REPORT ON THE CURRENT STATUS OF SERVICES FOR PERSONS WITH MENTAL ILLNESS IN MAINE'S JAILS AND PRISONS

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Introduction

There are compelling national statistics about the numbers of persons with mental illness and those dually diagnosed with mental illness and substance abuse problems who are incarcerated. At mid-year 1998, there were an estimated 283,800 mentally ill offenders incarcerated in the nation's prisons and jails.[1] Inmates with mental illness and those dually diagnosed often have difficulty, because of their mental illness, adjusting to incarceration. They may be victimized by other prisoners because of the vulnerability caused by their illness or, they may commit repeated infractions of rules, and spend long periods of time in segregation units or maximum security settings. They are also placed in segregation units as a protection from other inmates. The result? Inmates with mental illness are disproportionately represented in most segregation units in the country.

In a system with little understanding of mental illness, limited mental health services, and a focus on security and punishment, not treatment, inmates with mental illness fare poorly. Sometimes they are placed in maximum-security seclusion simply because they are experiencing symptoms of their illness.[2] The lack of treatment for people with mental illness who are incarcerated and the impact of isolation and segregation on this vulnerable population, has placed many prisons across the nation under class action for violations of federal laws. The laws in question include the Americans with Disabilities Act (ADA), the Civil Rights of Institutionalized Persons Act (CRIPA), and the violation of the Constitutional protection against cruel and unusual punishment. The U.S. Department of Justice's Civil Rights Division investigates and litigates institutional reform cases. Recently, this Department has entered into consent decrees covering 20 juvenile correctional facilities in Puerto Rico, 13 juvenile correctional facilities in Kentucky, all five mental retardation facilities in Tennessee, eight men's prisons in Michigan, and a number of jails throughout Mississippi.[3] In fact, in 1998, 21 states were under certified class action suits involving the issue of providing adequate mental health services for inmates.[4]

Maine Statistics

The Maine Inpatient Psychiatric Treatment Initiative: Civil and Forensic Final Report, indicates that between July of 1998 and June of 1999, 90 jail inmates were referred for AMHI placement. The report also notes that due to an inadequate number of forensic beds in Maine, the ability to serve jail inmates with mental illness is limited. The number of inmates requiring inpatient psychiatric treatment is generally higher in jails than in prisons due to the shorter stays and larger numbers of persons served. Therefore, each jail admission has the potential for mental illness and/or the risk of suicide. With Maine jails reporting 35,000 admissions each year and national estimates that 15% of those admissions will require specialized placement due to serious mental illness, there

[1] Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers, 7/1999

[2] Prison Madness: The mental helth crisis behind bars and what we must do about it. Kupers, T. 1999.

[3] www.usdoj.gov/crt/activity.html – Department of Justice website, 9/6/00

[4] Treatment of Offenders with Mental Illness; Ed. Robert Wettstein, The Guilford Press, 1998. Pg. 212.

may be over 5,000 jail inmates needing mental health treatment in any given year in our jails.[5]

The same report indicates that there are 1,700 prison inmates in Maine. National statistics tell us that 10%-16% (170-272) need mental health treatment and 1% (17) require specialized placement for serious mental illness. Complicating this picture is a 1997 evaluation of the State's Forensic Service which found that (l) Maine's forensic doctors had been using the wrong standard when evaluating hundreds of defendants (2) nationally, about 2% of defendants are found not guilty by reason of insanity, and (3) in Maine, the rate is about .05%., presumably because of the bias of the forensic service.[6] This means that persons with mental illness in Maine who have committed a crime while mentally ill, and whose mental illness is a cause of the crime, are more likely than those in other states to go to jail instead of treatment.

