Interview with Kelly Steele, Manager, Ninth Circuit Problem Solving Court Programs, (July 18, 2017).

308. Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry (Feb. 17, 2017); Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017).

successful programs. Below are models from other areas and jurisdictions and their successes.

1. Duval County, Florida

In 2015, community leaders who were part of the Jacksonville Community Council Inc. (“JCCI”) realized they had a mental health crisis.³⁰⁹ JCCI commissioned a study on the mental health crisis in Duval County. As part of that study, community leaders visited the CMHP.³¹⁰ As a result of the study and the visit, several programs were put in place.

In 2016, First Schools Plus, a mental health service program in Duval County schools, began to put licensed mental health professionals in selected schools.³¹¹ In 2016, there were nearly 1,000 referrals and sixty-one percent of those students received services.³¹² This program has been seen as an immense success based on the number of individuals receiving services.

In 2017, a mental health central receiving system was opened to divert people suffering from mental illnesses from the local jail to receive mental health services.³¹³ All officers receive CIT training through the Jacksonville Sheriff’s Office.³¹⁴ These officers now have a way to divert individuals suffering from SMI rather than taking them to the county jail. This is important because the Duval County Jail is the largest mental health provider in the county.³¹⁵

Duval County also uses some similar components of the CMHP. The county operates a mental health court.³¹⁶ In addition, Duval County, through some of its non-profit hospitals, provides training to 10,000 individuals in the community for recognizing signs of severe mental illness and to help connect high risk individuals to services faster.³¹⁷ This is a way of trying to keep people suffering from mental illnesses from entering the court system by recognizing their mental health issues and stabilizing them before they would enter the court system.³¹⁸

Judge Karen Cole has been an instrumental figure in helping solve the mental health crisis in Duval County. She along with community leaders made a site visit

309. See Times-Union Editorial Page, *Florida’s mental health crisis deserves to be a high priority*, FLA. TIMES UNION (Feb. 18, 2015, 4:23 PM), <http://jacksonville.com/opinion/editorials/2015-02-18/story/floridas-mental-health-crisis-deserves-be-high-priority> (describing two panel discussions emphasizing the high priority for prevention, adequate resources, and to remove stigma).

310. Telephone Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017).

311. Editorial Board, *JCCI Mental Health Study has produced lasting impact*, *supra* note 301.

312. *Id.*

313. Jessica Palombo, *Duval Needs \$1.5 Million to Open Mental Health Care ‘Central Receiving System’*, WJCT PUB. MEDIA (Nov. 23, 2016), <http://news.wjct.org/post/duval-needs-15-million-open-mental-health-care-central-receiving-system>.

314. *Id.*

315. *Id.*

316. Telephone Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017).

317. Ryan Benk, *10k to Receive Mental Health Training in Jacksonville*, WJCT PUB. MEDIA (Jan. 26, 2017), <http://news.wjct.org/post/10k-receive-mental-health-training-jacksonville>.

318. *Id.*

to the CMHP. Judge Cole stated that the visit was a huge success.³¹⁹ It brought community leaders together and helped with the development of a number of programs.³²⁰ The county's program is still in its inception and pieces are being borrowed from the CMHP.³²¹ However, the county does not have the same type of funding as Miami-Dade County. There are no statistics as to the success of the programs as it is in its inception, but it is perceived in the coming years that the statistics will justify the program's funding.³²²

2. Pinellas County, Florida

Pinellas County visited the CMHP in December 2013.³²³ Pinellas County operates a unique mental health jail diversion program.³²⁴ The program was started in 2004.³²⁵ The program has diverted nearly 6,000 individuals suffering from mental illnesses out of the criminal justice system.³²⁶ There has been a ninety percent reduction in recidivism among those that have completed the program.³²⁷ The jail diversion program diverts individuals out of the criminal justice system into community-based treatment.³²⁸ The program lasts ninety days.³²⁹ The program acts in the place of a mental health court.³³⁰

The ninety-day program provides services which include "face-to-face assessments, transportation, transitional housing, psychiatric evaluations, treatment plans, prescription medication therapy, intensive case management, court liaisons, and finding additional community resources."³³¹ "The program provides access to community-based health and substance-abuse treatment services."³³² "Clients receive treatment services, case management, housing, and medications."³³³

Pinellas County has CIT training but lacks a triage or central receiving facility and adequate housing for placement of individuals once they have completed the program.³³⁴ This is due to a lack of funding.³³⁵ However, it is estimated that the jail

319. Telephone Interview with Karen Cole, Circuit Judge, Fourth Judicial Circuit (July 17, 2017).

320. *Id.*

321. *Id.*

322. *Id.*

323. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (May 25, 2017).

324. Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017). *See also, Jail Diversion Program*, PUB. DEF. SIXTH JUDICIAL CIRCUIT, http://www.wearethehope.org/jail_diversion.htm(last visited Aug. 26, 2018).

325. *Jail Diversion Program*, *supra* note 324.

326. *Id.*

327. *Id.*

328. *Id.*

329. Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017).

330. *Id.*

331. *Jail Diversion Program*, *supra* note 324.

332. *Id.*

333. *Id.*

334. Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017).

