Transforming Services for Persons with Mental Illness in Contact with the Criminal Justice System

Final Report

Franklin County, Pennsylvania
April 2009

Transforming Services for Persons with Mental Illness in Contact with the Criminal Justice System

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Franklin County, Pennsylvania

ACTION: Transforming Services for Persons with Mental Illness in Contact with the Criminal Justice System

Introduction

The purpose of this report is to provide a summary of the *ACTION: Cross-Systems Mapping* and *Taking Action for Change* workshops held in Franklin County, Pennsylvania on April 16 and 17, 2009. The workshops were sponsored by the *Franklin County Prison Board and Criminal Justice Advisory Board*. This report (and accompanying electronic file) includes:

- A brief review of the origins and background for the workshop
- A summary of the information gathered at the workshop
- A cross-systems Sequential Intercept Map as developed by the group during the workshop
- A beginning action plan as developed by the group
- Observations, comments, and recommendations to help Franklin County achieve its goals

Recommendations contained in this report are based on information received prior to or during the *ACTION* workshops. Additional information is provided that may be relevant to future action planning.

Background

The Franklin County Prison Board and Criminal Justice Advisory Board requested the *ACTION: Cross-Systems Mapping* and *Taking Action for Change* workshops to provide assistance to Franklin County with:

- Creation of a map indicating points of interface among all relevant local systems
- Identification of resources, gaps, and barriers in the existing systems
- Development of a strategic action plan to promote progress in addressing the criminal justice diversion and treatment needs of adults with mental illness in contact with the criminal justice system

There is a history of strong criminal justice/behavioral health collaboration in Franklin County. Members of the Franklin County's Prison Board and Criminal Justice Advisory Board have been working to make changes in the infrastructure of the Franklin County service delivery system to better address the needs of people with mental illness and substance use disorders involved in the criminal justice system. Most notable is the Day Reporting Center established in 2007 which offers substance abuse treatment services and an alternative to incarceration. A strategic decision was made to focus the initial work of the county on the people who become booked into the Franklin County Jail. It offered the most immediate opportunity to make a positive change. The impact has been significant, resulting in a reduction in the length of jail stays and the overall inmate population. In a noteworthy reverse of the national trend, the Franklin County Jail has reduced the jail stay by ten days and cut the jail population to 293 inmates from the expected population of 411. Based on this track record of success, the Criminal Justice Advisory Board engaged Policy Research Associates to provide the *Cross Systems Mapping and Taking Action for Change* workshops to explore other points for strategic intervention.

The participants in the workshops included 41 individuals representing multiple stakeholder systems including corrections, courts, county government, mental health, substance abuse, medical providers, human services, probation and parole, attorneys, advocates, family members, consumers, and law enforcement. A complete list of participants is available in the resources section of this document. The workshop was facilitated by Patty Griffin, PhD, Senior Consultant for Policy Research Associates (PRA) and the CMHS National GAINS Center, and Connie Milligan, LCSW, Director of the Mental Health Crisis Network for Jails in Kentucky and PRA consultant.

About the Workshop

ACTION: Cross-System Mapping and Taking Action for Change

Policy Research Associates, Inc. (PRA) is known nationally for its work in regard to justice involved people with mental illness and co-occurring substance use disorders. The ACTION workshop, *Cross-System Mapping* and *Taking Action for Change*, are unique PRA services tailored to each community. These workshops provide an opportunity for participants to visualize how mental health, substance abuse, and other human services intersect with the criminal justice system.

These two consecutive workshops are unlike other types of consultations or staff development training programs. A key element is the collaborative process. Meaningful cross-system collaboration is required to establish effective and efficient services for people with mental illness and co-occurring substance use disorders in the criminal justice system. This makes the composition of the group extremely important. While some workshops involve advertising to the entire provider community, it is essential that the organizers gather a group that represents key decision makers from the relevant provider systems and varied levels of staff. PRA staff work with this group, serving as expert guides to help the group:

- Create a local cross-systems map
- Identify opportunities and gaps in services
- Optimize use of local resources
- Identify necessary actions for change
- Prioritize actions for change which have been identified
- Develop an action plan to facilitate this change

Upon completion of the workshops, this cross-systems map included in this report is provided in both print and electronic formats. It is meant to be a starting point. The electronic file can be revised over time to reflect the accomplishments and changes in the planning process.

Keys to Success: Cross-System Task Force, Consumer Involvement, Representation from Key Decision Makers, Data Collection

Existing Cross-Systems Partnerships

A number of strengths were identified in advance of the workshop based on the results of the Community Collaboration Questionnaire:

- There is a strong criminal justice/mental health collaboration in the Criminal Justice Advisory Board. The Franklin County Criminal Justice Advisory Board is comprised of a broad cross section of stakeholders with a vested interest in the needs of people with substance abuse and mental illness who become involved with the criminal justice system. It is experienced in bringing the necessary people to the table as issues arise.

- Franklin County Mental Health-Mental Retardation, Keystone Center, and Probation have staff identified to work with individuals with mental illness and substance use disorders involved with the criminal justice system.
- A Day Reporting Center (DRC) offers treatment for substance abuse problems in lieu of incarceration and has reduced the jail census.
- Cross training is conducted for Human Service Training Days.
- There is a new jail diversion program.

Consumer Involvement

- There was significant consumer involvement at the *Cross Systems Mapping* workshop with several family members and peer specialists present. Several had extensive experience working with the criminal justice system as advocates.
- There is a peer run warm line (a service where people can make a telephone call to a trained volunteer for advice) that offers some limited services.
- Peer support services are valued by the Criminal Justice Advisory Board, and it was noted as a priority for expanded services.

Representation from Key Decision Makers

- There was broad representation from a wide variety of Franklin County's critical decision makers. This included Franklin County government officials, judges, jail warden and staff, jail diversion staff, mental health and substance abuse administrators, Managed care, medical/mental health administrators, court personnel, district attorney's office, private defense attorney, public defenders office, consumers and family advocates, and staff from community corrections.
- There was one official from law enforcement representing the Pennsylvania State Police.

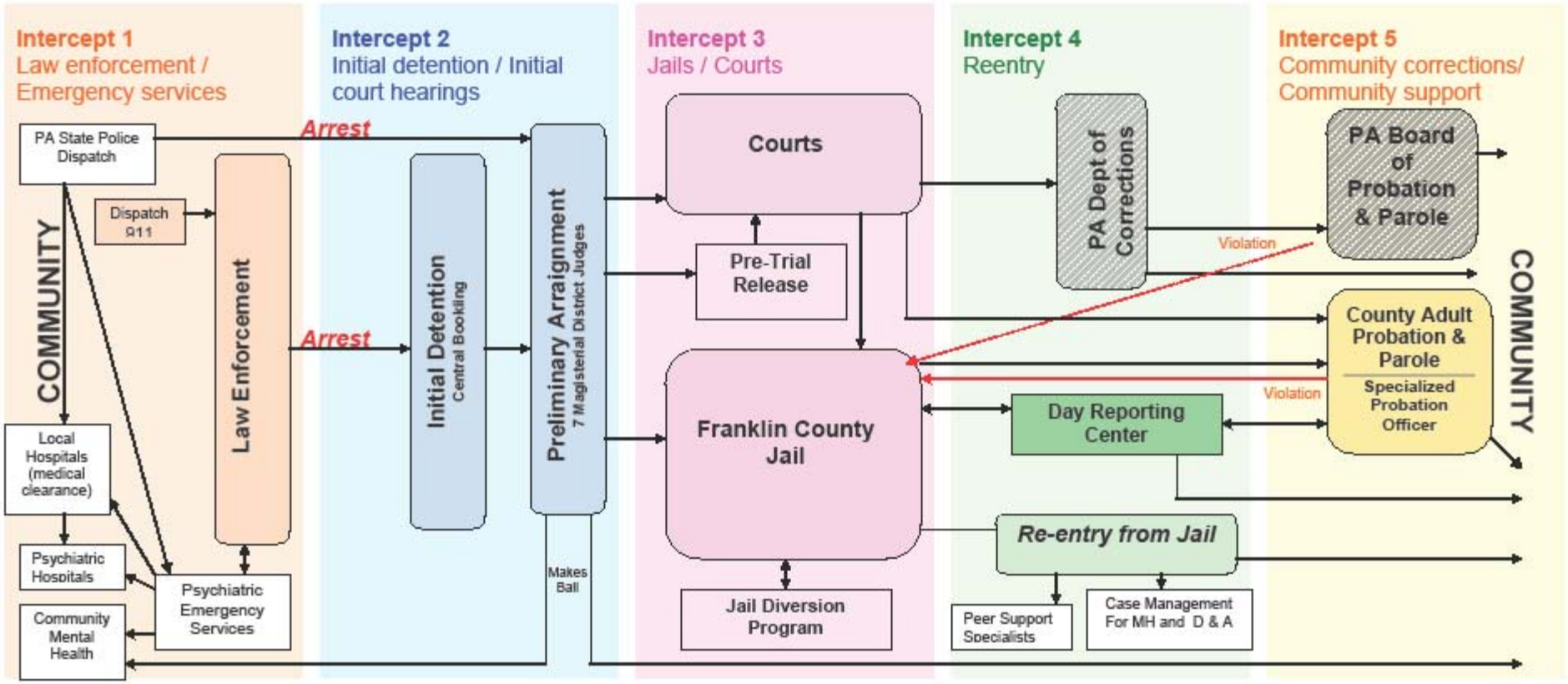
Data Collection

- Both the jail and the mental health systems (including those in the managed care Medicaid medical/mental health system of care) have extensive data systems that offer information on the target population.
- The Franklin County Jail has an offender database as does the Day Reporting Center.
- The jail mental health provider has data about inmates on their mental health caseload.

Cross-Systems Mapping

Franklin County, Pennsylvania

Franklin County, PA Sequential Intercepts for Change: Criminal Justice - Mental Health Partnerships Spring 2009



Objectives of the Cross-Systems Mapping Exercise

The *Cross-Systems Mapping* exercise has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring substance use disorders flow through the Franklin County criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention/Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.

2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

The Franklin County Cross-Systems Map created during the workshop can be found in this report on page 11.

Franklin County Cross-Systems Map Narrative

The *Cross-Systems Mapping* exercise is based on the Sequential Intercept Model developed by Mark Munetz, MD, and Patty Griffin, PhD.[1] During the exercise, participants were guided to identify gaps in services, resources, and opportunities at each of the five distinct intercept points.