At the same time that the number of persons with mental illness are being incarcerated, mental health services in Maine's jails and prisons are known to be inadequate. The 2000 survey of mental health services in Maine's 15 jails showed that 9 had no psychiatric coverage at all, and 3 had only 1.5-3 hours of psychiatric coverage/week. Six jails had no social work/psychologist services. Only one jail in Maine had 40 hours of mental health coverage/week. The average number of hours of mental health coverage in Maine's jails was 9 hours/week. Ten jails in Maine had no nursing coverage.[7] Complicating this picture is the 1992 report which surveyed jails across the country, which reported that 40% of Maine's jails were holding people with mental illness without criminal charges.[8]

Increased Numbers; Increased Costs

Deinstitutionalization of persons with mental illness, tough on crime laws, three strikes and you're out, and the war on drugs have increased the prison population by 141% between 1983 and 1994. There are over 2,000,000 people in jail or prison in this country. Four new prisons open every month to house the growing number of men and women that we are convicting of crimes.[9] The Corrections Corporation of America, a for- profit corporation that contracts with states to run correctional institutions, has ranked among the top five performing companies on the New York Stock Exchange for the past 3 years. The corporation's revenue rose by 81% in 1995 alone. The U.S. Department of Justice admits that for every $100 million state legislatures spend on new prison construction, they are committing the taxpayers to spend $1.6 billion over the next three decades to operate the new facilities.[10] . Moreover, the average cost of keeping a state prisoner for a year in 1990 was $15,604; the average cost in 1995 was $22,000 per

[5] Maine Inpatient Treatment Initiative: Civil and Forensic, Final Report, 2/29/00, page 68-69
[6] Portland Press Herald "Report Faults Insanity Tests Done by State Because of Their Personal Beliefs. 3/21/97
[7] Ibid. page 70.
[8] Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals. Torrey, etal. Pubic Citizen's Health Research Group and the National Alliance for the Mentally Ill. 1992. Pg. 17.
[9] The Road to Return, video. Project R, Breaking the Cycle of Crime. Tulane University, New Orleans, L.A. 2000.
[10] Prison Madness, Kupers. Pg. 269.

year. In Maine in 1990, the Department of Corrections budget was $64,311,056. In 1999 it was $83,113,317.

Even though we are spending a great deal of money incarcerating our citizens, our money may not be not wisely spent. Recidivism rates are staggering. 90% of all prisoners will serve their full term and be released; 63% will return within 3 years of release; 80% of ex-prisoners with serious mental illness will be re-imprisoned.[11]

Legal Standards and Class Action

Correctional services are complicated by the legal standards that must be met when housing prisoners – especially those with mental illness. In fact federal law requires that once it is determined that an inmate has a serious mental disorder, a host of legal issues and mandates come into play. Three essential, constitutionally required factors must be in place:

- Adequate physical resources in terms of beds, treatment and program space and the like.
- Adequate human resources in terms of an appropriate number of properly trained or experienced personnel who can identify and treat the seriously mentally ill; and
- Access: that is, an inmate must be able to obtain admission to these physical and human resources within a reasonable time.

Failure to provide these things is an invitation to a lawsuit at significant cost and the needless suffering for those who are imprisoned. National accreditation guidelines published by the National Institute of Corrections and the National Commission on Correctional Health Care provide standards for mental health service systems inside prisons. These standards are also generally admissible in a lawsuit challenging mental health care.[12]

Supermaximum Security Prisons and Other Segregation Units Cause Psychotic Syndrome

As noted earlier, inmates with mental illness are over represented in our toughest prison settings. Symptoms of mental illness (i.e., delays in response time, paranoia, difficulty interpreting the actions of others, command hallucinations, and so on) can make complying with prison rules difficult. Because of rules violations, symptoms of mental illness, and vulnerability for harm from other prisoners, placement in the punishing environment of segregation can occur. Self-harm and suicidality also lead to segregation and isolation. Complicating the picture is a correctional staff that usually lacks training in mental illness and a prison system based in the belief that recalcitrance and outbursts are a reflection of manipulation and "badness" rather than a reflection of illness. Thus begins a vicious cycle of infractions, isolation, increased psychiatric symptoms, additional infractions, and additional time in isolation. As infractions can add days,

[11] Ibid. Pg. 87
[12] Treatment of Offenders with Mental Disorders. Ed. Robert Wettstein. Pgs. 221-223.

months, and years to one's sentence, people with mental illness may end up spending more time in prison or jail than others who committed similar crimes.

