



How Have States Addressed Behavioral Health Needs through the Justice Reinvestment Initiative?

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Millions of people in the US live with behavioral health¹ (BH) disorders that often go untreated (SAMHSA 2019b), a problem that is particularly prevalent in the criminal justice system (Osher et al. 2012). To address this, states participating in the Justice Reinvestment Initiative (JRI) have drawn on emerging evidence about successful interventions to improve outcomes for people and communities, often by establishing cross-sector collaborations between BH and criminal justice systems. In this brief, we describe what JRI has revealed about how people with BH disorders interact with the criminal justice system.² We also highlight state strategies for better identifying and responding to people with BH disorders.

The Intersection of Behavioral Health and Criminal Justice

Communities are grappling with a range of pervasive behavioral health disorders, including opioid use disorders, methamphetamine use, and serious mental illness (SMI).³ In 2018, approximately 19 percent of US adults had any mental illness (AMI); this group included 5 percent of all adults with an SMI. In addition, 8 percent of adults had a substance use disorder (SUD) and 4 percent had a co-occurring AMI and SUD. Despite these rates, comprehensive community care is lacking and relatively few people access treatment. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2018, approximately 43 percent of adults with AMI, 18 percent with a SUD, and 10 percent with a co-occurring AMI and SUD accessed treatment (SAMHSA 2019b).⁴

People affected by BH disorders are overrepresented in the criminal justice system.⁵ The Department of Justice most recently reported that 51 percent of people in prison and 71 percent of people in jail have or have had a mental health problem (Bronson and Berzofsky 2017).⁶ Moreover, 58 percent of people serving state prison sentences and 63 percent of people serving jail sentences met the criteria for drug dependence or abuse (Bronson et al. 2017).⁷

The criminal justice system is ill-equipped to address BH needs, creating a “revolving-door” phenomenon whereby people with BH disorders cycle in and out of the system. Corrections institutions are often understaffed, underfunded, and lack expertise in behavioral health (Osher et al. 2012; SAMHSA 2019a). Moreover, corrections environments are generally not conducive to effective treatment, resulting in inadequate care, unaddressed needs, and poor linkages to community treatment. People with BH disorders often face worsening conditions while incarcerated and are not meaningfully connected with appropriate services upon release, increasing their risk of reincarceration, emergency-room use, and hospitalization (SAMHSA 2019a).

Research shows that effective supervision and evidence-based BH treatment can reduce recidivism. Moreover, research suggests that combining evidence-based treatment with practices that address criminogenic risk factors reduces recidivism more effectively than mental health treatment alone (Matejkowski et al. 2011; Skeem, Steadman, and Manchak 2015). Many jurisdictions are learning from this evidence and incorporating new practices to better address justice-involved people with BH disorders.

Systemic Behavioral Health Challenges Identified through JRI

Many states and localities—including jurisdictions participating in JRI—have worked to better address their communities’ behavioral health needs. Funded through a public-private partnership between the Bureau of Justice Assistance and Pew Charitable Trusts, JRI is a data-driven, consensus-based approach to justice system improvement that provides a framework for managing corrections and supervision populations more effectively and cost-efficiently. Each state participating in JRI convenes an interbranch workgroup; analyzes criminal justice data; and develops a tailored policy package to reduce recidivism, improve public safety and return on investment, and better align its justice system with research on best practice (Harvell et al., forthcoming).

Most states that have engaged in JRI identified challenges at the intersection of BH and criminal justice, including the following:

- a lack of effective community-based treatment options that could help people avoid justice-system involvement or access services upon release
- a large (and growing) number of prison beds occupied by people with less serious drug or property convictions likely related to underlying SUDs

- high recidivism among people affected by BH disorders, driven largely by revocation from community supervision

Through JRI data analysis, states learned about the unaddressed needs of people in their communities affected by BH disorders. Examples include the following:

- **Missouri** found that 35 percent of people admitted to prison were admitted to receive addiction treatment. This has been a growing issue in Missouri, particularly among women (CSG 2018a).
- **Nevada** found that 73 percent of people who violated probation or parole had a BH need and that 44 percent of reviewed violations—like failing to complete treatment or failing a drug test—were related to a SUD (ACAJ 2019).
- **North Dakota** found that 70 percent of surveyed judges reported sentencing people to prison to connect them with BH treatment (CSG 2017c).
- **Wyoming** found that although 86 percent of people on probation or parole had a BH need, only 57 percent with an identified need accessed treatment (Adu-Num et al. 2018).