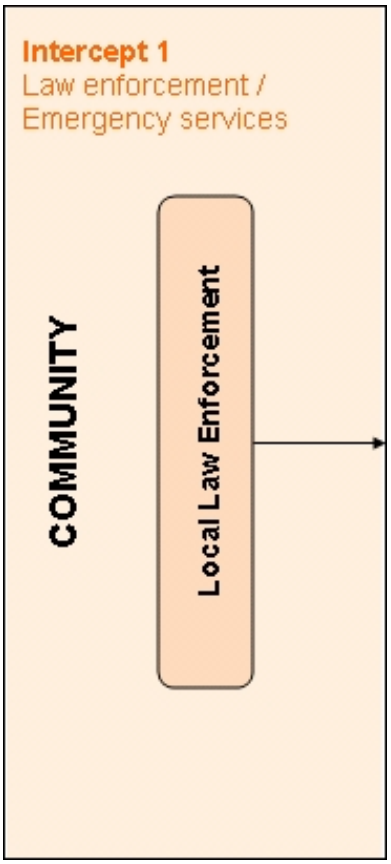
This narrative may be used as a reference in reviewing the Franklin County Cross-Systems Map. It reflects information gathered prior to and during the *Cross-Systems Mapping* exercise. At each Intercept, it provides a description of local activities as well as gaps and opportunities. Interested individuals may choose to revise or expand information gathered in the activity.

Franklin County is located in south central Pennsylvania in Cumberland River Valley between Philadelphia and Pittsburgh. The county's urban and rural geography covers 772 square miles, which poses issues for service delivery. The county is comprised of 141,668 individuals, with 74% home ownership and a fairly stable and diverse economy.

[1] Munetz, M. & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, 57, 544-549.

Intercept I: Law Enforcement / Emergency Services

General Description of Services and Cross-System Collaboration



In addition to the Pennsylvania State Police and Sheriff's Department, Franklin County has a number of other law enforcement jurisdictions including those in Waynesboro, Shippensburg, Mercer, Chambersburg, Greencastle, Washington Township, and Shippensburg University. In the rural areas of Franklin County, most of the responsibility falls to the Pennsylvania State Police to provide response to people with mental illness who are in crisis. The State Police have a dispatch call center while the other law enforcement jurisdictions use Franklin County's 911 Emergency Services.

Typically a person in a mental health crisis will be transported by the State Police or a local law enforcement officer to one of the general hospitals. In Waynesboro, individuals are seen by the Keystone Crisis's 24/7 mobile crisis response staff. In Chambersburg, they are seen by the mental health staff on site. Mental health and substance abuse assessments are completed to determine the need for inpatient hospitalization or outpatient services.

Evidence of substance use complicates and increases the time involved to arrive at a disposition. There are limited options for drug detoxification, and hospitalization decisions are not made until blood alcohol levels are lower than .08.

There are limited community resources for individuals in crisis. There are no crisis specific hospital beds. The resources of mobile mental health crisis services are at capacity. Keystone's crisis services are available to people without going directly to a local hospital emergency room, but this is not widely known. The general hospital emergency room and the two freestanding psychiatric hospitals, Roxbury Treatment Center and Brook Lane provide the primary inpatient options for voluntary admissions as well as involuntary admissions approved by the delegate pursuant to Section 302 of the Mental Health Procedures Act.

There is a 24/7 information and referral telephone line that offers coordination of services and resources when someone is in crisis. There is also a consumer run "warm line" that offers supportive telephone counseling for limited hours from Friday through Sunday.

Data provided by Jim Gilbert for January 2009 indicates 712 open cases with Franklin/Fulton County Mental Health and 518 cases open with Franklin/Fulton County Mental Retardation.

There have been a number of positive changes initiated by the Criminal Justice Advisory Board. The police received mental health training which included presentations by the Family Training and Advocacy Center. The Mental Health Association has promoted the training of peer specialists which are acknowledged as a helpful addition to the service array.

- Resources
- Gaps

Identified Gaps

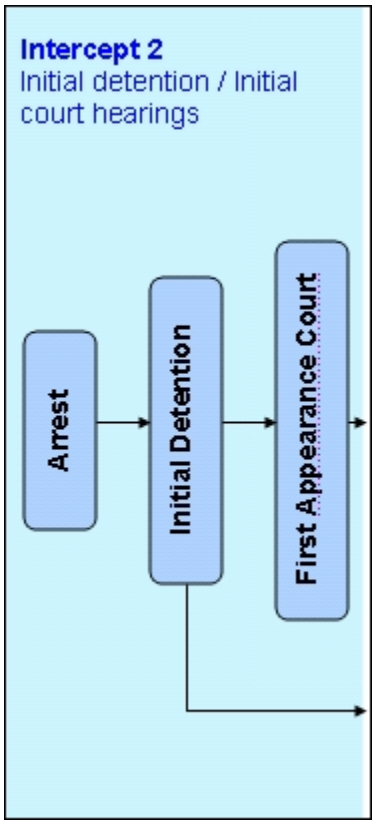
- Never enough mental health training for law enforcement officers
- Long waits in the emergency room for case disposition are a source of frustration for both police and the individual
- Limited community detoxification options
  - Jail often functions as de-facto detox
  - Detox will not accept if the person is under arrest
- Intoxicated people
  - Required to go through triage in hospital emergency rooms
  - Have to wait until blood alcohol levels are lowered before accessing voluntary commitment and detox
    - It may take eight hours or more for a person's blood alcohol level to drop to the required level
- Some people are uncomfortable that hospital emergency rooms require all patients to disrobe and wear hospital gowns
- Most people do not know that they can go directly to Keystone Crisis Services; they think it is necessary to go through a hospital emergency room for medical clearance to access crisis services
- Need more mobile crisis staff
  - Can be delays in crisis response due to limited staff
  - Struggling to find funding to support expansion of mobile crisis
- No crisis beds
- Very tight budget for non-medical assistance eligible population --- "huge challenge"
  - Recent $50,000 decrease to MH/MR budget
- Mental health system's focus on self determination can make it difficult to keep people engaged in treatment
  - People can say "no" to offer of mental health services; this can be particularly problematic for people with co-occurring mental health and substance use disorders
- Warm line has limited hours (Friday, Saturday, and Sunday)
- Mismatch between standard working hours for most providers and 24/7 nature of crisis
  - Providers refer to Crisis during non-working hours
- People may not be familiar with all the services that are available

Identified Opportunities

- Several years ago, the Criminal Justice Advisory Board sponsored mental health training for police
  - Included Family Training and Advocacy Center presentations
- Peer specialists
  - Through the Mental Health Association
  - One and perhaps two other groups are discussing developing peer specialist positions
- Looking at adding forensic peer specialists to the system
  - Some folks will attend the upcoming May training presented by the Main Link Center
- Warm line run by peer specialists
- Statistics from 911, Crisis, and Coroner's Office

Intercept II: Initial Detention / Initial Court Hearing

General Description of Services and Cross-System Collaboration



After an individual is arrested, one of Franklin County's seven Magisterial District Judges (MDJs) explains the charges and court process, determines bail, schedules the preliminary hearings, and initiates incarceration if bail is not posted. The MJD can also make referrals to other resources. Most people are released under bail. These hearings take place at the jail by video conference. During business hours (M-F 8:30 – 4:30), law enforcement takes an individual directly to the MDJ for an immediate disposition.

People not released by the Magisterial District Judge are booked into jail. The Franklin County Jail has a centralized booking process. There are over 3,500 bookings and 3,000 admissions to the jail a year. Franklin County Jail utilizes several screening instruments to help identify mental health, substance abuse, and suicide risk issues; one screen is completed by the arresting officer and another is self-report overseen by the booking officer.

During the booking process, a person can be identified as appropriate for referral into the pretrial release Jail Diversion program. The staff is able to quickly intervene and make referrals for interventions. The grant funded Jail Diversion Program started in January 2009. By April, it had diverted 12 individuals. This program takes referrals from the Day Reporting Center, probation officers, attorneys, and mental health. The "Recovery Team" includes a Forensic Case Worker, Forensic Peer Specialist, and specialized counsel. They are able to check at intake to determine if an individual is known to the public mental health system. At this time though, it is not possible to check eligibility for services of those who are registered with the Medical Assistance provider or have private insurance. Primecare, the jail mental health provider, makes referrals for those with severe mental illness.

A description of the jail diversion process is included in Appendix A. Also provided are flowcharts describing the diversion process for individuals with severe mental illness already receiving Intensive Case Management services and those not known to the system. At this time, the Jail Diversion program has one forensic case manager and services are not yet available 24/7.

- Identified Gaps
  - Not a steady enough flow at initial detention to support 24/7 staff
  - Probation budget difficulties limit dedicating staff to the pretrial program; they must carry a broader caseload
  - Magisterial District Judges try to handle everything themselves
    - Often do not know who to call, what services are available, or what services would be best for a specific individual
      - MDJs need quick and easy information on the individual and appropriate, available community resources that could facilitate possible diversion, especially after hours
    - Involved in a number of informal dispositions
    - Sometimes people who are not arrested reach out to MDJs for assistance

- Resources
- Gaps

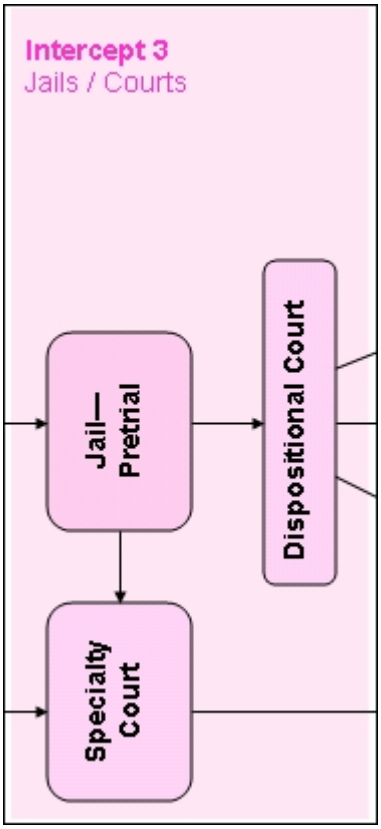
- No easy directory or referral assistance
- Referrals to hospital emergency room services are often necessary because of long waiting lists for psychiatric services
- Limited public transportation
- Summons cases bypass all other cases
- Public defenders have limited time for non-incarcerated defendants
    - May be weeks before they see these defendants

Identified Opportunities

- New pretrial Jail Diversion program
- Central booking process
- Magisterial District Judges can directly intervene
- Information and referral line run by Franklin County Human Services at 262-2562; walk-in services available and contract for help after-hours

Intercept III: Jails / Courts

General Description of Services and Cross-System Collaboration



The Franklin County Jail's screening process identifies individual risks and needs and initiates a number of innovative services that help link people who have mental illness or substance abuse issues to services. The correctional officers do a suicide screen based on the New York State correctional screening system. Mental health staff perform the Brief Jail Mental Health Screen within three hours of admission. They also do a separate suicide screen. A protocol is in place to identify particularly high risk individuals who are under 25 years of age and are being admitted to the jail for the first time. The Texas Christian University (TCU) substance use assessment is used for inmates who are sentenced or technical violators.