335. *Id.*

diversion program saves the taxpayers millions of dollars each year.³³⁶ For example, in 2004, it was estimated the program saved the taxpayers over \$5 million.³³⁷

Pinellas County has not adopted all of the CMHP programs because of a lack of funding.³³⁸ However, it has become creative by instituting the Safe Harbor homeless facility and a chronic inebriation program that helps with those suffering from mental illness and co-occurring substance abuse issues.³³⁹ Although the county does not have the same financial resources as Miami-Dade County, it has become creative and successful with the programs it has initiated.

3. Nineteenth Judicial Circuit, St. Lucie and Indian River County, Florida

The Nineteenth Judicial Circuit, which includes St. Lucie and Indian River counties, deals with the problem of the criminalization of mental illness.³⁴⁰ Although no representative has visited the CMHP from the Nineteenth Circuit, Circuit Court Judge Cynthia Cox has worked closely with Judge Leifman on issues dealing with mental illnesses in the criminal justice system.³⁴¹ She has been the administrative judge for the mental health courts in the Nineteenth Circuit and has been instrumental in their success.³⁴² The Nineteenth Circuit does have CIT training but does not have a central receiving system due to a lack of funding.³⁴³ As a result, mental health diversion and services are provided through the mental health courts.³⁴⁴

The mental health courts were started in the early 2000s.³⁴⁵ Currently, there are roughly 500 participants in the mental health courts in St. Lucie and Indian River counties.³⁴⁶ The mental health courts have adopted many of the principles of the CMHP.³⁴⁷ Inside the mental health courts, there is a misdemeanor and felony diversion program.³⁴⁸ The mental health courts also offer services and programs similar to those in the CMHP to those found not guilty by reason of insanity and with competency issues.³⁴⁹ In addition, there is a traditional track through which participants are placed on probation.³⁵⁰ Finally, the courts also utilize the SOAR

336. *Id.*

337. *Jail Diversion Program*, *supra* note 324.

338. Telephone Interview with Bob Dillinger, Public Defender, Sixth Judicial Circuit (July 18, 2017).

339. *Id.*

340. Telephone Interview with Cynthia Cox, Circuit Judge, Nineteenth Judicial Circuit, Fla. (July 26, 2017).

341. *Id.*

342. *Id.*

343. *Id.*

344. *Id.*

345. *Id.*

346. *Id.*

347. *Id.*

348. *Id.*

349. *Id.*

350. *Id.*

program to help the participants receive the government benefits they need for housing and treatment.³⁵¹

Lack of funding is a major reason for not adopting all of the CMHP.³⁵² However, the program in place has been very successful and saves the circuit an average of \$3 million a year in jail costs.³⁵³ According to Judge Cox, this is due to the creative use of funds and building programs within the mental health court system.³⁵⁴

4. *Franklin County, Ohio*

Franklin County, Ohio, has problems with the criminalization of mental illness.³⁵⁵ The county currently houses 2,300 inmates in its county jail with forty-five percent suffering from some type of mental illness.³⁵⁶ Representatives from the county visited the CMHP in October 2015.³⁵⁷ Based on the visit, the county developed a number of programs to help with their mental health crisis.³⁵⁸ First, the county instituted CIT training for law enforcement officers and developed a mental health crisis center where law enforcement officers could divert individuals with SMI to provide mental health and co-occurring substance abuse services.³⁵⁹ In addition, a program was developed to place individuals with SMI, who have been deemed frequent users of the system, in social service programs to obtain the needed services.³⁶⁰ In 2016, a misdemeanor and felony diversion program was started for individuals involved in the criminal justice system who suffered SMI.³⁶¹ Finally, a mental health court was instituted. Funding mental health diversion programs is an issue. However, the county has tried to be creative in using the key components of the CMHP that are financially feasible in order to reduce the criminalization of mental illness in the county.

5. *Cook County, Illinois*

Cook County, Illinois, has adopted some components of the CMHP. In particular, it uses a combination of supportive housing, which includes community mental health treatment services and rent subsidies.³⁶² In addition, Cook County utilizes

351. *Id.*

352. *Id.*

353. *Id.*

354. *Id.*

355. Telephone Interview with Michael Daniels, Justice Policy Coordinator, Franklin Cnty., Ohio (July 26, 2017).

356. *Id.*

357. *Id.*

358. *Id.*

359. *Id.*

360. *Id.*

361. *Id.*

362. Michael Ollove, *New Efforts Aim To Keep The Mentally Ill Out Of Jail*, HUFF POST (May 19, 2015), http://www.huffingtonpost.com/2015/05/19/mentally-ill-jail_n_7316246.html.