BOX 1

Methodology

The Urban Institute reviewed documents to identify which states engaged in JRI passed policies impacting people with BH disorders. We reviewed policy briefs and memos from technical assistance providers; media reports from JRI engagements; JRI legislation; and state agency reports on the development, implementation, and impact of JRI policies. We also consulted with technical assistance providers to understand implementation progress, challenges, and examples of key successes. Finally, we collected data on outcomes including savings, reinvestment, and sizes of prison and community supervision populations from publicly available documents, technical assistance providers, and stakeholders.

The following sections discuss strategies states engaged with JRI have used to improve outcomes for people affected by BH disorders, as well as implementation-related challenges and innovations.

Improved Responses to Behavioral Health through JRI

After identifying systemic challenges, many states engaged in JRI codified and implemented strategies to improve system responses to justice-involved people with BH disorders. Many strategies involved specific intervention points throughout the system (figure 1), whereas others aimed to build systemwide capacity. The sections that follow elaborate on these strategies, which we divide into three core areas:

- **improved identification** of people with BH disorders and resources for serving them
- **enhanced diversion mechanisms** to prevent deeper system involvement for people with BH disorders
- **expanded treatment and improved supervision practices** to promote quality treatment programs and evidence-based practices

Improved Identification

To better assist people with BH disorders, states must first identify the BH needs of people in their criminal justice systems and the capacity of their system to respond to those needs. The following are strategies states have used to accomplish this.

REQUIRING STATEWIDE GAP ANALYSES

Some states use gap analyses to assess their systems by documenting the prevalence of people with BH needs and the availability of BH services. Since 2016, Idaho has conducted an annual gap analysis and published a joint report by its Department of Correction and Department of Health and Welfare to examine treatment needs among people on community supervision and identify funding gaps preventing the state from meeting those needs (IDOC and IDHW 2019). Moreover, Maryland's 2016 gap and needs analysis included a study on the prevalence of BH disorders among people in jails and prisons, and on probation and parole, as well as a feasibility study on local jails' and service providers' capacity to administer treatment (GOCCP 2016).

INITIATING DATA LINKING

Linking data within the justice system and between the justice and BH systems can reduce duplicate efforts and improve care coordination. Oregon worked to link state health agency data with jail data to identify the relatively few people with the greatest BH needs who accounted for a significant proportion of criminal justice and hospital bookings (Allen and Warney 2019). Similarly, Wyoming's Department of Corrections and Department of Health jointly examined the overlap between the supervision population and people accessing treatment, revealing when and where treatment occurred (Adu-Num et al. 2018).

ADOPTING OR EXPANDING SCREENING AND ASSESSMENT

Many states have adopted specialized BH screening or assessment practices to identify people's BH needs and determine appropriate services and treatment. Maryland encouraged judges to order presentencing drug and mental health assessments to inform sentencing.⁸ Rhode Island required the Division of Rehabilitative Services adopt validated BH assessments to inform treatment and case management plans for people on community supervision (CSG 2018b).⁹

BOX 2

Improved Identification in Oklahoma

In its 2012 JRI legislation, Oklahoma made a criminogenic risk assessment, mental health screening, and substance use screening available before sentencing to inform decisions about sentencing, treatment, and supervision.

The Oklahoma Department of Mental Health and Substance Abuse Services created the Offender Screening Program and expanded it with support from a JRI maximizing grant. Using validated screening instruments, certified treatment providers conduct criminogenic risk assessments and substance use and mental health screens for everyone charged with a felony in county jails. Based on these screenings, referral recommendations are made to link people with community-based alternatives that best meet people's needs and increase the likelihood of successful diversion from prison.