Referrals are made to Primecare, to the Day Reporting Center and to the newly started Jail Diversion Program.

The jail focuses on detoxification and treatment readiness rather than substance abuse treatment. Medical detoxification is offered through the jail's contract with Primecare. Approximately 20% of inmates entering the facility receive medical detox services. This service is a tapered medical detox. In a recent month, 40 individuals were detoxed: 11 for alcohol, 20 for heroin or opiates, 3 for benzodiazapines, and 6 for multi-substances.

Primecare also provides medical and medication management to those in need. While the jail's drug formulary does not always match the formulary in the community, Primecare is able to make exceptions on an individual basis. Individuals returning from the state hospital are kept on the same medications as prescribed by hospital psychiatrists.

According to Primecare's weekly mental health caseload documentation, there were 122 to 135 inmates on the mental health caseload throughout the month of January 2009. These include inmates with serious and non-serious mental illness. Of the 135 inmates on the mental health caseload, 48 had a serious mental illness.

The Franklin County Jail has encouraged the use of supportive services through its faith-based organizations and peer supports. Significant numbers of volunteers provide help through the faith-based organizations. Peer support has been utilized since 2006. It is a service that the Criminal Advisory Justice Board would like to see expanded, despite losing funding for forensic peer specialists in 2009.

There are a number of cross-system communication processes within Franklin County Jail that enhance service delivery for people with mental illness and/or substance abuse problems. There is a weekly mental health service meeting that includes all relevant staff both in and out of the jail along with the Jail Diversion Program and the Day Reporting Center. This group reviews everyone on the mental health list, the acute list, in segregation, and on report in last seven days. The focus is on management and identifying what's the next step for the individuals. The Community Liaison Intervention Project (C.L. I. P.) worker and other staff meet monthly to review all inmates in segregation to determine

service needs. These meetings can adjust service plans and provide new referrals to better meet individual needs.

As is the case across the country, people receiving Social Security benefits may have their benefits suspended after incarceration for one calendar month and will have benefits terminated if incarcerated for 12 calendar months. The jail receives up to $400 per person in incentives from the Social Security Administration to report benefit recipients who are incarcerated. This does not offset the costs to Franklin County of people who have lost their public benefits due to incarceration. Those who have Medical Assistance may lose their eligibility after admission to jail

A number of efforts are made to creatively bridge the gap for aftercare medications. Primecare provides a prescription for three days of medications. There is typically waiting list of six weeks to see a psychiatrist in the community. The Court Liaison Intervention Project has contracted with a psychiatrist to prescribe transitional psychotropic medications and to treat the individual until the community psychiatrist is able to see them. Salvation Army assists with paying for medications. The Jail Diversion program is considering a similar process.

The Franklin County Day Reporting Center (DRC) is a county intermediate punishment program that allows offenders who meet the program's criteria to be released from the jail early. The jail's Pre-Trial Release Program staff contact offenders in the jail who are eligible for the program. The Day Reporting Center provides supervision and treatment and is designed to address criminogenic risk factors. Services include life skills groups, Moral Reconation Therapy (MRT), drug and alcohol abuse treatment groups, case management groups, preparation for general education diplomas (GED), adult basic education, and job readiness groups. People entering this program have sentences of 60 days or longer reduced by one third. Since the Day Reporting Center opened in 2005, the average length of stay at the jail has decreased by 10 days, and the average daily population has decreased to 293 inmates from an expected trend to 411 inmates.

The Public Defenders Office has a case worker position responsible for referrals from attorneys and can also offer assistance in planning for diversion opportunities.

Judges use the leverage of the criminal courts as a case management tool to work closely with individuals to make a positive impact. There is some interest by the courts in developing services at this intercept and options are being examined.

Identified Gaps

- Resources
- Gaps

- Need to identify individuals with severe mental illness as early as possible in the process
  - Inadvertent delays in jail may occur because of late identification and then waits for psychiatric evaluation
  - Judges would like more information earlier in the criminal justice process
- Some people with mental illness are missed in the match with the public mental health system: those with private insurance and those who do not have to register with Behavioral Health Services
- People can lose their Medical Assistance and other benefit eligibility when entering jail
  - However, County Assistance Office does not check aggressively
- Lost funding for forensic peer specialists in jail in early 2009
- $400 incentive payments from Social Security Administration does not offset costs to county when someone loses their Medical Assistance eligibility creating a significant impact on community
- Limited substance abuse services in jail
- Different formularies exist between jail and community services

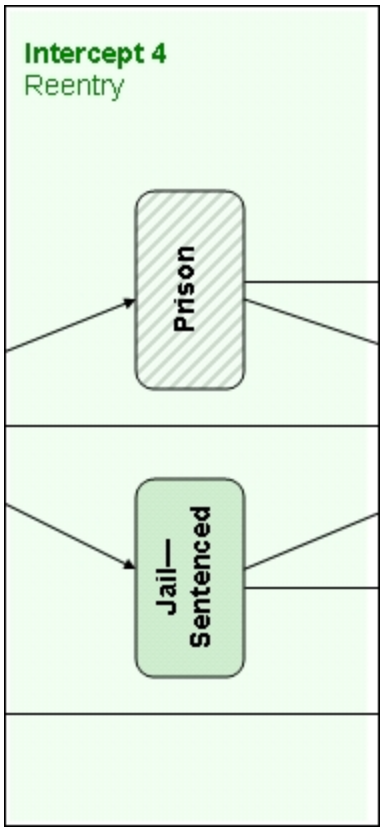
  - Although jail medical/mental health provider willing to make exceptions in individual cases
- May not be possible to continue treatment received in the community after person goes to jail
- May be a long period of time from arrest to time when someone develops a clear understanding of the mental illness of the defendant
  - May be very deep into prosecution by that point
  - Judge may not be aware until late in the process and then have limited options
- Judges may not understand the system of community resources as well as they might like
- Long waits for psychiatric evaluation
- The Medical Assistance system does not have a connection to the Day Reporting Center to determine enrollment in the Medical Assistance managed care system
- Community volunteer groups offer assistance but often do not have a plan ready to provide that assistance
  - Time would be needed to help them develop a useful plan

Identified Opportunities

- Jail has long history of using forensic peer specialists
  - Started in 2006
  - Jail made it easy for forensic peers to work in jail
- Case worker in Public Defenders Office responds to referrals from their attorneys
- The Court Liaison Intervention Project Worker, reviews each jail commit to check for open or past public mental health cases
- New Jail Diversion Program
- Weekly review meeting in the jail for mental health cases other than the services available for those committed by delegate pursuant to Mental Health Procedures Act section 302
- Jail has reduced jail census by 20 to 30 percent
- Significant contribution of the Day Reporting Center
- Use of Moral Reconation Therapy in Day Reporting Center and jail
- Active faith-based community offering assistance to jail

Intercept IV: Re-Entry

General Description of Services and Cross-System Collaboration



Reentry begins upon intake to the jail.

A recently formed Reentry Committee meets weekly to jointly plan for reentry and communicate expectations to inmates. Participating in this committee are staff from mental health/mental retardation, jail medical/mental health, drug and alcohol abuse treatment services, the Day Reporting Center, and Probation. Assessments include: jail classification, risk assessment (LSI-R), and drug abuse screening (TCU drug screen). Community drug and alcohol abuse treatment staff assess for community placement. Sentencing is scheduled for Wednesdays with a follow up meeting on the following Tuesday. The goals are to improve use of data, avoid letting any individuals "slip through the cracks," and coordinate all services/interventions. These goals will help to ensure that each individual is connected to community services and corrections and receives the proper level of supervision.

While in jail, inmates are supervised by an institutional probation officer. There are currently 142 persons on the caseload. Probation is starting to do risk assessment at this stage.

Criminal justice professionals see parole as an opportunity to reduce criminal recidivism. To be released on parole, an approved parole plan is required. Approximately 72 people are paroled each month.