It's important to recognize that one of the difficulties faced by prison administrators and legislators is the dual mandate of treatment and custody of prisoners – especially as they pertain to inmates with mental illness. We expect removal of criminally violent and "insane" persons from society. Our laws, however, mandate the provision of adequate psychiatric treatment[13] and, because most prisoners will return to our communities, a hope of "correction" – or a return as law abiding citizens also exists. Because of new and successful treatments and an improved understanding of the impact of years of isolation and institutionalization, we now know that maximum-security settings and isolation for long periods of time actually *reduce* a person's ability to return safely to society. Given the fact that 90% of prisoners return to our communities and over one third recidivate – we are compelled to question the efficacy of our approach. There is a also a body of research about the impact of isolation, like that of supermaximum security prisons and other segregation units as follows:

- It is well established that sensory deprivation can produce major psychological effects on humans including perceptual distortions, visual, auditory, and olfactory illusions, vivid fantasies often accompanied by striking hallucinations, derealization experiences, and hyper- responsivity to external stimuli. In fact these symptoms are called a *prison induced syndrome* and are accompanied by cognitive impairment, massive free floating anxiety, extreme motor restlessness, emergence of primitive aggressive fantasies, often accompanied by fearful hallucinations, and a decreasing capacity to maintain observing, reality-testing ego functions. In some cases subjects develop overt psychosis – accompanied by persecutory delusions. Some subjects suffer a marked dissociative catatonic like stupor with mutism.[14]
- Studies show that the duration of confinement in isolation is a crucial variable, i.e., the longer the isolation, the more profound the symptoms.
- There is evidence that the person's psychological makeup has a direct affect on the impact of isolation. Although massive free floating anxiety seems to occur universally, as do simple hallucinations and loss of reality testing, prisoners who have been abused as children, those with chronic long-term mental illness, and those who have experienced psychosis in isolation units in the past are especially vulnerable to solitary confinement. In fact, it was found that inmates placed in solitary confinement at Pelican Bay (California's Supermaximum security prison – considered a model for the nation) included some of the most psychiatrically vulnerable of the inmate population.[15]
- Case law (the Madrid case), exists which calls this kind of treatment torture. The Court in that case found that if the particular conditions of confinement cause a serious mental illness, greatly exacerbate mental illness, or deprive inmates of

[13] Ibid. pgs. 2-3.
[14] If the Shu Fits: Cruel and Unusual Punishment at California's Pelican Bay State Prison. Vol. 45. Pg. 1109-1110.
[15] Ibid. pg. 1114-1115.

their sanity, then prison officials have deprived inmates of a basic necessity of human existence, they have crossed into the realm of psychological torture.[16]

- Studies at Pelican Bay's maximum-security unit conducted by Dr. Haney indicate that inmates isolated for long periods of time may become profoundly hopeless and despairing, socially withdrawn, and disoriented when around others once released. Others suffer from intolerable levels of frustration due to the deprivations, the restrictions, and the totality of control. Because these feelings of frustration are aggravated by the complete absence of activity or meaningful outlets through which they can vent this frustration, the frustration can lead to outright anger and then to rage. Ultimately, an inmate's expression of frustration is marked by irrationality, in the sense that it leads the inmate into behavior that further insures his continued mistreatment. Dr. Haney found levels of deprivation so profound and the resulting frustration so immediate and overwhelming that for some, an understanding of the counterproductive consequences of their behavior is unlikely ever to be learned. He concluded that this downward spiral can only be halted by dramatic changes in the inmate environment, changes that will produce less painful and damaging conditions of confinement. He also indicated that often, the most violent cell extractions witnessed by inmates in segregation units are directed at inmates with obvious psychiatric problems.[17]
- 2000 class action paperwork from New Jersey[18] specifically relates to conditions within their super-maximum security prison. The class action suit includes the following examples of the results of failure to provide adequate mental health care to inmates living in segregation units:
  - One plaintiff was repeatedly sentenced to disciplinary detention and administrative segregation for self mutilation and suicide attempts;
  - One plaintiff incurred a series of disciplinary charges resulting in segregation time after being denied his psychotropic medications for three weeks;
  - One plaintiff swallowed a belt buckle and another time set herself on fire in a plea for help.
  - One plaintiff has spent the last five years in segregation.

- Testimony from the American Friends Service Committee, Criminal Justice Program in March of 1999 includes the following descriptions of life in this country's segregation units:
  - John was directed to leave the strip cell and a urine soaked pillowcase was placed over his head like a hood. He was placed in a device called "the chair" where he remained for over 30 hours.
  - An inmate in Arizona died after being shocked by jailers 22 times with stun guns.
  - A mentally ill man in California spread feces over his body. Guards' response was to put him in a bath so hot it boiled 30% of his skin off his body.