As of January 2019, the Offender Screening Program was available in most Oklahoma counties and nearly 30,000 people had been screened. Less than 18 percent of screened people had gone to prison as their final disposition. Moreover, Oklahoma reported that people were spending an average of 57 fewer days awaiting sentencing in jail, saving the state \$15.5 million. Meanwhile, counties that had not fully implemented the program had much higher rates of prison admissions for nonviolent offenses. The data gathered from the screenings helped the Department of Mental Health and Substance Abuse Services identify diversion opportunities and gaps in services, and subsequently informed investments in diversion and the statewide expansion of BH services.

Sources: Oklahoma H.B. 3052 (2012); "Oklahoma Justice Reinvestment Initiative Project," award no. 2015-ZB-BX-0001, Bureau of Justice Assistance, 2015; "Offender Screening Web System," ODMHSAS (Oklahoma Department of Mental Health and Substance Abuse Services), 2019; Communication with the ODMHSAS staff, November 2019.

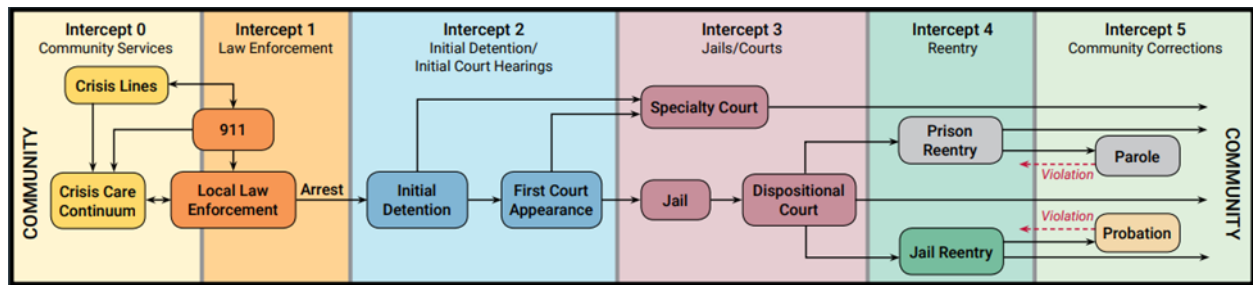
Enhanced Diversion Mechanisms

Recognizing that justice involvement often worsens outcomes for people affected by BH disorders, many states have used JRI to create or invest in diversion opportunities. Diversion can be used to prevent people from moving deeper into the justice system or from becoming justice involved altogether.

The Sequential Intercept Model (figure 1) helps jurisdictions understand how people with BH disorders move through the justice system, identify gaps and opportunities for addressing these people's needs, and strategically improve system responses (Munetz and Griffin 2006).¹⁰ Many strategies involve diverting people with BH disorders away from the system.

FIGURE 1

Understanding the Sequential Intercept Model



Source: “The Sequential Intercept Model,” Policy Research Associates, accessed January 1, 2020, <https://www.prainc.com/sim/>.

The following are mechanisms states engaged in JRI have used to redirect people with BH disorders to more appropriate interventions and responses.

NEW OR STRENGTHENED CRISIS CARE

Community service providers (“Intercept 0” in figure 1) have a critical opportunity to ensure the treatment needs of people affected by BH disorders are met before justice system involvement. Many states identified insufficient crisis care infrastructure as a factor contributing to growth in justice populations. To address its deficit, Arkansas established crisis stabilization units (CSUs) where people can access residential care staffed by medical personnel rather than be sent to jail (box 3).¹¹

ALTERNATIVES FOR LAW ENFORCEMENT

Law enforcement officers (“Intercept 1” in figure 1) often respond first to people experiencing behavioral health crises and play a critical role in identifying and connecting people to appropriate services. Some states, including Arkansas and Nevada, have adopted crisis intervention team (CIT) training and standards to help officers recognize and appropriately respond to people affected by BH disorders (box 4 elaborates on Arkansas’s implementation).¹² Moreover, Rhode Island gave officers discretion to release and refer people with serious mental health needs to outpatient treatment or inpatient facilities.¹³

MODIFIED PENALTIES

Many states engaged in JRI have modified sentencing policies to divert some people with less serious offenses from incarceration (“Intercept 2” in figure 1).¹⁴ Noting that many who commit less serious offenses have untreated BH disorders, states have prioritized prison space for people convicted of serious and violent offenses. Some JRI states have accomplished this by establishing or expanding presumptive probation, whereby people with certain offenses must receive probation rather than a prison sentence. To reduce unnecessary incarceration and free up resources for evidence-based treatment and supervision, South Dakota established presumptive probation for its two least serious felony classes and reclassified some more serious offenses into these categories (Elderbroom et al. 2016). Other states revised penalty structures for certain drug and property offenses. Louisiana’s

penalty structure inadequately distinguished addiction-driven drug offenses from commercial drug offenses, which it addressed by downgrading certain low-level drug offenses (DPS&C and LCLE 22019; Louisiana Justice Reinvestment Task Force 2017).