- Resources
- Gaps

Identified Gaps

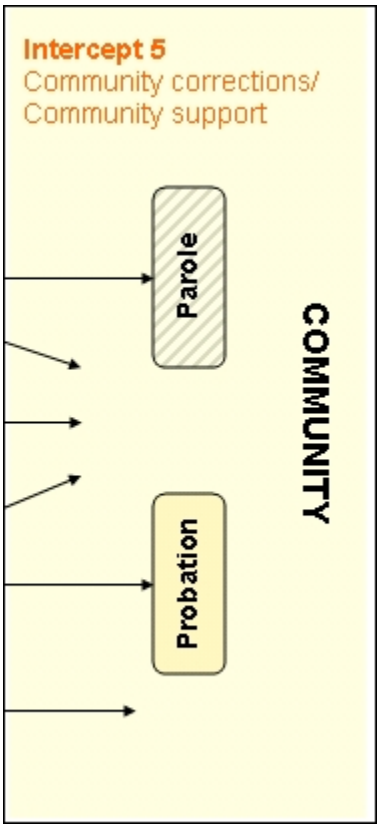
- Not enough housing
  - At any given time, there may be 120 inmates who cannot be paroled because of lack of housing
  - Especially for dual diagnosis or mental health inmates
    - "The Franklin County Jail becomes our housing unit for mentally ill"
  - Frequent users
    - Burned their bridges
    - No funding and no income
    - Benefits typically have been discontinued
    - Stay until they max out (complete entire sentence)
    - Try to convince community to give another chance to these individuals
  - Hard to make the case for more resources from the state or other sources when the county is describing their "20 people in need" compared to the much higher numbers of the big cities
    - Try to convince community to take a chance on this
  - Gaps in funding
  - Pennsylvania Housing Finance; long-term endeavors that take a long time to come to fruition
  - Crisis has grants available for first month's rent or security deposit

        - "Setting them up to fail"
            - Such as putting them in a house without food
            - Already behind before you walk out the door (have to pay probation, etc.)
    - Waiting list for housing but they continuously get bumped (by state hospital)
- Without the assistance of the Jail Diversion program "bridge medications", there is a gap between the three days of aftercare medication provided by the jail and the six week waiting list to see a psychiatrist for aftercare medication
- Not enough psychiatrists in the community
- Assigned case management works well "as long as client follows through"
    - Have to be open in Franklin/Fulton County Mental Health/Mental Retardation
- Access to psychiatric evaluations is delayed
    - 68% of adults seen within 60 days
    - Jail diversion adults seen within seven days
- Few people with severe mental illness attend the Day Reporting Center
    - Some have difficulty succeeding in the program
- Differences in treatment philosophies from community treatment providers who focus on disease model to criminal justice system emphasis on Moral Reconation Therapy
- Community needs education and communication about successful partnering
- Given high rate of co-occurring disorders, important to get continuous substance abuse treatment in jail and follow up in the community
    - That philosophy differs from the policy direction the Criminal Justice Advisory Board chose when they focused substance abuse treatment resources in the Day Reporting Center
- Need for co-occurring treatment for people after release

Identified Opportunities

- Tag on their electronic file that they must be transported to crisis at the hospital when discharged
    - The jail will provide the transportation
- Psychology staff willing to modify Moral Reconation Therapy at Day Reporting Center for individuals with severe mental illness
- Inmates with severe mental illness can be referred to Keystone Life Skills Center for activities similar to those provided in Day Reporting Center
- Jail Diversion program has developed a variety of strategies to ensure that people being released from jail are able to continue on their medication until seen by a community psychiatrist
- Jail Diversion program has used their grant funding to fill in a lot of gaps in the systems; i.e., medication, special counsel, etc.
- Efforts are made to get people back on their Medical Assistance within one to two weeks of leaving jail
- Systematic oversight processes to ensure those leaving on parole have a comprehensive transitional plan
    - Late last year, Probation started forming a collaborative agreement with MH/MR
    - MH/MR working to develop specialized case managers to work with the forensic population
    - Goal is to set up regular meetings to keep parolees out of jail, stable, and safe
    - Check medication adherence
- For people going to drug and alcohol programs, they work with County Assistance Office to get presumptive Medical Assistance eligibility

Intercept V: Community Corrections / Community Support



General Description of Services and Cross-System Collaboration

Franklin County Adult Probation has one officer supervising probationers with mental illness and probationers with sex offense convictions. There are 105 individuals on this specialized caseload including 30 with mental health problems, 10 of whom have severe mental illness. This probation officer works to reduce rates of violation for his mental health probationers by working closely with the individuals and their case managers. There has been some success with approximately four violations of probation in the last six months for this group.

The Jail Diversion Program is also willing to include probationers with severe mental illness at risk of violating probation. Referrals may come from the specialized probation officer, the Public Defenders Office, or sometimes by the jail staff. The hope is that involvement in the Jail Diversion Program will factor positively when individuals come before the judge for their violation of probation hearings.

Late last year, the Probation Department and Franklin/Fulton County Mental Health/Mental Retardation Program (MH/MR) started to form a collaborative agreement. MH/MR is considering developing specialized case managers to work with the forensic population who would proactively schedule regular meetings with clients to support stabilization.

- Resources
- Gaps

Identified Gaps

- Long waiting lists for psychiatric services for private and county services
- State's definition of severe mental illness limits eligibility for many services
  - Leaves out a number of people with mental health problems not designated "severe"
- Inconsistent access to peer support
  - Ideally there would be peer support across the system
- Specialty Mental Health Probation Officer carries large caseload (105) and includes both probationers with mental health issues and sex offenders
  - Adult Probation would like to have two dedicated probation officers; one to focus on people with mental illness with the other to focus on the sex offender population; budget limitations make this impossible at this point in time
- Some people are unable to work
  - Some supportive employment options available but more would be helpful
- Limited transportation options
  - Case managers transport a good deal
  - County transportation costs $15 for a one way trip
  - Medical Assistance covers just medical appointments, not probation appointments
  - Jail Diversion transports some people, but tries "not to be a taxi"
  - Although those on probation and parole do not seem to have a problem reporting; "I always can get to probation"
- People come to jail without birth certificates or identification so do not have identification when they leave the jail

  - Sometimes the Department of Motor Vehicles is helpful in obtaining new identification but it depends upon who is on duty
- Community providers may have different treatment philosophies than criminal justice system
- Most people with co-occurring disorders are served in the mental health system
- County is in the bottom three counties in Pennsylvania for per capita funding for human services

Identified Opportunities

- Probation staff report a low rate of re-incarceration for mental health probationers supervised on the specialized mental health/sex offender caseload
- Collaboration of specialized mental health caseload with Jail Diversion Program for probationers with mental illness at risk of violation
- Workgroup currently focusing on examining ways to integrate mental health and substance abuse services to address people with co-occurring disorders
  - Working on an integrated screening instrument
  - Developing provider expertise in both areas
  - Cross training
  - Goal of developing a seamless system
    - Continuous care that does not require starting over again because of moving to a new setting
  - Not focusing on the criminal justice system at this point, although some criminal justice related staff involved in workgroup

Taking Action for Change

Franklin County, Pennsylvania

Objectives of the Action Planning Activity

The action planning activity begins a detailed plan for the community. It identifies tasks, time frames and responsible parties for the first few identified priorities.

Action Planning Process

The stakeholders assembled for the workshop were enthusiastic participants in the development of a strategic action plan. A copy of the Franklin County Action Plan can be found beginning on page 31 of this document. The action planning process promotes the development of specific objectives and actions steps related to each of the priority areas, identifies individuals responsible for implementation of each action step, and proposes reasonable timeframes for completion of the identified tasks.

The group focused on priorities 1, 2, 3, and 7a during the action planning process. The remaining priority areas will require additional work in order to clarify and complete the full matrix. The rest of the action plan should be completed by the Behavioral Health Subcommittee of the Criminal Justice Advisory Board as soon as is feasible. Opportunities for both “early and quick victories” and longer-term strategies should be identified for the objectives for each priority area.

Franklin County Priorities

Subsequent to the completion of the *Cross-Systems Mapping* exercise, the assembled stakeholders began to define specific areas of activity that could be mobilized to address the gaps and opportunities identified in the group discussion. A total of ten distinct priorities were identified, including both opportunities for tactical interventions to promote "early quick victories" and more strategic interventions to stimulate longer-term systems changes. Listed below are the priority areas as ranked by the workshop participants with number of votes indicated in parentheses.

Top Ten Priorities

- Housing (22 votes)
- Improved Information Sharing (19)
  - Data at front door of jail
    - Even when Missy is not there
- Earliest identification and diversion (12)
  - Increase diversion opportunities at police contact
  - Develop expanded alternatives to arrest
  - Drop off points, non-hospital, and crisis beds
- Explore broad range of engagement strategies (10)
  - Develop effective treatment and supports to help people recognize their mental illness
  - Peer specialists from beginning to end
- Recruit and keep psychiatrists/psychiatric nurse practitioners (9)
- Cross-system education (9)
- Increase strategies to get benefits back (4)
- Expand Pretrial Release and Jail Diversion Programs (3)
- Develop more strategies to increase non-county funding sources for human services (3)
- Increase transportation options (3)

Franklin County, Pennsylvania: 2009 **Priority Area 1 :** Housing				
Objective		Action Step	Who	When
1.1	Engage and use community resources that may be interested in this issue	▪ Get a number of groups interested in this issue together to pool resources ▪ Give them the information and direction to be able to lead ▪ Approach the jail's faith-based volunteers about being involved		
1.2	Discuss issue with CJAB	▪ Perhaps raise issue in Executive Committee meeting in May --- Judge Walsh ▪ Consider asking CJAB to contract with consultant ▪ Consider requesting funding from PCCD --- perhaps a CJAB enhancement fund grant ▪ Look at money available right now (Cumberland County, for example)	CJAB --- Alaina Ingels	
1.3	Begin educating landlords to provide housing for this population	▪ Get County endorsement and leadership ▪ Identify landlords willing to work with this population ▪ Examine the work Allegheny County is doing working with landlords (outreach to landlords, 24/7 support) ▪ Discuss issue in Housing Authority meeting at the end of the month o Ascertain Housing Authority's willingness to take leadership role, given history of working with developing housing for people with severe mental illness ▪ Timing is good to approach landlords given the large amount of available commercial and residential space ▪ Look at Diana Myers and Associates' work in the state	Kim – Raise issue with Housing Authority in meeting scheduled the end of April	
1.4	Coordinate county agencies and various groups working separately on these issues	▪ Local Housing Options Teams (LHOT) ▪ Develop buy-in from local housing authority		
1.5	Inventory what is now available	▪ Start with a review of what data is available across the systems ▪ Tracy as a contact person (had a grant) ▪ Identify groups/organizations that are open to renting to this population		

1.6	Develop a system-wide need assessment	▪ Could use home plans as a beginning o Some people in jail do not have home plans (for those maxing out) ▪ Conduct records review ▪ Create a secondary database		
1.7	Identify barriers to housing for the target population of people with severe mental illness and often co-occurring disorders involved in the criminal justice system	▪ Explore work of Corporation for Supportive Housing ▪ Explore why landlords are unwilling to rent to target population ▪ Include Salvation Army's experience		
1.8	Explore role private foundations might provide in supporting housing	▪ TB Woods Foundation for Enhancing Communities ▪ Alexander Stewart Foundation ▪ Summit ▪ Staunton Farm Foundation ▪ Appalachian Regional Commission ▪ Rural Health Outreach Program		
1.9	Discuss options with Trust Fund specific to Fulton County	▪ The fund targets mental retardation population in Fulton County but may be able to be more expansive to co-occurring mental health and mental retardation population		
1.10	Consider joint efforts with Fulton County	▪ Look at stimulus money for possible options for housing		