Assistive Community Treatment (“ACT”) teams composed of mental health specialists who help coordinate treatment, housing, and employment.³⁶³ Finally, Cook County utilizes CIT training and has adopted a mental health court for felony offenders.³⁶⁴

In fact, Cook County has a successful mental health diversion program which operates through its mental health court.³⁶⁵ Unlike the CMHP, the diversion program only focuses on felony offenders.³⁶⁶ According to Judge Lawrence Fox, Director of Problem Solving Courts in Cook County, the county’s studies show that misdemeanor diversion does not work as well as focusing on felony offenders.³⁶⁷ According to Fox, the idea is to target high risk offenders and the model has been a success.³⁶⁸

In using these components and strategies, Cook County has experienced success in combating the criminalization of mental illness. There has been an eighty-six percent reduction in arrests of those with mental illnesses.³⁶⁹ Further, there has been an eighty-six percent reduction in jail time for those suffering from mental illnesses.³⁷⁰ Finally, there has been a seventy-six percent reduction in hospitalizations for those participating in the programs.³⁷¹

6. King County, Washington

King County, Washington, utilizes several components of the CMHP in its mental health diversion programs. King County utilizes supportive housing and ACT which has provided for intensive community-based mental health treatments.³⁷² This is done through jail diversion programs that utilize CIT training and a crisis solutions center.³⁷³ These programs have led to a forty-five percent reduction in jail booking for those participating in the programs.³⁷⁴

363. *Id.*

364. Thomas J. Dart, *Mental Health Template*, COOK CTY. SHERIFF’S OFF., <https://www.cookcountysheriff.org/mental-health-template/> (last visited Sept. 9 2018); *see also*, *Eliminating Barriers To The Treatment of Mental Illness*, TREATMENT ADVOC. CTR., <http://www.treatmentadvocacycenter.org/browse-by-state/illinois> (last visited Sept. 9, 2018).

365. Telephone Interview with Lawrence Fox, Director, Cook Cnty., Ill., Problem Solving Courts (July 31, 2017).

366. *Id.*

367. *Id.*

368. *Id.*

369. Ollove, *supra* note 362.

370. *Id.*

371. *Id.*

372. *Id.*

373. *Crisis Diversion Programs*, KINGCOUNTY.GOV, <http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/diversion-reentry-services/crisis-diversion-programs.aspx> (last updated Oct. 27, 2017).

374. *Id.*

One of the unique features of King County program is the development of a crisis solutions center, which has three linked programs.³⁷⁵ First, there is a crisis diversion facility “for adults in crisis who need stabilization and referral to appropriate community-based services.”³⁷⁶ Second, there are crisis diversion interim services “for individuals who need intensive case management to identify and engage in available housing and support options upon returning to their home community.”³⁷⁷ Finally, there is a mobile crisis team “that responds with police and other first responders in the community to provide . . . crisis stabilization and linkage to appropriate services and supports” in moments of crisis.³⁷⁸

King County also utilizes a mental health court program.³⁷⁹ This program provides a diversionary court for those whose crimes are linked to a mental illness.³⁸⁰ The diversionary court is open to individuals with both misdemeanor and felony charges.³⁸¹

King County’s diversion program was evaluated by researchers at Seattle University, who concluded that the program was successful.³⁸² The evaluation results suggest that the program is relieving an otherwise substantial and unnecessary burden on law enforcement officers.³⁸³ This is done by diverting individuals with SMI out of the criminal justice system to mental health professionals who can triage cases and divert the individuals to more appropriate treatment.³⁸⁴

7. Bexar County, Texas

Bexar County, Texas, utilizes a complex jail diversion program in its fight against the criminalization of mental illness that incorporates a number of the components of the CMHP.³⁸⁵ First, the county utilizes a pre-arrest diversion program which includes CIT training and the use of a crisis center to provide needed mental health and substance abuse services.³⁸⁶ In addition, there is a pre-trial diversion

375. *Id.*

376. *Id.*

377. *Id.*

378. *Id.*

379. *Welcome to the King County District Court Regional Mental Health Court*, KINGCOUNTY.GOV, <https://www.kingcounty.gov/courts/district-court/regional-mental-health-court.aspx> (last updated Jan. 24, 2017).

380. *Id.*

381. *Id.*

382. Jacqueline B. Helfgott et al., *A Descriptive Evaluation of the Seattle Police Department’s Crisis Intervention Team/Mental Health Partnership Pilot Project*, SEATTLE UNIVERSITY (2012); see also Sarah C. Walker et al., *Washington State Mental Health Diversion Guidebook: A Guide for Juvenile Courts*, UNIV. OF WASH. & CTR. FOR CHILD. & YOUTH JUST., http://www.modelsforchange.net/publications/765/Washington_State_Mental_Health_Diversion_Guidebook.pdf.

383. *Id.*

384. *Id.*

385. Leo Evans, *Blueprint for Success: The Bexar County Model, How To Set Up A Jail Diversion Program In Your Community*, <http://www.naco.org/sites/default/files/documents/Bexar-County-Model-report.pdf>.

386. *Id.* at 11–21.

program offering pre-trial mental health services and a court diversion program.³⁸⁷ Finally, the county has adopted a collaboration model involving different agencies and different members of the community to cooperate in facilitating proper services.³⁸⁸

The program has seen immense success. On average, the program diverts 4,000 individuals annually from incarceration to treatment and has diverted 20,000 individuals since the program's inception.³⁸⁹ In addition, the county saves \$5 million for jail costs and \$4 million annually for inappropriate admissions to the emergency room.³⁹⁰ Finally, before the program, physical force was required at least fifty times each year in taking the mentally ill into custody.³⁹¹ Since the inception of the program, only three incidents of physical force have been used in dealing with the mentally ill.³⁹² The program has had immense success as there is only a four percent recidivism rate for those completing programs and seventy to eighty percent of the participants complete the program.³⁹³ Based on its success, Bexar County has become a national model for success in the area of fighting criminalization of mental illness.³⁹⁴