NEW OR EXPANDED COURT DIVERSION OPTIONS

Some states expanded judges' diversion options by authorizing them to account for people's BH needs and connect them with appropriate treatment ("Intercept 3" in figure 1). For instance, Nevada expanded opportunities to use SUD treatment in lieu of jail time and permitted judges to defer people's sentences while they complete drug treatment.¹⁵ Many states have also used JRI to establish, expand, and/or standardize drug and problem-solving courts. Georgia expanded accountability courts (e.g., drug and mental health courts) and participants' recidivism rates decreased (CVIG 2019).

BOX 3

Establishing Crisis Stabilization Units and Crisis Intervention Team Training in Arkansas

Arkansas's prison population grew by 31 percent between 2004 and 2015, prisons were at capacity, and people were increasingly held in county jails awaiting transfer to prison. Moreover, a lack of sanctioning options and inadequate community-based BH interventions fueled revocations from supervision (Legislative Criminal Justice Oversight Task Force 2016).

In 2017, Arkansas passed JRI legislation to establish crisis stabilization units and implement crisis intervention team training. CITs are partnerships between law enforcement, healthcare providers, and mental health professionals that help communities respond to people who commit nonviolent offenses while experiencing BH crises. The state also requires that police officers complete CIT training to learn how to divert people affected by BH disorders to CSUs rather than jails. New cadets receive 16 hours of CIT training, current officers receive 8 hours, and in agencies with at least 10 officers, one officer must receive a 40-hour training so they can train other officers and stakeholders (CSG 2017a). By September 2019, the two CSUs that opened in 2018 had received more than 2,600 total referrals and 1,600 total admissions. By November 2019, four 16-bed CSUs were operational and expected to provide care to approximately 4,800 people annually.

Sources: Criminal Justice Efficiency and Safety Act of 2017, Arkansas Act 423 (2017); "Arkansas Crisis Stabilization Units Are Keeping People Out of Jail," CSG Justice Center, September 24, 2019, <https://csgjusticecenter.org/jr/arkansas/posts/arkansas-crisis-stabilization-units-are-keeping-people-out-of-jail/>; Governor Asa Hutchinson, "Now Open: All 4 Arkansas CSUs," September 13, 2019, <https://governor.arkansas.gov/news-media/weekly-address/now-open-all-4-arkansas-csus/>.

Expanded Treatment and Improved Supervision Practices

Many states engaged in JRI found that their supervision agencies did not tailor supervision to people with BH disorders. As a result, some of these states have developed strategies to connect people to quality treatment postrelease, coordinate care better, and respond to BH-related violations more appropriately. Some states have also addressed treatment quality by, for example, creating standards for treating justice-involved people with BH disorders. The following sections provide strategies for strengthening supervision and implementing evidence-based practices.

IMPROVING CONTINUITY OF CARE AND FACILITATING LINKAGES

States have made transitioning from prison to the community easier in several ways. Nevada provides a 30-day supply of medication upon release to people who received medication while in prison and helps people preparing for release enroll in Medicaid and Medicare.¹⁶ Concurrently with JRI, Nebraska made it easier for justice-involved people to reactivate Medicaid postrelease by suspending rather than terminating assistance for people who are incarcerated.¹⁷

BOX 4

Supporting Reentry for People with SUD and Housing Needs in Omaha, Nebraska

Recognizing the lack of transitional housing and sober-living options for people on postrelease supervision, Nebraska's Administrative Office of Probation launched a transitional-living initiative for people convicted of specific less-serious offenses who have diagnosed BH disorders and are at high risk of reoffending. The office collaborated with the Nebraska Department of Correctional Services and Douglas County Corrections to establish Project Integrate, a program for people entering postrelease supervision in Douglas County. The state used a JRI maximizing grant to expand and fund transitional housing for people diagnosed with BH disorders who need stable, short-term supportive housing and services. By November 2019, more than 250 people had been referred to Project Integrate and 11 service providers had partnered with the Administrative Office of Probation to offer targeted housing and wraparound programming tailored to clients' needs.