Priority Area 2: Improve Information Sharing Across Systems of Care				
Objective		Action Step	Who	When
2.1	Have data available when someone enters jail; develop a data link with the Court Liaison's group	▪ Explore ways to structure the system so it is not dependent upon a single individual but it is systematized instead o System needs to be able to offer information when unknown staff are present o Consider having a team of individuals working together so that there is more than one person who can have access to the information	John Wetzel Behavioral Committee of CJAB	Next meeting
2.2	Develop a data link with BSU	▪ Capability to limit jail's access to "client active in the system" ▪ Find financial resources to support change through electronic means		
2.3	Enhance speed of determining eligibility for jail diversion program	▪ Reduce time so commitment to jail is not necessary		
2.4	Explore the legal issues around whether and how this is appropriate	▪ Get MIS to the table ▪ Talk to OMHSAS ▪ Get a written opinion from County's counsel ▪ Review information provided in *Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems* GAINS fact sheet	John Wetzel to meet with Dept. of Human Services to work on this issue	
2.5	Look for ways to get changes on this issue quickly	▪ Consider using an alert file on people who have previously been in jail receiving mental health care or who have been identified as having suicide risk so they are immediately identifiable ▪ Consider jail sharing data in advance of 7 a.m. hearings --- as an interim process ▪ Get a release of information at Central Booking ▪ Consider utilizing 24/7 managed care eligibility hotline o Caution: Can bring in care manager into planning for diversion but may alert managed care of individual's status in jail	John Wetzel Missy Reisinger	

Priority Area 3: Increase earliest identification and diversion				
Objective		Action Step	Who	When
3.1	Increase diversion opportunities at police contact	▪ Karen Blackburn will share the Sequential Intercept 1 report from a state working group ▪ Include State Police since they do significant portion of the law enforcement response in the community ▪ Explore the co-responder model in Dauphin County ▪ Explore mandatory MPO training (the chair is a state police officer) ▪ Examine any available statistics about law enforcement/mental health contacts (any hot spots?); including crisis statistics ▪ Talk to new chief of Chambersburg Police Department The Laurel Highlands CIT (Somerset, et al county) as a good model		
3.2	Develop expanded alternatives to arrest			
3.3	Look at other state strategies	▪ Pursue with State Mental Health Association ▪ Consider Kentucky's statewide work	Kenny Wuertenburg	
3.4	Planned Center of Excellence for Jail Diversion	▪ State strategic plan will include statewide training discussions		
3.5	Meet with Police Chiefs			
3.6	Examine how crisis services work at Keystone	▪ Police contacts crisis service; it contacts the delegate on call ▪ Other PA counties allow 2 physicians along with "doc and cop" commitments without delegate review (Franklin County requires delegate review) ▪ Different process outside of regular working hours	Claire Hornberger and Rick Wynn	
3.7	Expand receiving center options for police	▪ Explore options for central receiving development that are as easy as taking to the jail ▪ A safe place that offers cool down, detoxification		
3.8	Examine role of 911 dispatchers and training for them	▪ Examine the extensive training that dispatchers currently receive ▪ Expand upon it to include more information on mental illness ▪ Include State Police in conversation because of their	John Wetzel and John Hart	

		involvement with target population		
3.9	Look at civil commitment (302) process	▪ Review 302 process o Franklin County has delegate process o 2 physicians are being used in other counties		

Franklin County, Pennsylvania: 2009 **Priority Area 4:** Explore broad range of engagement strategies				
Objective		Action Step	Who	When
4.1	Develop effective treatment and supports to help people recognize their mental illness			
4.2	Provide peer specialists throughout consumers' involvement with the criminal justice system			

Franklin County, Pennsylvania: 2009 **Priority Area 5a:** Recruit and keep psychiatrists/psychiatric nurse practitioners				
Objective		Action Step	Who	When

Franklin County, Pennsylvania: 2009 **Priority Area 5b:** Cross-system education				
Objective		Action Step	Who	When

Franklin County, Pennsylvania: 2009 **Priority Area 6:** Increase strategies to get benefits back				
Objective		Action Step	Who	When

Franklin County, Pennsylvania: 2009 **Priority Area 7:** Expand Pretrial Release and Jail Diversion Programs				
Objective		Action Step	Who	When
7.1	Expand Pretrial Release Program	▪ Can take as many clients as Magisterial District Judges refer ▪ Develop education meeting with MDJs to tell them about the pretrial process and the specific program that is targeted specifically for them ▪ Include packet of information for MDJs similar to packet put together for police some years ago	Neil Burkeholder	

7.2		▪ Put all DMJs on list for "Intro to Human Services" ▪ Kim will meet with DMJs in one of their periodic meetings	Kim Lucas	
7.3	Jail provide the DMJ more information at time of setting bail	▪ Provide Pretrial risk assessment, ▪ Provide information from the police	Michele	
7.4	Explore possible civil commitment being initiated at jail for transfer to inpatient hospital	▪ Should meet 302 criteria and have criminal charges ▪ Further discussion needed to balance rights and other issues		

Franklin County, Pennsylvania: 2009

Priority Area 7b: Develop more strategies to increase non-county funding sources for Human services

Objective		Action Step	Who	When

Franklin County, Pennsylvania: 2009

Priority Area 7c: Increase transportation options

Objective		Action Step	Who	When

Conclusions and Recommendations: Summary

Participants in the *Cross-Systems Mapping* and *Taking Action for Change* workshops showed genuine interest in improving the continuum of resources available for people with severe mental illness and often co-occurring substance use disorders involved in the Franklin County criminal justice system. Franklin County is poised to tackle a number of critical issues that will greatly improve services for this group. The assembled stakeholders spent time crafting strategies related to improving the collaborative infrastructure for the group, expanding reentry planning across each of the intercepts, developing sustainable and expanded funding for local efforts, and addressing the gaps and opportunities at Intercept I --- Law Enforcement and Emergency Services.

The Franklin County Action Plan matrix should be completed by the planning group as soon as is feasible. The remaining priority areas will require additional work in order to clarify and complete the full matrix. Opportunities for both "early and quick victories" and longer-term strategies should be identified in each priority area. We suggest that the group start by reviewing the systems map and supporting information developed through the workshop for accuracy and completeness.

Franklin County is currently doing excellent work to enhance collaboration, improve services, and increase diversion opportunities for people with mental illness involved in the criminal justice system. The recommendations offered below can be used to build on recent accomplishments to enhance cross-system collaboration and the current service delivery system. These recommendations reflect the priorities the workgroup identified during the workshop and support many of the Office of Mental Health and Substance Abuse Services (OMHSAS) Forensic Workgroup recommendations outlined in the November 2006 document entitled, "Recommendations to Advance Pennsylvania Reponses to People with Mental Illness and/or Substance Use Disorders Involved in the Criminal Justice System" (prepared for the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) and the OMHSAS Advisory Committees).

Summary of Recommendations

The recommendations are organized according to the Sequential Intercept Model. Some of the recommendations cross all the intercepts and may reflect a need for larger regional and statewide initiatives or coordination. The recommendations also cite the OMHSAS Forensic Workgroup's recommendations when relevant.

Cross-Intercepts

- At all stages of the Sequential Intercept Model, data should be developed to document the involvement of people with severe mental illness and often co-occurring disorders in the Franklin County criminal justice system. Some data was available to illustrate the scope and complexity of the problems discussed during the workshop, but the data was often difficult to interpret because it was not coordinated or summarized.
    - Efforts should be made to summarize important information on a regular basis and share with the larger planning group, other stakeholders, and funders
    - Consider the "Mental Health Report Card" used by the King County Washington Mental Health, Chemical Abuse and Dependency Services to document progress in meeting relevant client outcomes.

  - For example, one outcome measure asks: Are we decreasing the number of times adults and older adults are incarcerated?
  - See: http://www.kingcounty.gov/healthservices/MentalHealth/Reports.aspx

- Expand peer counseling, support, and specialists to promote recovery. Build on the energy and interest of consumers who attended the workshop by expanding the work of the Peer Specialists to criminal justice involved populations. The consumers attending the workshop were knowledgeable, experienced, and had many thoughtful ideas about ways services can be improved in Franklin County.
  - Several localities around the country (New York City and Memphis, for example) have found that peer specialists with a personal history of involvement in the mental health and criminal justice systems have been effective in engaging individuals who have previously resisted traditional mental health efforts
  - Continue to include consumers in future planning efforts

- Continue to include and build upon the work of the family members who have shown interest in collaborating to improve the continuum of criminal justice/behavioral health services. Many communities have found family members and consumers to be the most effective "voices" in helping to bring increased resources to the community.

- Review screening and assessment procedures for mental illness, substance abuse, and co-occurring disorders across the intercepts
  - As noted in the following section on Evidence Based practices, the recently published GAINS Center monograph by Peters, Bartoi, and Sherman, *Screening and Assessment of Co-Occurring Disorders in the Justice System,* includes the most up to date information about screening and assessment tools in criminal justice settings
  - The authors note, "Accurate screening and assessment of co-occurring disorders in the justice system is essential for rapid engagement in specialized treatment and supervision services. Screening for co-occurring disorders should be provided at the earliest possible point in the justice system to expedite consideration of these issues in decisions related to sentencing, release from custody, placement in institutional or community settings, and referral to treatment and other related services. Due to the high prevalence of co-occurring disorders among offenders, all screening and assessment protocols used in justice settings should address both disorders. The high prevalence of trauma and physical/sexual abuse among offenders indicate the need for universal screening in this area as well. Motivation for treatment is an important predictor of treatment outcome and can be readily examined during screening. Drug testing is also an important component of screening and serves to enhance motivation and adherence to treatment."