Even with its immense success, representatives from Bexar County visited the CMHP.³⁹⁵ The reason for the visit was to see how the CMHP's diversion programs worked within the court system.³⁹⁶ Bexar County's programs focus on the law enforcement side and in particular its CIT and pre-arrest diversion.³⁹⁷ They viewed the CMHP to help develop their court programs.³⁹⁸ The reason for this, according to Gilbert Gonzalez, Director of the Mental Health Department for Bexar County, is that the CMHP approach is different in that Bexar County's programs focus on law enforcement diversion where Judge Leifman brings "great experience in fighting the criminalization of mental illness through the court system."³⁹⁹ Gonzalez said the greatest challenge for Bexar County's programs, other than that of funding, is that of "educating those within the court system of the value and need for mental health diversion."⁴⁰⁰

387. *Id.*

388. *Id.*

389. *Id.* See also Susan Parmerleau, *Jail Diversion Program A Huge Success*, MY SAN ANTONIO (January 22, 2016, 3:54 PM), <http://www.mysanantonio.com/opinion/commentary/article/>.

390. Evans, *supra* note 385, at 1.

391. *Id.*; see also Parmerleau, *supra* note 389.

392. *Id.*

393. Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017).

394. Parmerleau, *supra* note 389.

395. Telephone Interview with Gilbert Gonzalez, Director, Bexar Cnty., Tex., Mental Health Dep't (Aug. 22, 2017).

396. *Id.*

397. *Id.*

398. *Id.*

399. *Id.*

400. *Id.*

8. *Douglas County, Kansas*

Douglas County, Kansas faces the problem of the criminalization of mental illness. The county has adopted a number of components similar to those of the CMHP in its fight against the criminalization of mental illness. Douglas County has provided CIT training to law enforcement officers throughout the county.⁴⁰¹ The county and municipal courts in Lawrence, Kansas have developed a mental health diversion program that includes both pre-booking and post-booking diversion programs for misdemeanors.⁴⁰² As part of the post-booking diversion program, the county has created mental health courts.⁴⁰³ Finally, the county has a goal in the near future of creating a mental health crisis stabilization and treatment center.⁴⁰⁴

Douglas County's program is in its infancy and there are no statistics available concerning the success of the program at this time.⁴⁰⁵ However, the county is unique in that it has hired a special consultant from the academic community, Margaret E. Severson, to help with the creation of its program.⁴⁰⁶ Ms. Severson is a professor at the University of Kansas and has studied mental illness in the court systems for many years.⁴⁰⁷ Based on her studies, she recommended the current components for Douglas County's program.⁴⁰⁸ According to Professor Severson, she is "optimistic that the Douglas County program is a successful approach to combating the criminalization of mental illness and that in the future the statistics will provide proof of this successful approach."⁴⁰⁹

9. *Los Angeles County, California*

In 2015, Los Angeles County, California, instituted a mental health diversion program to help reduce the number of individuals suffering from SMI who are housed in the county jail.⁴¹⁰ Los Angeles County currently has over 16,000 inmates housed in its jail system, which ranks as one of the largest in the United States.⁴¹¹ Roughly 4,000 of those inmates suffer from SMI.⁴¹²

The mental health diversion program, which is called the Office of Diversion and Reentry, is headed by retired Superior Court Judge Peter Espinoza.⁴¹³ In

401. Rick Cagan, *Mental Illness & Jails*, JUST. MATTERS IN KAN., http://www.justicemattersinkansas.org/mental_illness_jails (last visited on Sept. 9, 2018).

402. *Id.*

403. *Id.*

404. *Id.*

405. Telephone Interview with Margaret E. Severson, Professor, Univ. of Kan. (Feb. 17, 2017).

406. *Id.*

407. *Id.*

408. *Id.*

409. *Id.*

410. Telephone Interview with Peter Espinoza, Director, Los Angeles Cnty. Office of Diversion and Reentry.

411. *Id.*

412. *Id.*

413. *Id.*

addition to the fact that key roles are played by judges in both the CMHP and the Office of Diversion and Reentry, the Los Angeles County program shares a number of other characteristics with those of the CMHP. First, the Los Angeles County program has a pre-booking diversion program which includes CIT training for law enforcement and four urgent care centers to provide mental health services to those diverted.⁴¹⁴ In addition, the program has a post-booking diversion program which consists of a misdemeanor diversion program that aims to place those diverted in community based treatment.⁴¹⁵ Finally, the program consists of a pre-trial felony diversion program which currently provides 1,000 beds for those experiencing mental health and co-occurring substance abuse issues.⁴¹⁶

According to Judge Espinoza, the program has been in place for a year and “we are starting to see some success.”⁴¹⁷ Currently, there are no concrete statistics available for the pre-booking diversion program due to the number of agencies involved and the age of the program.⁴¹⁸ However, at least 291 inmates have been diverted from the county jail to community-based treatment through the misdemeanor diversion program and eighty percent of the individuals have successfully completed or continue to receive services.⁴¹⁹ In addition, 127 individuals have been diverted through the felony diversion for case management services and 209 have been placed in the community re-entry program.⁴²⁰