Sources: "Nebraska Justice Reinvestment Initiative: Maximizing State Reforms," award no. 2016-ZB-BX-4014, Bureau of Justice Assistance, 2017; "Nebraska Probation: Transitional Living Initiative," Nebraska Judicial Branch Program and Project Quick Look, July 16, 2019; Communication with the Center for Effective Public Policy, July 2019.

EXPANDING TREATMENT

Many states expanded treatment for people on community supervision. North Carolina created Treatment for Effective Community Supervision, a program that includes substance use and cognitive-behavioral-intervention classes, housing, intensive outpatient treatment, and local reentry councils (Sentencing Commission 2018). Alabama created nonresidential day-reporting centers to help people on supervision better access BH treatment.¹⁸ North Dakota created Free Through Recovery, a program that provides care coordination, recovery services, and peer support (North Dakota Behavioral Health Division 2019). And West Virginia created the Treatment Supervision Program to provide outpatient services, peer recovery coaches, recovery residences, and other supports to people with SUD on community supervision (Warnberg and Harvell 2019).

ESTABLISHING STANDARDS OF CARE

Utah required that its Division of Substance Abuse and Mental Health collaborate with the Utah Department of Corrections and Utah Substance Abuse Advisory Council to establish standards for treating justice-involved people, including comprehensive services for addressing criminal-risk factors. Utah also required substance abuse and mental health treatment providers that treat justice-involved

people to become certified.¹⁹ As of November 2019, the state listed more than 190 justice-certified BH providers.²⁰

IMPROVING SYSTEM RESPONSES TO TECHNICAL VIOLATIONS

To reduce prison admissions owing to supervision revocations (which often occur for technical violations like failing drug tests), some states established alternative or graduated responses that sometimes address violations' underlying causes. To respond to and deter substance abuse–related violations and other technical violations, Nebraska's JRI legislation authorized revisions to its probation and parole departments' incentives and sanctions matrices and made custodial sanctions an alternative to formal revocation.²¹

BOX 5

Experimenting with Pay-for-Performance Models to Expand Treatment Services in Missouri

Missouri's prison population increased 6 percent between 2010 and 2015 and was projected to continue growing (CSG 2017b). Analysis revealed that 35 percent of people admitted to prison in Missouri in 2016 were sent specifically to receive SUD treatment (CSG 2018a). In its 2018 JRI legislation, the state spent \$5 million to create the Justice Reinvestment Treatment Pilot in three counties to expand community-based treatment for people on probation or parole who have BH disorders and are at moderate or high risk of reoffending. The pilots use a "pay for performance" model that incentivizes service providers to improve outcomes in five domains: treatment retention, client housing stability, client employment stability, number of substance-use related sanctions, and number of technical violations of supervision. In FY 2020, Missouri reinvested \$6 million to continue the three initial pilots and launch pilots in three expansion counties.

Sources: "Justice Reinvestment Initiative," Missouri Department of Corrections, accessed November 14, 2019; "Missouri's Justice Reinvestment Initiative," CSG Justice Center, presentation given November 2019, <https://dmh.mo.gov/sites/dmh/files/media/file/2019/01/mhc-meeting-justice-reinvestment-initiative-11082018.pdf>; Communication with the Council of State Governments Justice Center, December 2019.

Challenges and Innovations

Many JRI states improved how they identify and address the needs of justice-involved people affected by BH disorders, some by adopting a more cross-cutting approach. However, states improving system responses also faced challenges, including insufficient high-quality services inside and outside their justice systems and insufficient funding for treatment and services.