Intercept I Law Enforcement and Emergency Services

- Provide regular training for local law enforcement, State Police, and other first responders (Forensic Workgroup IVC).
  - Include local law enforcement agencies and additional State Police in the planning for this training
  - Include the 911 dispatch call center staff and the State Police Call Center Dispatch in the training
  - Cross train and train collaboratively the Keystone Crisis mobile mental health crisis responders, 911 and State Police Dispatch staff, and other first responders

- Include the use of Forensic Peer Specialists in the training
- Consider current Pennsylvania work being done to provide training to law enforcement on mental health issues; see work of:
  - Family Training and Advocacy Center; contact John MacAlarney, JD (jmacii@comcast.net)
  - Montgomery County Emergency Services; contact Don Kline, PhD (dkline@mces.org)
  - Crisis Intervention Team programs currently in operation or in planning:
    - Allegheny; contact Amy Kroll (AKroll@dhs.county.allegheny.pa.us)
    - Philadelphia; contact Michele Dowell (MDowell@pmhcc.org)
    - Laurel Highland Region; see: www.laurelhighlandscit.com/
    - Bucks County (first training scheduled for September); see www.namibucks.org

- Examine and expand crisis response to provide 24/7, immediate response.
  - Consider the development of a central location for law enforcement to bring people for immediate mental health assessment (Forensic Workgroup IVC)
  - Formalize or clarify the local emergency rooms' current roles in this process
  - Explore the development of a crisis stabilization unit or beds to reduce higher end hospitalization and provide more options for diversion
    - Consider partnerships with local hospitals, universities, criminal justice, and mental health to create blended funding for this service
  - Integrate peer support into the current crisis response process
    - Consider expansion of role and hours of the consumer run "warmline" in order to increase peer support (Forensic Workgroup IVC)
    - Peer support at this level of care could help reduce crisis and contact with law enforcement

Intercept II Initial Detention and Initial Hearing

- Provide additional training and resources to the Magisterial District Judges (MDJ) to enhance their role in diversion.
  - Provide resource information and 24/7 contact people to assist in identifying people with mental illness who could be diverted and allow for prompt referrals
  - Consider expansion of linkages to Pretrial Services and the Jail Diversion program to support diversion at this stage

- Consider use of telephonic methods of assessment.
  - Explore option of Civil Commitment being initiated at the Franklin County Jail
    - The jail screening process identifies people with mental health risk and needs – use this information to pass on to a person who can formalize the assessment and recommendation to a 302 Delegate

- Increase information sharing to enhance rapid identification of current mental illness and history of services so diversion can be immediately initiated. (Forensic Workgroup IVA).
  - Develop "super release forms" across all relevant parties so information can be shared

- In cases of critical mental health emergencies, develop a linkage system to the mental health crisis staff for consultation, collaboration, and information sharing to enhance law enforcement's ability to make early diversion
- Utilize an alert system in the jail to show past history of mental health issues in jail so rapid identification can be enhanced
- Network information across all relevant parties in this phase of diversion

Intercept III Jails and Courts

- Explore further implementation of treatment readiness and engagement strategies in the jail that focus on inmates with mental illness, substance abuse problems, and those with co-occurring disorders.
  - See: Enhancing Motivation for Change (TIP 35)
    - http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.61302

- Develop a clear role and plan for use of faith based volunteers in the Franklin Co. Jail.
  - Consider what specific roles they could play in supporting this target population
  - Consider expanding and clarifying their role during reentry

- Support the courts' desire to expand court monitored diversion options (Forensic Workgroup IVC).
  - Explore opportunities to provide necessary resources for the expansion of diversion service options in the courts
  - Work with the Supreme Court Problem Solving Court Liaison for technical assistance
  - Explore grant funded opportunities for diversion
  - Link court based services with the other diversion options operated by pre-trial release program and the jail

Intercept IV Re-entry from Jail and State Prison

- Formalize and systematize the re-entry process for all individuals with mental illness leaving the jail. This is an ideal opportunity to ensure continuity of care and work proactively to avoid return to the criminal justice system.
  - Consider using the APIC model and GAINS Center re-entry check list (Forensic Workgroup IVC) noted below
  - Develop a protocol for ensuring continuity of care when the release from jail was not anticipated by the jail mental health staff
  - Focus particular, intensive attention on those with repeated jail admissions

- Systematically develop "in-reach" efforts into the jail to identify those with severe mental illness and often co-occurring disorders in order to facilitate continuity of care and alternatives to incarceration.
  - Coordinate the resources offered by the jail's mental health staff, community providers, probation, and others
    - Data from Pierce County Washington indicates that individuals with severe mental illness were four times more likely to attend their first post-release mental health appointment if someone from the community mental health system met with them while they were still in jail

- Explore ways to enhance the "bridge medication" when a person reenters the community so there is not a lapse in services.
  - Consider the development of rapid re-entry follow up appointments with select providers for those who have serious mental illness or are on medication that needs to be maintained to reduce recidivism

- Expand Peer Support Specialists to help with re-entry.
  - Utilize the experience and resources of The Main Link Forensic Peer Support program in Bradford and Sullivan counties
    - See: http://www.themainlink.net/peer.php
  - Examine the work The Main Link program is doing with a new work release program for jail inmates with severe mental illness

- Systemically expedite access to Medical Assistance, Social Security, and other benefits to facilitate successful reentry to the community.
  - Explore more consistent, rapid reinstatement of Medical Assistance benefits (Forensic Workgroup IVA)
    - Include local and state Medicaid people in the process
  - See further information in the next section regarding the SOAR program

- Explore methods to help people obtain birth certificates or other needed identification.
  - Take advantage of the extensive information the jail, courts, and community corrections agencies have to create a streamlined process to obtain identification

- Enhance the services of the Day Reporting Center to accommodate people with severe mental illness.
  - Consider beginning with individuals with co-occurring substance use disorders and severe mental illness
  - Work with Forensic Case Management staff for service delivery
  - Consider the work of the Dual Treatment Track (DTT) of the Day Reporting Center in Chesterfield/Colonial Heights Virginia which serves individuals who are awaiting trial and are substance-addicted and also diagnosed with a severe mental illness
    - Services at the DTT are self paced and include intensive supervision, outpatient substance abuse treatment, psychiatric services, mental health/co-occurring disorder education, and Moral Reconation Therapy
      - The program serves clients by utilizing and bridging local resources
      - On any given day, there are 30-35 people in the DTT program
    - The program is a joint effort with the local Community Services Board (for mental health, substance abuse, and mental retardation services) and typically takes six months to complete
      - The DTT program can continue to follow an individual after disposition. In 2007, DTT cost $34 a day per client, excluding medications

- For more information: http://www.chesterfield.gov/HumanServices/CommunityCorrections/programs_dualTreatment.asp

Intercept V – Community Corrections and Community Support

- Enhance access to psychiatric services in the community.
  - Explore strategies to appeal to private providers to offer access to services for this population
  - Explore options to incentivize private providers provide services to this population

- Expand services for co-occurring disorders in the community to meet the needs of this group of people at re-entry.

- Build on the low rates of violation of probation.
  - Expand staff as need for Specialized Mental Health Probation
  - Consider the growing empirical research on which community corrections strategies improve outcomes (including reducing criminal recidivism) for people with mental illness under community corrections supervision
    - The Justice Center of the Council of State Governments recently published a monograph summarizing the most up to date research and thinking on this topic
    - For instance, research suggests that three strategies by community corrections officers can reduce criminal recidivism or improve linkages to services for probationers with mental illness:
      - "Firm but fair" relationships between officers and supervisees
      - Officers' use of compliance strategies that favor problem solving as opposed to threats of incarceration and other negative pressures
      - Officers' "boundary spanning" work to develop knowledge about behavioral health and community resources, establish and maintain relationships with clinicians, and advocate for services
    - In addition, specialized probation caseloads "are regarded as a promising practice for improving outcomes" for this population
    - Defining features of specialized caseloads include:
      - Smaller caseloads composed exclusively of people with mental illness
      - Significant and sustained training on mental health issues
      - Extensive collaboration with community-based service providers
      - Problem-solving strategies to enhance compliance with supervision requirements
    - For more information, see: http://consensusproject.org/downloads/community.corrections.research.guide.pdf
    - This information may also be useful for inclusion in the diversion efforts

- Expand supportive employment options.
  - Utilize the specialized MH probation officer to assist in this process

- Enhance transportation service.

- Cost of county van is out of reach for most of the people in this population – consider reducing the cost for diversion program and community corrections participants
- Explore strategies to expand Medical Assistance supported transportation services for court related appointments

- Explore expansion of housing options for people with mental illness in the criminal justice system.
  - Housing is essential for successful re-entry and to reduce recidivism; three groups are doing interesting work to develop housing alternatives for this population
  - The Corporation for Supportive Housing's Frequent Users Initiative has been implemented in a number of cities and states across the country to foster innovative cross-system strategies to "improve quality of life and reduce public costs among persons whose complex, unmet needs result in frequent engagement with emergency health, shelter and correctional services
    - These programs identify and target a small group of individuals whose overlapping health and mental health needs place them at high risk of repeated, costly and avoidable involvement with correctional and crisis care systems"
    - The Corporation leverages local partnerships and community-based services linked with housing to improve outcomes at a reduced public cost for the frequent user population
  - The New York City Departments of Correction and Homeless Services, with assistance from the Department of Health and Mental Hygiene and the New York City Housing Authority have implemented the Frequent Users of Jail and Shelter Initiative
    - Initial results show that the average number of days in jail decreased by 52% among housed participants, while jail days actually increase for members of a comparison group
    - For information about the New York City and other Frequent User initiatives: http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=4456&nodeID=81
  - The Ohio Department of Rehabilitation and Correction and the Corporation for Supportive Housing have teamed up to pilot permanent supportive housing to individuals being released from state prisons in order to reduce recidivism
    - See the Interim Report of the first year of the pilot: http://www.endlongtermhomelessness.org/case_studies_success_stories/knowledge_center/evaluation_of_the_ohio.aspx
  - Diana T. Myers and Associates is a housing and community development consulting firm based in Pennsylvania that specializes in planning affordable, accessible housing for people with disabilities and works with government and nonprofit clients to design and coordinate programs and develop housing for people with disabilities
    - The York County Criminal Justice Advisory Board (CJAB) engaged this group in 2007 to conduct a housing study targeting people with serious mental illness involved with the criminal justice system; the group is now working with Centre County
    - See: http://www.lebcounty.org/lebanon/lib/lebanon/PowerPoint_-_Housing_and_the_Sequential_Intercept_Model.pdf

- Explore work with the faith-based community, especially in the areas of reentry, housing, transportation, and community support.

Evidence-Based and Promising Practices

Specific screening, engagement, assessment, treatment, service, or criminal justice practices were not examined during the course of the Cross-Systems Mapping exercise. At some point, Franklin County may want to assess its successful use of evidenced-based and promising practices in each of these areas. Key areas to examine are listed below.