Judge Espinoza is very optimistic that the program will be successful.⁴²¹ According to Espinoza, “we are already seeing positive results even though the program is just in its inception.”⁴²² “However, the success of the program will ultimately be based on the development of resources to provide resources to those suffering from severe mental illness within the county.”⁴²³

10. *Lee County, Florida*

Lee County, Florida suffers from the effects of the criminalization of mental illness like many other areas.⁴²⁴ Lee County has implemented some of the major components of the CMHP.⁴²⁵ There has been CIT training in the county since 2005.⁴²⁶ Eighty percent of Ft. Meyers police officers, forty percent of Cape Coral

414. *Id.*

415. *Id.*

416. *Id.*

417. *Id.*

418. *Id.*

419. *Id.*

420. *Id.*

421. *Id.*

422. *Id.*

423. *Id.*

424. Telephone Interview with Belinda Smith, Administrative Services Coordinator for Specialty Courts, Lee Cnty., Fla. (Aug. 22, 2017).

425. *Id.*

426. *Id.*

police officers, twenty-five percent of the deputies at the Lee County Sheriff's Office, and five percent of the county's correctional officers have been trained.⁴²⁷ Similar to the CMHP, the county uses the CIT training to divert individuals to a triage center which was started in 2008.⁴²⁸

The main component of mental health diversion is managed through the mental health courts in Lee County.⁴²⁹ The court handles both misdemeanor and felony cases.⁴³⁰ The court diverts about seventy percent of the participants while thirty percent enter pleas and are placed on probation or community control.⁴³¹ Seventy-two percent of the participants graduate from the program and, of those graduates, only six percent reoffend within a year of graduation.⁴³² Those in the program tend to be those with higher risks of reoffending and have greater mental health needs.⁴³³ Lower level offenders are diverted through the triage center.⁴³⁴ The county utilizes the SOAR program.⁴³⁵ Thus, Lee County has been successful in its use and implementation of the mental health diversion programs.

D. Conclusion of Jurisdictional Study

Jurisdictions and areas across the country suffer from the criminalization of mental illness. Some of these jurisdictions have been proactive by developing programs to combat the criminalization of mental illness. At least fifteen different jurisdictions have visited the CMHP to gain ideas and most have implemented programs based on some of those ideas. Reports from the previously identified jurisdictions indicate that these implemented programs have been a success. They also provide examples of how different areas have been creative due to financial limitations in combating the criminalization of mental illness. They also provide a good framework of ideas for other jurisdictions trying to implement similar programs. In all, the research described in this thesis indicates that the CMHP has had a positive influence on other jurisdictions and that other jurisdictions are finding success in implementing parts of the CMHP or utilizing similar components to those of the CMHP.

V. THE NEED FOR IMPROVEMENT

Programs like the CMHP have been tremendously successful. However, programs like these also have weaknesses. First, programs like the CMHP do not address every issue that the communities and court systems face in regard to the

427. *Id.*

428. *Id.*

429. *Id.*

430. *Id.*

431. *Id.*

432. *Id.*

433. *Id.*

434. *Id.*

435. *Id.*

criminalization of mental illness. This is often the case because there is a lack of legislation to adequately address mental health issues in the court system and the community. Further, in order for programs like the CMHP to operate effectively, they must be adequately funded. Many communities do not have the resources to effectively run programs like the CMHP and thus, they are not as successful. The lack of funding and effective legislation are two of the major issues cited by all jurisdictions dealing with the issue of the criminalization of mental illness.

A. The Need for More Legislation

1. Legislative Help for Court Systems

The CMHP and other similar programs have been extremely successful. But even with their success, the CMHP and other similar programs do not adequately address every issue and cannot solve every problem relating to the criminalization of mental illness. A major weakness is the lack of legislation to help court systems and communities battle this problem.

One of the major problems facing courts is the lack of legal remedies to help alleviate the problems associated with the criminalization of mental illness. In most cases, it is the lower courts that deal with the problems of criminalization of mental illness. The reason for this is that these courts are usually the courts that are assigned or have jurisdiction over misdemeanor-type cases. The problem arises because most states will not allow a county court judge presiding over misdemeanor cases to order an involuntary forensic commitment. As a result, the defendant is normally released from custody as soon as he is found incompetent to proceed only to be repeatedly recycled through the court system after each arrest.

In Florida, for example, the Florida Supreme Court has held that a judge cannot order a defendant charged with a misdemeanor in a criminal case to be involuntarily committed to a forensic mental health facility.⁴³⁶ In *Onwu v. State*, a county court judge presiding over a misdemeanor case ordered a mental evaluation of the defendant to determine his competency to proceed in the criminal case.⁴³⁷ After receiving the competency evaluations, the defendant was found to be incompetent to proceed.⁴³⁸ As a result, the judge moved to initiate proceedings in order to involuntarily commit the defendant to a state forensic mental health facility.⁴³⁹ The defendant challenged the judge's authority claiming that under chapter 916, Florida Statutes, only a circuit court judge has the authority to involuntarily commit the defendant to a state forensic mental health facility.⁴⁴⁰

436. *Onwu v. State*, 692 So. 2d 881, 883 (Fla. 1997).

437. *Id.* at 882.