One issue states needed to creatively address was how to **treat people with BH disorders in rural areas**. Alabama and South Dakota, for example, faced challenges building rural networks of service providers. Alabama issued a request for proposals from service providers to deliver BH treatment to people on probation and parole in rural areas, but the response was minimal. Rather than issue another request, the state established day reporting center "lites," smaller centers in high-need rural areas

offering BH services out of probation offices.²² South Dakota recognized the importance of expanding treatment to rural areas, and its JRI oversight council supported a FY 2014 investment of \$13,500 for a rural telehealth SUD pilot program. The South Dakota Department of Social Services collaborated with key stakeholders to launch the pilot program, which provides videoconferencing (in lieu of in-person group SUD counseling programs) for up to 100 people on probation or parole living in rural areas. The program is now a permanent service (Shames and Subramanian 2016).²³

Funding treatment is also often difficult. Connecting uninsured people to appropriate community care—whether before or after justice involvement—can be particularly challenging. Through the Affordable Care Act, more than half of US states have opted to expand Medicaid eligibility,²⁴ which has enabled more justice-involved people to be covered postrelease and improved access to BH medication and treatment (Wachino and Artiga 2018). Although Medicaid cannot be used to provide healthcare in corrections facilities, Medicaid expansion increases opportunities for people leaving facilities to become insured (Antonisse et al. 2019; Wachino and Artiga 2018). Some states have leveraged Medicaid expansion as a funding source through JRI for people who need community-based treatment. West Virginia, for instance, used Medicaid to fund BH treatment and services for people on community supervision (Warnberg and Harvell 2019), and Massachusetts is piloting a public-private program informed by JRI policy recommendations and funded through Medicaid that will strengthen care coordination between the Massachusetts Department of Correction and community BH providers. In two Massachusetts counties, people with BH disorders in corrections facilities and on community supervision will receive individualized treatment plans and one-on-one support toward positive reentry outcomes.²⁵

Recognizing that discrete criminal justice interventions cannot address the needs of people affected by BH disorders alone, several JRI engagements are also taking a **cross-cutting approach to behavioral health**. For example, Oregon, the first state to explicitly approach JRI with a BH focus, sought to identify statewide behavioral health and recidivism-reduction strategies for making BH services more effective for justice-involved people.²⁶ The state's 32-person Behavioral Health Justice Reinvestment Steering Committee identified three key BH and justice system issues: gaps in the continuum of care, difficulties developing local alternatives to jail, and inconsistent information sharing.²⁷ As a result, Oregon established the IMPACTS (Improving People's Access to Community-Based Treatment, Supports, and Services) program to increase access to community-based supports and services, expand the BH service provider workforce, and provide permanent, supportive housing for people affected by BH disorders.²⁸ IMPACTS represents a commitment from local, regional, tribal, and state stakeholders to address people's BH needs and help them avoid justice involvement.

Conclusion

People with behavioral health disorders are disproportionately represented in the US justice system, which is often ill-equipped to meet their needs. The Justice Reinvestment Initiative has helped states examine the intersection of BH and criminal justice and adopt strategies to better address justice-involved people with BH disorders. Through JRI, states have improved at identifying people's BH needs

by conducting gap analyses, linking data systems, and strengthening screening and assessment practices. They have also focused on diversion by investing in crisis response, modifying sentencing structures, and implementing problem-solving courts. Moreover, they have expanded treatment and improved supervision by creating alternatives to revocation and strengthening communities' continua of care. These strategies have helped states target justice resources to reduce recidivism and maintain public safety.

Finally, as in Oregon, JRI is moving toward a cross-cutting approach to address the needs of justice-involved people with BH disorders. And beyond JRI, federal agencies are expanding resources at the intersection of criminal justice and behavioral health through programs like the Bureau of Justice Assistance's Comprehensive Opioid Abuse Program, Justice Mental Health Collaboration Program, and Police-Mental Health Collaboration (La Vigne et al., forthcoming).²⁹ These initiatives are important steps toward addressing the needs of the millions of people affected by BH disorders in the US.