Criminal Justice

- A focus on increasing cultural competence and decreasing disparities in access/availability to behavioral healthcare in all system changes planned and at each intercept
    - Appendix B includes a short bibliography of helpful resources that address cultural competency issues in criminal justice and behavioral health settings
    - In addition, Appendix C includes a brief description of the SPECTRM program, "Sensitizing Providers to the Effects of Treatment and Risk Management: Expanding the Mental Health Workforce Response to Justice-Involved Persons with Mental Illness." This program uses a cultural competence model to help service providers better understand the "help seeking needs of the population they serve and deliver services tailored to their unique needs."
- Consideration of the impact of trauma in regard to policy and procedures at all intercepts
- The need for gender-informed practices at all intercepts
- Facilitation of transitional planning and linkage of individuals to appropriate services in the community
    - The APIC model and the transitional planning checklist, currently being used by the Jericho Project, provides criminal justice, behavioral staff, and others with a concrete model to consider for implementing transitional planning across all intercepts. See Appendix D for a copy of the publication, *A Best Practice Approach to Community Re-Entry for Inmates with Co-Occurring Disorders: The APIC Model.*
- Aftercare medications
- Information sharing across criminal justice and treatment settings
    - See *Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems* and an example of an information sharing MOU [Appendix E]

Screening, Engagement, Assessment, and Treatment

- Screening and assessment of co-occurring disorders
    - See the monograph *Screening and Assessment of Co-Occurring Disorders in the Justice System* for the most up to date information about screening and assessment tools in criminal justice settings.
        - http://gainscenter.samhsa.gov/pdfs/disorders/ScreeningAndAssessment.pdf
- Integrated treatment of co-occurring mental illness and substance use disorders that focuses on recovery and includes illness self-management strategies and services for families
    - *Illness Management and Recovery*; a fact sheet developed by the GAINS Center on the use of this evidence-based practice for criminal justice involved populations that may be of value to the jail mental health staff and community providers [Appendix F]
    - *Integrating Mental Health and Substance Abuse Services for Justice-Involved Persons with Co-Occurring Disorders*; a fact sheet focused on integrated treatment [Appendix G]
- Services that are gender sensitive and trauma informed
    - See the monograph *The Special Needs of Women with Co-Occurring Disorders Diverted from the Criminal Justice System*
        - http://gainscenter.samhsa.gov/pdfs/courts/WomenAndSpects.pdf
- Treatment of trauma-related disorders for both men and women
    - *Addressing Histories of Trauma and Victimization through Treatment* [Appendix H]
- Assertive Community Treatment and intensive forensic case management programs

  - *Assertive Community Treatment to Criminal Justice Settings*; a fact sheet on ACT for forensic populations [Appendix I]
- Services that seek to engage individuals and help them remain engaged in services beyond any court mandate.
  - *The EXIT Program: Engaging Diverted Individuals Through Voluntary Services* [Appendix J]

Service

- Utilization of a systemic approach to accessing benefits for individuals who qualify for Medical Assistance, SSI, and SSDI, including individuals who are homeless and those recently released from jail or prison
  - *Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders* [Appendix K]
  - See the SSI/SSDI Access and Recovery (SOAR) website for planning and technical assistance efforts designed to improve access to Social Security benefits.
    - http://www.prainc.com/SOAR/
- Employing consumers in delivery of in-reach, case management and training services
  - *Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists* [Appendix L]
  - *Overcoming Legal Impediments to Hiring Forensic Peer Specialists* [Appendix M]
- The use of natural community supports, including families, to expand service capacity to this vulnerable population
- *Supported Employment*; a fact sheet on supported employment programs and programs that assist individuals in accessing mainstream employment opportunities [Appendix N]
- *Moving Toward Evidence-Based Housing Programs for Persons with Mental Illness in Contact with the Justice System*; a fact sheet on safe housing for persons with mental illness involved with the criminal justice system [Appendix O]
- Addressing the needs of veterans who become involved in the criminal justice system
  - *Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions* [Appendix P]

Closing

Franklin County is fortunate to have the Behavioral Health Subcommittee of the Criminal Justice Advisory Board and a wide range of stakeholders across the mental health, substance abuse, and criminal justice systems. Participants in the *ACTION*: *Cross-Systems Mapping* and *Taking Action for Change* workshop made significant efforts to understand and discuss challenging issues. They displayed genuine interest in improving the continuum of criminal justice/behavioral health services in Franklin County by developing a coordinated strategy to move forward with the priorities crafted by the workshop participants.

By re-convening and supporting the work of the group in coming months, it will be possible to maintain the momentum stimulated during the *Cross-Systems Mapping* and *Taking Action for Change* workshops and build on the creativity and drive of key local stakeholders. Policy Research Associates, Inc. hopes to continue its relationship with Franklin County and to observe its progress. Please visit the National GAINS Center or Policy Research Associates, Inc. websites for more information and for additional services to assist in these endeavors.

Additional Resources

Web Sites Sponsored by PRA	
Policy Research Associates	www.prainc.com
National GAINS Center/ TAPA Center for Jail Diversion	www.gainscenter.samhsa.gov
SOAR: SSI/SSDI Outreach and Recovery	www.prainc.com/soar

Additional Web Sites	
Center for Mental Health Services	www.mentalhealth.samhsa.gov/cmhs
Center for Substance Abuse Prevention	www.prevention.samhsa.gov
Center for Substance Abuse Treatment	www.csat.samhsa.gov
Criminal Justice/Mental Health Information Network	http://cjmh-infonet.org
Council of State Governments Consensus Project	www.consensusproject.org
Florida Criminal Justice – Mental Health Technical Assistance Center	www.floridatac.org
Justice Center	www.justicecenter.csg.org
Mental Health America	www.nmha.org
National Alliance on Mentally Illness	www.nami.org
National Center on Cultural Competence	www11.georgetown.edu/research/gucchd/nccc
National Center for Trauma Informed Care	http://mentalhealth.samhsa.gov/nctic
National Clearinghouse for Alcohol and Drug Information	www.health.org
National Criminal Justice Reference Service	www.ncjrs.org
National Institute of Corrections	www.nicic.org
National Institute on Drug Abuse	www.nida.nih.gov
Office of Justice Programs	www.ojp.usdoj.gov
Ohio Criminal Justice Center for Excellence	www.neoucom.edu/cjccoe
Partners for Recovery	www.partnersforrecovery.samhsa.gov
Reentry Policy Council	www.reentrypolicy.org
Substance Abuse and Mental Health Services Administration	www.samhsa.gov

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Cross-Systems Mapping & Taking Action for Change

Appendix A: Franklin County Materials

Franklin County Jail
*"We put the **CORRECT** in Corrections"*
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Deputy of Records