438. *Id.*

439. *Id.*

440. *Id.*

The Florida Supreme Court held that the county court judge did not have the authority to commit the defendant to a state forensic mental health facility.⁴⁴¹ The court relied on the statutory language which provides that only a circuit court judge can make the necessary findings to order a forensic commitment.⁴⁴² As a result, the court reasoned that a judge did not have the authority to order an involuntary forensic commitment in a misdemeanor case.⁴⁴³

Most states follow the same approach as provided for in Florida law and do not allow forensic commitment in misdemeanor cases.⁴⁴⁴ As argued in *Onwu*, the main reason for this is that there is usually a shortage of bed space in state forensic facilities and a forensic commitment of misdemeanants would only exacerbate the situation.⁴⁴⁵ Due to the lack of bed space, the states are concerned with the fiscal impact of flooding the forensic hospitals with misdemeanants.⁴⁴⁶ However, as the court noted in *Onwu*, it only takes the legislature to amend the statute or draft new legislation that would allow misdemeanants to be committed to forensic hospitals.⁴⁴⁷

The Florida legislature has recently passed legislation that will help county courts combat the criminalization of mental illness. The amended portions fall under the civil mental health laws commonly called Baker Act proceedings. In particular, the legislature recently amended statutory provisions that allow a criminal county court judge to make an ex-parte order requiring an involuntary examination if the judge believes the person is suffering from mental illness.⁴⁴⁸ Further, under Fla. Stat. § 394.4655, a criminal county court judge can now order the individual to involuntary outpatient treatment services.⁴⁴⁹ However, the statutes still will not allow the criminal county court judge to order and require involuntary inpatient placement.⁴⁵⁰

These amended provisions do not address the problem discussed in the *Onwu* decision. However, they do provide a tool for criminal county court judges when facing mental health issues in their courts. In particular, in the event that a defendant is found incompetent to proceed, rather than just releasing the defendant, the county court judge could enter an order under Fla. Stat. § 394.4655 requiring an involuntary mental health examination and if appropriate, could order outpatient treatment. Although not perfect, this provides a significant tool for a criminal

441. *Id.* at 883.

442. *Id.*

443. *Id.*

444. See Symposium: *The Criminal Defense Lawyer's Fiduciary Duty to Clients With Mental Disability*, 68 *FORDHAM L. REV.* 1581, 1624 (2000).

445. *Onwu*, 692 So. 2d at 882.

446. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Apr. 28, 2017).

447. *Onwu*, 692 So. 2d at 883.

448. FLA. STAT. § 394.463(2)(a)(1) (2016).

449. FLA. STAT. § 394.4655(2) (2016) (stating that “a person may be ordered to involuntary outpatient services” by the court if the person is at 18 years old, has a mental illness, is unlikely to survive safely in the community without supervision, and has a history of lack of compliance with treatment for their mental illness).

450. FLA. STAT. § 394.467 (2016); FLA. STAT. § 394.455(10) (2016).

county court judge that did not previously exist. Further, these types of legislation can be a model for other jurisdictions to follow.

2. *Legislation for Communities at Large*

The National Alliance for Mental Illness (“NAMI”) recently “warned the U.S. Senate Judiciary Committee that the criminalization of people living with mental illnesses has reached crisis proportions and called for support of federal, state, and local reforms to overcome failings in both the mental health care and criminal justice systems.”⁴⁵¹ NAMI has urged for more legislation to help in the fight against the criminalization of mental illness.⁴⁵² In particular, NAMI supports bills like the Mental Health and Safe Communities Act, introduced by Senator John Cornyn of Texas, and similar bills that would help in combating the criminalization of the mentally ill.⁴⁵³

Bills like the Mental Health and Safe Communities Act are essential in solving the problem of criminalizing the mentally ill.⁴⁵⁴ If passed, the Mental Health and Safe Communities Act will provide more funding for mental health care especially in the area of the criminal justice system.⁴⁵⁵ It will provide for the collection of data concerning the role of mental illness in homicides.⁴⁵⁶ Also, it will provide funding for training of law enforcement officers in active shooter scenarios especially when dealing with those that have mental illnesses.⁴⁵⁷ Finally, it will correct errors in background checks and qualifications for gun ownership in order to keep those with severe mental illnesses from owning guns.⁴⁵⁸

These are just examples of current legislation that will help both the court systems and communities combat the criminalization of mental illness. It is clear that this type of legislation will help fill in gaps that cannot otherwise be handled by programs such as the CMHP. It is also evident that these types of legislative helps will be very successful in alleviating the problems associated with the criminalization of mental illness.

451. Press Release, National Alliance for Mental Illness, NAMI Warns Senate about Criminalization of Mental Illness; Supports Cornyn Bill (Feb. 2016), <https://www.nami.org/Press-Media/Press-Releases/2016/NAMI-Warns-Senate-about-Criminalization-of-Mental>.

452. *Id.*

453. *Id.* In February 2016, NAMI Senior Policy Advisor Ronald S. Honberg presented NAMI’s support of the Mental Health and Safe Communities Act, introduced by Senator John Cornyn of Texas, before the Senate Judiciary Committee.

454. Mental Health and Safe Communities Act of 2015, S. 2002, 114th Cong. (2015).

455. *Id.* at § 105(a)(2)(A)-(B); see also Sarah Trumble, *Mental Health and Safe Communities Act: The Good, the Bad, and the Fixable*, THIRD WAY (Oct. 30, 2015), <http://www.thirdway.org/memo/mental-health-and-safe-communities-act-the-good-the-bad-and-the-fixable>.