[16] Ibid. pg. 1119
[17] Ibid. pg. 1124
[18] Plaintiffs v. Fauver, Hilton, Veyer, O'Neill, Forker, Farrell, Cevasco, CMS, Inc., and CBS of New Jersey. Index No. Civil 96-1840.

- A New Jersey prisoner has been held in total isolation since 1986.
- A Pennsylvania inmate has been in isolation for 17 years.
- A mentally ill inmate in New Jersey was forced to perform sexual acts upon himself in order to get food or cigarettes.

Maine's Maximum Security Prison

In 1992, Maine opened the Maine Correctional Institution (MCI), Maine's first Supermaximum security prison. In 1993, a former prison warden accused the department of using the new prison to house people with mental illnesses. Although the Department of Corrections had built the new prison to house Maine's most violent and dangerous prisoners, he claimed that the Supermax was being used to house inmates with mental illness and that those inmates were subject to the same deprivations and heightened discipline as violent and aggressive inmates.[19]

It is important to describe conditions at Maine's Supermax (which are similar to other supermaximum security prisons across the country). A 6/1/99 description of conditions at Maine's Supermax prison written by an inmate describes the following:

- There are 100 beds at the Supermax -- divided into two sides – B side and C side, also known as the hard and soft sides. There are 50 cells on each side. The cells are 7 ft. by 12 ft with solid steel doors, except for a vision window for the food trays. This is always kept locked. Two stainless steel tables are connected to the walls of the cell and there is a stainless steel sink/toilet unit. The light is always on in the cell. There is a window that gives a limited view of outside. Beds are concrete with a mattress on top. The bed is equipped for five point restraints to be attached. However, rather than use this, MCI uses a restraint chair, known as "the black chair".
- The B-side, the hard side, has 10 special management (SMU) cells, two of which have speakers and cameras for 24 hour monitoring of the inmates placed in them. Prisoners in B-side cells cannot leave them, except when showering, unless a Sergeant is present and they are in 4-point restraint.
- Restraint chairs are used when inmates are "problems". The inmate is secured in the chair, mace sprayed, stripped and maced again. Prisoners remain unwashed after these procedures and the chemicals burn their skin. Perspiration reactivates the chemicals. Although a 1998 case involved a towel wrapped around the head of a man in the chair who then lost consciousness, the chairs are still in use.
- Food at the Supermax is prepared a mile down the road at the Bolduc unit. Sometimes the food sits for up to 45 minutes before being served to inmates in their cells.
- Prisoners on side B of the Supermax may not work or participate in other prison services. They may receive up to 3 one-hour visits a week that are non-contact only. Visitation involves handcuffs, separation from visitors by a window, and phones are used to communicate. Prisoners in the special management unit have visits in 4-point restraints. All prisoners on "B" side are strip-searched anytime

[19] Portland Press Herald, 2/10/200. "A teens last trip to prison."

they leave their cells. Sometimes guards ask prisoners to put their fingers in their "buttocks" first as part of the search and then to put the same fingers in their mouths for an oral check. Refusal to do so can result in the loss of privileges and/or a write up for a refusal to follow an order. Recreation from "B" side is 5 times a week for 1 hour in the dog run outside. No inside recreation is allowed. Three 15-minute showers are allowed each week. These showers count toward the one-hour of recreational time.

- Prisoners on the C side are allowed two hours of recreation time and have access to a basketball and hoop and a parallel bar.
- Prisoners in the SMU (disciplinary cells) on B-side have their recreation in an empty concrete yard with 25 feet walls enclosed in razor wire. They remain in 4-point restraint during recreation. B-side prisoners have three 15 minute phone calls each week – made via a phone passed through the feed slot in the door. C-side have unlimited calls during their 2-hour recreation time 7 days a week. There is no use of the phone if a prisoner is on "discipline".
- Because of the isolation in the Supermax, inmates haven't the opportunity to commit many rules violations. The general reasons an inmate is "written up" in the Supermax are throwing of feces, threatening someone, or fighting. Informal violations procedures allow inmates to voluntarily giving up privileges, like use of the phone, instead of a formal violation. Formal violations involve write ups, a hearing, and possibly a longer sentence at the Supermax.
- Limited access to books is allowed in the Supermax, unless you are on discipline – which means no books. Prisoners on C side are allowed to work. C-side is the step down toward re-entry into the general population. However, transfer from C-side to the general population can take years.
- The non-SMU cells on B-side require that prisoners be in 4 point restraint and escorted by two guards at all times when they are out of their cells.