Notes

- ¹ We use "behavioral health" to refer broadly to mental illnesses, substance use disorders, or the co-occurrence of the two.
- ² This brief is one of a series exploring topics related to the Justice Reinvestment Initiative. Learn more at <https://urbn.is/JRI>.
- ³ SAMHSA defines SMI as any mental, behavioral, or emotional disorder that substantially interferes with or limits one or more major life activities. Schizophrenia, bipolar illness, and major depressive disorder are most commonly associated with SMI, but other disorders may be considered SMIs if they result in functional impairment.
- ⁴ Per SAMHSA, "This survey excludes people with no fixed address (e.g., people who are homeless and not in shelters), military personnel on active duty, and residents of institutional group quarters, such as jails, nursing homes, mental institutions, and long-term care hospitals" (2019b, 5).
- ⁵ It is also important to note that most people with mental illnesses are not violent and do not commit crimes; "Criminal and Juvenile Justice," SAMHSA, accessed October 7, 2019, <https://www.samhsa.gov/criminal-juvenile-justice>.
- ⁶ Bronson and Berzofsky (2017) define "mental health problem" as meeting the criteria for serious psychological distress within the last 30 days. Estimates of mental health history are based on self-reported data. Totals are calculated by summing percentages of people with serious psychological distress and people with a history of a mental health problem.
- ⁷ Bronson and coauthors (2017) used the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) to define drug dependence/abuse.
- ⁸ Justice Reinvestment Act of 2016, Maryland S.B. 1005 (2016).
- ⁹ An Act Relating to Corrections, Rhode Island S. 2936 (2016).
- ¹⁰ "The Sequential Intercept Model: Advancing Community-Based Solutions for Justice-Involved People with Mental and Substance Use Disorders," Policy Research Associates, accessed December 19, 2019, <https://www.prainc.com/wp-content/uploads/2018/06/PRA-SIM-Letter-Paper-2018.pdf>.
- ¹¹ Criminal Justice Efficiency and Safety Act of 2017, Arkansas Act 423 (2017).
- ¹² Arkansas Act 423 (2017); Nevada A.B. 236 (2019).

- ¹³ An Act Relating to Courts and Civil Procedure, Rhode Island H. 5064 (2017).
- ¹⁴ See Harvell and coauthors (2016) for a full discussion.
- ¹⁵ Nevada A.B. 236 (2019).
- ¹⁶ Nevada A.B. 236 (2019).
- ¹⁷ Nebraska L.B. 605 (2015).
- ¹⁸ Communication with the Council of State Governments Justice Center, April 2018.
- ¹⁹ Criminal Justice Programs and Amendments, Utah H.B. 348 (2015).
- ²⁰ “Community Treatment Providers by City,” Utah Department of Human Services Substance Abuse and Mental Health, accessed December 13, 2019, <https://dsamh.utah.gov/pdf/jri/Judge's%20List%20by%20City1.pdf>.
- ²¹ Nebraska L.B. 605 (2015).
- ²² Communication with the Council of State Governments Justice Center, April 2018; *FY 2018 Annual Report*, State of Alabama Board of Pardons and Paroles, 2018.
- ²³ Communication with the Council of State Governments Justice Center, 2016
- ²⁴ Counts as of July 2019; “Overview of the Affordable Care Act and Medicaid,” Medicaid and CHIP Payment Access Committee, accessed on October 9, 2019, <https://www.macpac.gov/subtopic/overview-of-the-affordable-care-act-and-medicaid/>.
- ²⁵ “Behavioral Health Initiative Enhances Connection to Community-Based Supports for Individuals Involved with the Criminal Justice System,” last updated July 15, 2019, <https://www.mass.gov/news/behavioral-health-initiative-enhances-connection-to-community-based-supports-for-individuals>.; “Massachusetts Set to Launch Behavioral Health Pilot to Reduce Risk of Recidivism,” Council of State Governments Justice Center, last updated July 24, 2019, <https://csgjusticecenter.org/jr/massachusetts/posts/massachusetts-set-to-launch-behavioral-health-pilot-to-reduce-risk-of-recidivism/>.
- ²⁶ Information drawn from Oregon’s phase I letter of interest, submitted May 2015.
- ²⁷ Communication with Council of State Governments Justice Center 2019.
- ²⁸ Oregon S.B. 977 (2019).
- ²⁹ “DOJ FY 2020 Program Plan,” Bureau of Justice, accessed November 13, 2019, https://www.bja.gov/ProgramDetails.aspx?Program_ID=66; “Police-Mental Health Collaboration,” accessed November 13, 2019, <https://pmhctoolkit.bja.gov/>.

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