456. Mental Health and Safe Communities Act of 2015, S. 2002, 114th Cong. § 2992(c)(6) (2015).

457. *Id.* at § 2992(c).

458. *Id.* at § 305(1) (correcting system errors that previously prevented individuals from purchasing a firearm); see also Sarah Orick, *Guns and Mental Health*, CONG. DIGEST (Apr. 9, 2016), <http://congressionaldigest.com/guns-and-mental-health/>.

B. Lack of Funding

The CMHP is an incredible program. However, many communities cannot establish such a program or even parts of the program because of a lack of resources. The monetary limitations keep most communities from experiencing the type of success that has been experienced by Miami-Dade County.

The CMHP initially started its program with a \$50,000 grant and later secured a \$300,000 federal grant to help build its program.⁴⁵⁹ However, the CMHP now spends nearly \$1.2 million each year on its program.⁴⁶⁰ In addition, Miami-Dade County is in the process of building a dedicated mental health diversion facility which will cost taxpayers over \$40 million.⁴⁶¹

Funds such as those spent by Miami-Dade County are not always available to other counties. Many counties resort to grants and other government aids in order to institute mental health programs that work with the criminal justice system. Many communities do not even have a dedicated facility or funds for treatment programs in order to divert individuals with SMI out of the criminal justice system. Thus, funding is a major issue for smaller communities.

Larger communities are not immune to the problem of limited funding. Los Angeles County has based the success of its program on the development of resources.⁴⁶² Bexar County, which promotes one of the best mental illness diversion programs in the country, faces funding issues. Officials in Bexar County noted that with budget cuts, the lack of resources makes it hard to service individuals with SMI in the criminal justice system.⁴⁶³ Thus, funding of mental health diversion programs is an issue for counties both large and small.

However, some jurisdictions are learning how to cope with less funding. For example, in Florida's Seventh Judicial Circuit, SMA Behavioral, which is the mental health provider for the circuit, has begun to develop pilot programs using grant money.⁴⁶⁴ Currently, they are using grant money to create crisis treatment units in the circuit's smaller counties to service individuals with episodes of severe mental illness.⁴⁶⁵ In addition, they have started a FACT program with non-recurring state funds to identify, target and service individuals in the circuit with a history of severe mental illness.⁴⁶⁶ It is the hope of SMA to continue to build programs and services with grant money in order to fund necessary programs. Other jurisdictions

459. Telephone Interview with Tim Coffey, Coordinator, Eleventh Judicial Circuit Mental Health Project (Apr. 28, 2017).

460. CMHP STATISTICS AND OUTCOMES, *supra* note 176, at 5.

461. Ovalle, *supra* note 257.

462. See *Jail Diversion Program*, *supra* note 324.

463. Matt Clarke, *Bexar County, Texas Fails to Properly Evaluate Mentally Ill Jail Prisoners*, PRISON LEGAL NEWS (Apr. 15, 2011), <https://www.prisonlegalnews.org/news/2011/apr/15/bexar-county-texas-fails-to-properly-evaluate-mentally-ill-jail-prisoners>.

464. Telephone Interview with Ivan Cosimi, CEO, SMA Behavioral Healthcare (Apr. 26, 2017).

465. *Id.*

466. *Id.*

could follow these examples to help build programs to service those with severe mental illness.

VI. JUDICIAL INTERVENTION AND COMMUNITY SUPPORT

The criminalization of mental illness is a real problem in our country. It is important that communities and their stakeholders come together to solve this problem. Judges seem to be the catalysts in raising community awareness of this issue and helping coordinate efforts in counties, states, and throughout the country. The majority of programs researched and cited above include participation by a representative of the judiciary as a key component of the program's success. It seems that the judiciary has a unique way of bringing attention to the problem of the criminalization of mental illness. As one judge stated, "When I was a public defender trying to address this problem, I called a meeting of all the key stakeholders, and no one came. When I became a judge, I called the same meeting. Everyone was five minutes early."⁴⁶⁷

Two programs or organizations which have been developed through coordinated efforts of judges have helped to bring attention to and help solve the problem of the criminalization of mental illness. The first of these is the Judges Criminal Justice/Mental Health Leadership Initiative. The second is the Stepping Up Initiative. Both programs have been instrumental in educating and helping solve the problem of the criminalization of mental illness.

A. *Judges Criminal Justice and Mental Health Leadership Initiative*

The Judges Leadership Initiative ("JLI") was founded to help harness the leadership skills of the judiciary in order to combat the criminalization of mental illness.⁴⁶⁸ The organization is funded by the JEHT Foundation, the United States Department of Justice and the United States Department of Health and Human Services Administration, and Center for Mental Health Services.⁴⁶⁹ The goal of the JLI is to support and enhance the efforts of judges who have already taken leadership roles in their communities fighting against the criminalization of mental illness.⁴⁷⁰ In addition, the goal is to promote leadership among more judges that will improve the response to people with mental illnesses that are in the criminal justice system.⁴⁷¹ This is done by providing activities and resources to judges who wish to participate. Thus far, the JLI has provided help in addressing 400 to 500 issues that deal with mental health in the criminal justice system.⁴⁷²

467. *Judges' Criminal Justice/ Mental Health Leadership Initiative* (Sept. 6, 2018), <https://www.bja.gov/publications/jli.pdf>.