Recent news reports about Maine's Supermaximum Security prison describe situations involving inmates with mental illness that are reminiscent of those described in the New Jersey Class Action paperwork.[20] These articles describe the suicide of a 19 year old transferred from the Lincoln County jail because of his depression and suicidality and the self mutilation of a 22 year old housed in the Supermax for four years. A judge involved in the second case called the circumstances at the Supermax "Draconian" and noted "it would be difficult to imagine any person – mentally healthy or not – bearing up under months of such conditions.

Mental Health Services in Maine's Prisons

The Maine State Prison in Thomaston currently provides mental health "residential treatment" for all of Maine's prison system. Their mental health stabilization unit has 31 "beds". Soon to open (staffing is still needed) are an additional 8 extended

[20] Portland Press Herald, 2-10-00; "A Teen's last trip to prison".; Maine Times, 8/16/00; "Cruel and unusual; 9/7/00, "State is mum on changes for inmate Ken Moore".

care "beds" for persons with chronic mental illness. Also in Thomaston, are 2 psychologists, 2 psychiatric nurses, 4 masters' level social workers, 8 caseworkers, and 16 hours a week of psychiatric time. In Windham, there is a psychologist, 16 hours of psychiatric time, 3 masters' level social workers, and some caseworkers. Prison personnel estimate that of the 100 beds in the Supermax, five to ten cells hold inmates with Axis I mental illness (i.e., major depression, bipolar disorder, schizoprhenia, etc.). If Axis II diagnoses were counted (i.e., personality disorders) the numbers would rise. Finally, although self harm (i.e., cutting, burning, and/or other suicidal gestures) are not usually considered to be infractions of prison rules with disciplinary consequences, they may be considered disciplinary infractions if staff believe that the actions are related to "manipulative behavior" rather than mental disorders. Finally, although there are national standards for prison accreditation, Maine's prisons are not accredited.

Segregation in Maine's Jails and Prisons

There is similarity between procedures at Maine's Supermax for persons with mental illness who break the rules and procedures in Maine's jails for inmates with mental illness who break the rules. Because inmates with mental illness are often considered "manipulative" instead of disabled, a Maine parent describes his son's experience in the Kennebec County Jail (summer 2000 and continuing) as follows: "They believe that once a person has been sent to jail and determined to be competent to stand trial, they are not mentally ill, even if they have many years of psychiatric hospitalizations and a psychiatric diagnosis. My son has spent most of his time in jail stripped naked and in isolation; he must earn back his clothing and other personal effects. His abscessed tooth and broken ankle went untreated for four weeks."[21] A mother says, "my daughter was released from jail with no medication and no plan for services. This will result in re-arrest for failure to follow probation requirements. Without medications and community support my daughter gets into trouble".[22] Given the correctional system's lack of training in, understanding of, and ability to treat mental illness, conditions in our jails and prisons for persons with mental illness are poor at best and torturous at worst.

As noted earlier, Maine's jails are woefully understaffed in terms of medical, nursing, and psychiatric care. Jail inmates with mental illness can end up in super-maximum security at the Maine Correctional Institute because of the lack of mental health services in county jails. Maine's experience is compatible with what is happening in jails across the country. In addition to aging jails, tight funding, and inadequate physical plants, the explosion of the jail population has increased problems for jail personnel and for jail inmates. Between 1978 and 1986, the number of inmates in U.S. jails increased by 73%. Estimates are that 11% of all jails were under a court order or consent decree as a result of constitutionally deficient procedures or programming in 1982.[23] Prior to the 1970s, jails did not assume responsibility for providing mental health services to inmates. However, with deinstitutionalization and reforms of the legal and criminal justice systems, things have changed. Former patients of mental hospitals are

[21] NAMI Maine's Citizens Advisory Committee on Jails and Prisons, 9/00
[22] NAMI Maine phone call, 8/00.
[23] The Mentally Ill in Jail: Planning for essential serivces. Steadman, etal. Guilford Press, 1989. Pgs. 3-4.

often arrested and incarcerated in local jails on misdemeanor charges as a way of dealing with their difficult behavior in the community.[24]

One of the complicating factors which affect the provision of mental health services in jails is the conflict between mental health and corrections staff. Multiple studies[25] describe conflicts related to location of services (in the jail or at the mental health center), confidentiality, payment, security, mission and goals, and transportation. In fact the studies show that custody and control functions routinely tend to displace therapeutic goals in dual-mandate organizations. Since the technology of custody far outstrips that of treatment, and since outcomes are so much more easily measured for custody than for treatment, it is assumed that custody considerations inevitably predominate.[26]

In 1995, the Maine Legislature recognized the need to divert people with mental illness from jail and prison for many of the reasons described above. A law was passed that required the State to develop and implement a strategy for diverting persons with serious mental illness from the criminal justice system. This statute has not been fully implemented.[27]

Recent Developments in Maine and Recommendations

Increased legislative focus on the plight of persons with mental illness in our jails and prisons has occurred because of the decision to build an expanded forensic capacity within a new state psychiatric treatment facility in Augusta. The report generated as part of that hospital development clearly highlights the need for multiple reforms within Maine including the addition of additional community-based services designed to prevent hospitalization and arrest. The recommendations made in the final report[28] are consistent with the requirements of Title 34-B, section 1219. All recommendations, those in the report and those in section 1219, which are good recommendations, are listed below:

Title 1219:

- The state shall develop a comprehensive state strategy for preventing the inappropriate incarceration of seriously mentally ill individuals and for diverting those individuals away from the criminal justice system. The strategy must be developed with the participation of: DHS, DOC, Bureau of Medical Services, CMHCs, shelters, consumers and their families, providers of inpatient mental health services, advocates, sheriffs, OSA, and Public Safety. That plan shall include:

    - The identification of existing programs or the creation of jail diversion and community mental health programs to serve persons with serious mental illness charged with minor crimes that are a manifestation of their illness, including identification of financing mechanisms for the programs and services provided.
    - The creation of systems for the evaluation of serious mental illness within 24 hours of contact with the criminal justice system, of persons charged with minor

[24] Ibid. pgs. 4-5.
[25] Ibid. pgs. 79-104.
[26] Ibid. pg. 92
[27] Title 34-B, section 1219
[28] The Maine Psychiatric Treatment Initiative: Civil and Forensic – Final Report, 2-29-00.

crimes and timely referral of those persons to appropriate community mental health programs.

- The creation of specific mechanisms for enabling police and correctional officers to communicate and consult on a timely basis with appropriate mental health personnel about specific cases.
- The establishment of plans for conducting training, in conjunction with the Maine Criminal Justice Academy of law enforcement and correctional personnel about serious mental illness and effective methods for evaluating, treating, and managing persons with serious mental illness.
- The establishment of plans for training mental health professionals who participate in state-funded educational training programs to work with people with serious mental illness in correctional facilities, including but not limited to, on-site field experience in correctional or jail diversion programs.
- The establishment of plans for providing comprehensive treatment, services and support to persons with serious mental illness following their release from correctional facilities.

Maine Inpatient Treatment Initiative Report Recommendations (jails/prison only)

- Increase mental health support to local jails through performance standards for community agencies providing services.
- Develop admission protocol regarding transfers from jails to the state forensic hospital.
- Provide training to law enforcement personnel regarding mental health as it pertains to minor law infractions.
- Train correctional officers in jails and prisons regarding serious mental illness and appropriate interventions.
- Develop partnerships between the Department of Corrections and community psychiatric hospitals to provide inpatient treatment for adolescent forensic patients.

In addition to the above, NAMI Maine recommends the following:

- Protocol and statutory changes which govern how super-maximum security units and the use of segregation anywhere in the correctional system are used for persons with mental illness.
- Increased funding for additional mental health services within Maine's jails and prisons.
- Expansion of the quality review and improvement role of prison boards of visitors with a focus on preventing class action via understanding accreditation standards.
- Requiring that Maine's jails and prisons are accredited and fully meet accreditation standards.
- Immediate involvement of DMHMRSAS in expanding the role of Maine's drug courts to assure the implementation of a blended mental illness and drug courts–

to divert persons with substance abuse problems, those with mental illness, and those who are dually diagnosed from jail and prison whenever possible.