468. *Id.*

469. *Id.*

470. *Id.*

471. *Id.*

472. Telephone Interview with Steven Leifman, Associate Administrative Judge, Eleventh Judicial Circuit of Florida (Oct. 19, 2017).

The JLI, led by one its co-founders and chairpersons, Judge Leifman, has recently partnered with Psychiatric Leadership Group to form the Judges and Psychiatrist's Leadership Initiative ("JPLI").⁴⁷³ The goal of the JPLI is to stimulate, support, and enhance efforts by judges and psychiatrists to improve judicial, community, and systemic responses to people with behavioral health needs who are involved in the justice system.⁴⁷⁴ This is done by creating a community of judges and psychiatrists through web-based and in-person training.⁴⁷⁵ In addition, the JPLI seeks to increase the reach of trainings in order to build the non-clinical skills of court professionals which will help improve individual and public safety outcomes.⁴⁷⁶ For example, the JLI recently provided training to effectively identify and manage individuals with mental illnesses within the Illinois court system.⁴⁷⁷ Finally, the JPLI's goal is to develop educational resources to increase judges' and psychiatrists' understanding of the latest research and best practices for people with mental illnesses involved in the justice system.⁴⁷⁸

B. Stepping Up Initiative

In 2015, the National Association of Counties, the Council of State Governments Justice Center, and the American Psychiatric Association Foundation launched the Stepping Up Initiative.⁴⁷⁹ The goal of the Stepping Up Initiative is to advance counties' efforts in reducing the number of adults with mental illnesses and co-occurring substance abuse disorders in jails.⁴⁸⁰ As part of this, elected officials of counties are being called upon to pass a resolution and "work with other leaders (e.g., the sheriff, judges, district attorney, treatment providers, and state and local policymakers), people with mental illnesses and their advocates, and other stakeholders to reduce the number of people with mental illnesses in jails."⁴⁸¹

As part of this resolution, the counties' stakeholders are asked to take the following six actions. First, convene or draw on a diverse team of leaders and decision makers from multiple agencies committed to safely reducing the number of people with mental illnesses in jails. Second, collect and review prevalence numbers and assess individuals' needs to better identify adults entering jails with mental

473. *Judges' and Psychiatrists' Leadership Initiative*, JUST. CTR.: COUNCIL OF ST. GOV'TS, <https://csgjusticecenter.org/courts/judges-leadership-initiative/> (last visited Sept. 6, 2018).

474. *Id.*

475. *Id.*

476. *Id.*

477. *Judges and Psychiatrists Partner to Deliver Training in Illinois on Individuals with Mental Illnesses in the Courts*, JUST. CTR.: COUNCIL OF ST. GOV'TS (June 29, 2011), <https://csgjusticecenter.org/cp/posts/judges-and-psychiatrists-partner-to-deliver-training-in-illinois-on-individuals-with-mental-illnesses-in-the-courts/>

478. *Judges' and Psychiatrists' Leadership Initiative*, *supra* note 473.

479. Nastassia Walsh, *The Stepping Up Initiative Overview*, NAT'L ASS'N OF COUNTIES, <http://www.naco.org/resources/programs-and-services/stepping-initiative> (last visited Sept. 6, 2018).

480. *Id.*

481. *Id.*

illnesses and their recidivism risk and use that baseline information to guide decision making at the system, program, and case levels. Third, examine treatment and service capacity to determine which programs and services are available in the county for people with mental illnesses and co-occurring substance use disorders. Then, identify state and local policy and funding barriers to minimize contact with the justice system and providing treatment and supports in the community. Fourth, develop a plan with measurable outcomes that draws on the jail assessment and prevalence data and the examination of available treatment and service capacity while considering identified barriers. Fifth, implement research-based approaches that advance the plan. Finally, create a process to track progress using data and information systems and to report on successes.

The Initiative has been very successful in that over 360 counties nationwide have adopted the resolution. A summit was held in 2016 to help refine strategies to implement the six-step plan. Further, the initiative is providing resources to counties in order to help them reduce their jail populations of those with mental illnesses and co-occurring substance abuse orders.

CONCLUSION

The CMHP has enjoyed tremendous success in its fight against the criminalization of mental illness. This is evident not only from the numerous statistics showing its success but also from the lives it has touched and the placement of individuals on the successful road to recovery. The CMHP has been nationally recognized and it is a model that has been followed by other jurisdictions and communities. These communities and jurisdictions have experienced successes the CMHP. The CMHP and other similar programs have provided a catalyst for other judges and community leaders to form national programs to combat the criminalization of mental illness like the Judges Leadership Initiative and the Stepping Up Initiative.

The only weakness is that the CMHP does not address every issue that encompasses the criminalization of mental illness. As a result, legislation is needed to address the problems of the criminalization of mental illness in the court systems and in communities. In addition, many communities lack the funding to experience the success of the CHMP. It is important for these jurisdictions to have proper funding or become creative in their use of funds. However, in light of these weaknesses, the CMHP is still the gold standard in providing an effective solution to the problem of criminalizing the mentally ill.