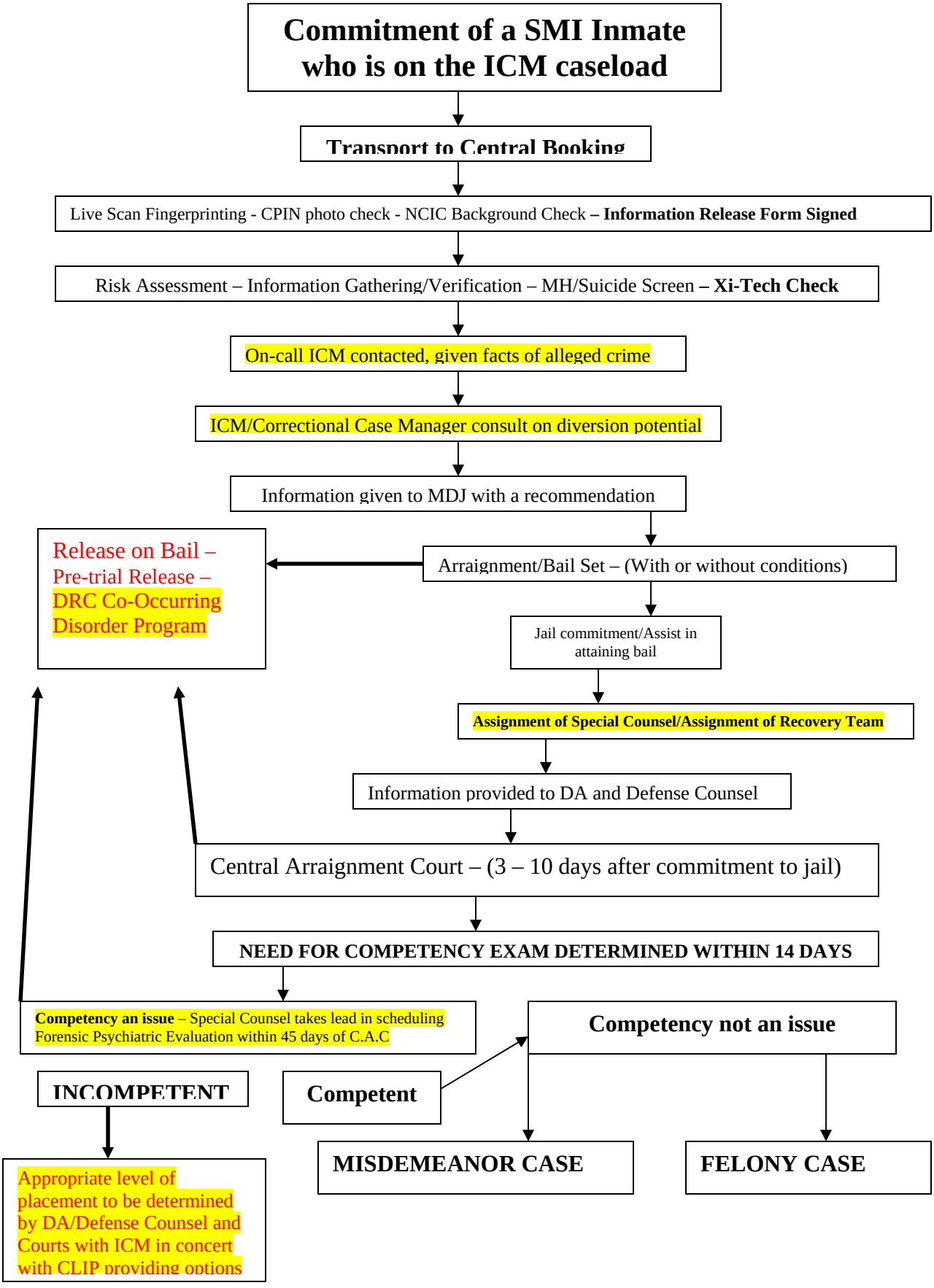
Monday, July 06, 2009

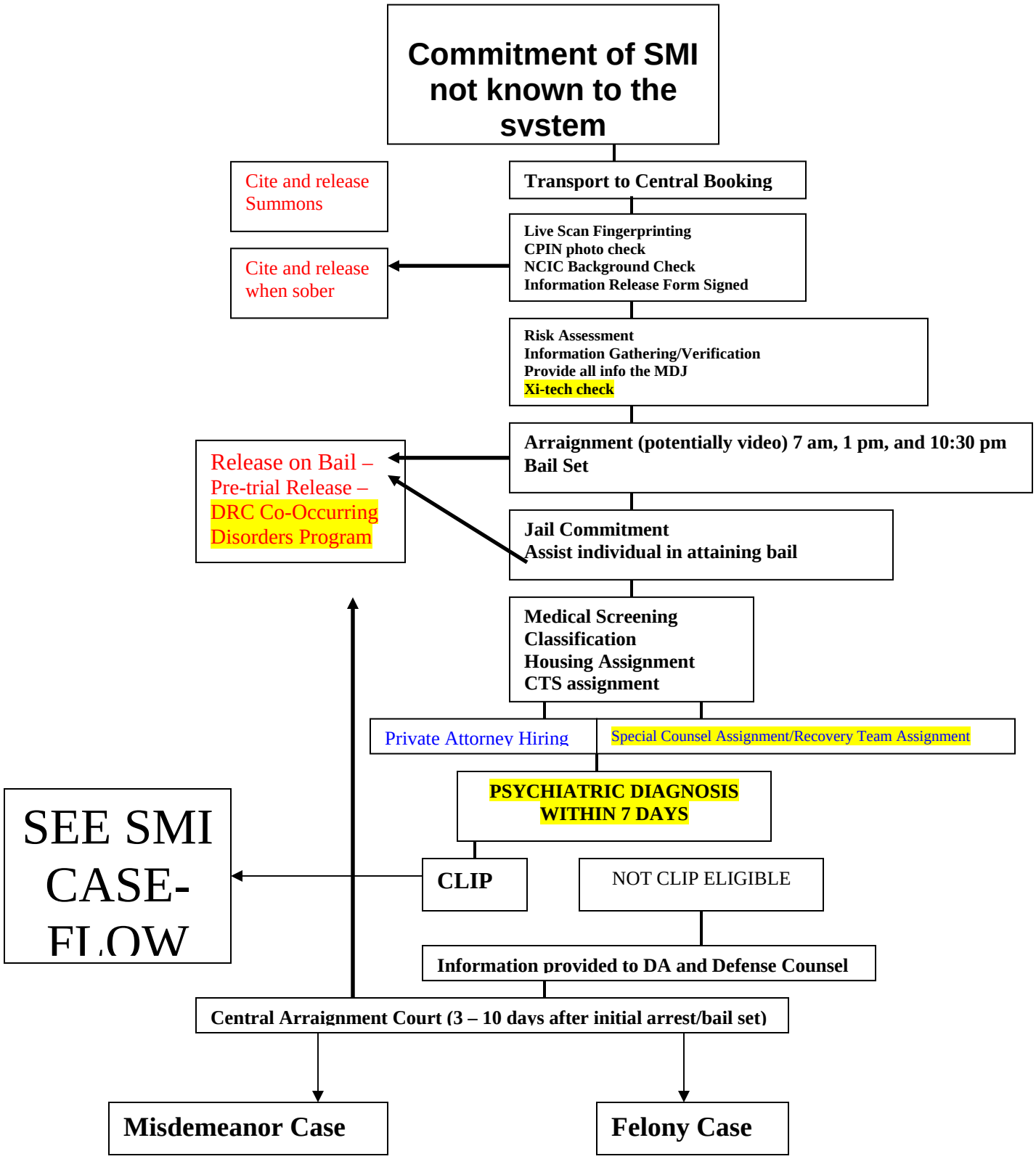
Jail Diversion Grant Flowchart

NOTES

- **DENOTES FUNDING THROUGH GRANT**
- **Forensic Caseworker and Forensic Peer Specialist together are the "Recovery Team"**
- **"Virginia Model" pre-trial risk assessment shall be modified and validated for Franklin County by Dr. Marie VanNostrand – the Model's developer.**

1. Individual is arrested
2. Transport to Franklin County Jail's Central Booking Center
    a. If arrestee doesn't meet criteria for 302 commitment
        i. "Virginia Model" pre-trial risk assessment administered
        ii. NCIC/Clean Criminal Background/History check completed
        iii. Informed Consent for release of (Mental Health) history completed
            1. Check of history with the Franklin County MH/MR department made via Xi-Tech or other selected MH/MR database
            2. Contact made to on-call MH/MR caseworker if arrangement can to be made for diversion
    b. If arrestee meets 302 criteria and arresting officer is both a witness to the potentially committable behavior and is willing to fill out the paperwork
        i. Delegate contacted, information paperwork given to delegate
        ii. If behavior meets criteria:
            1. Jail staff transports to Chambersburg Hospital
            2. ER Doctor makes determination
            3. Detainee is committed to Chambersburg Hospital, all criminal paperwork held until release
                a. Forensic Caseworker assigned
                b. Forensic Peer Specialist assigned
3. Arraignment by Magasterial District Judge
    a. Conditions of release, recommended by a combination of the Risk Assessment and MH/MR caseworker assessment made prior to arraignment
    b. Forensic Caseworker Assigned
        i. Caseworker begins to line up appropriate housing/community supports
        ii. Picks up individual at release and takes them to community housing, etc.
    c. Forensic Peer Specialist Assigned
        i. Peer specialist accompanies Forensic Caseworker to pick up release arrestee
        ii. Sets up appointment at selected location
    d. Special Counsel (Specializing in both Criminal and Civil (as it relates to the MH Act) assigned
        i. Special Counsel works with recovery team
        ii. Ensures that the individual is properly represented throughout the system
4. Additional Community Options Suggested through this grant
    a. Research based/Best Practices Co-Occurring disorder model developed as an addition to the DRC that would accept both sentenced and pre-trial/diverted individuals
    b. OTHERS??????????????????????????????????????


Commitment of a SMI Inmate who is on the ICM caseload
Transport to Central Booking
Live Scan Fingerprinting - CPIN photo check - NCIC Background Check – Information Release Form Signed
Risk Assessment – Information Gathering/Verification – MH/Suicide Screen – Xi-Tech Check
On-call ICM contacted, given facts of alleged crime
ICM/Correctional Case Manager consult on diversion potential
Information given to MDJ with a recommendation
Release on Bail – Pre-trial Release – DRC Co-Occurring Disorder Program
Arraignment/Bail Set – (With or without conditions)
Jail commitment/Assist in attaining bail
Assignment of Special Counsel/Assignment of Recovery Team
Information provided to DA and Defense Counsel
Central Arraignment Court – (3 – 10 days after commitment to jail)
NEED FOR COMPETENCY EXAM DETERMINED WITHIN 14 DAYS
Competency an issue – Special Counsel takes lead in scheduling Forensic Psychiatric Evaluation within 45 days of C.A.C
Competency not an issue
INCOMPETENT
Competent
MISDEMEANOR CASE
FELONY CASE
Appropriate level of placement to be determined by DA/Defense Counsel and Courts with ICM in concert with CLIP providing options


Commitment of SMI not known to the system
Transport to Central Booking
Cite and release Summons
Live Scan Fingerprinting
CPIN photo check
NCIC Background Check
Information Release Form Signed
Cite and release when sober
Risk Assessment
Information Gathering/Verification
Provide all info the MDJ
Xi-tech check
Arraignment (potentially video) 7 am, 1 pm, and 10:30 pm
Bail Set
Release on Bail –
Pre-trial Release –
DRC Co-Occurring Disorders Program
Jail Commitment
Assist individual in attaining bail
Medical Screening
Classification
Housing Assignment
CTS assignment
Private Attorney Hiring
Special Counsel Assignment/Recovery Team Assignment
PSYCHIATRIC DIAGNOSIS WITHIN 7 DAYS
SEE SMI CASE-FLOW
CLIP
NOT CLIP ELIGIBLE
Information provided to DA and Defense Counsel
Central Arraignment Court (3 – 10 days after initial arrest/bail set)
Misdemeanor Case
Felony Case

Cross-Systems Mapping & Taking Action for Change

Appendix B: Resources on Cultural Competence for Criminal Justice/ Behavioral Health

"Adapting Offender Treatment for Specific Populations." In Center for Substance Abuse Treatment, *Substance Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series 44. DHHS Pub. No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration, pp. 93-95.

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Cross-Systems Mapping & Taking Action for Change

Appendix C: Sensitizing Providers to the Effects of Incarceration on Treatment and Risk Management (SPECTRM): Expanding the Mental Health Workforce Response to Justice-involved Persons with Mental Illness

Sensitizing Providers to the Effects of Incarceration on Treatment and Risk Management (SPECTRM)

Expanding the Mental Health Workforce Response to Justice-Involved Persons with Mental Illness

The CMHS National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness February, 2007

People with serious psychiatric disorders experience high rates of incarceration. Through their experiences in the uniquely demanding and dangerous environment of jail and prison, many develop a repertoire of adaptations that set them apart from persons who have not been incarcerated. Although these behaviors help the person adapt and survive during incarceration, they seriously conflict with the expectations of most therapeutic environments and interfere with community adjustment and personal recovery after release.

Simultaneously, mental health providers are frequently unaware of these patterns and misread signs of difficult adjustment as resistance, lack of motivation for treatment, evidence of character pathology, or active symptoms of mental illness. Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM) targets provider training with a defined modality of rehabilitation to expand the willingness and ability of clinicians to help individuals with mental health issues reach their recovery goals.

History of SPECTRM

Despite recent increased attention to the prevalence of persons with mental illness in the criminal justice system, little attention has been paid to the cultural impact of incarceration when these individuals are released from incarceration and enter civil inpatient or community-based treatment settings. Rotter and colleagues found that when individuals were directly transferred upon release from prison to a civil hospital inpatient unit, they experienced difficulties adjusting to their surroundings and displayed more disruptive behaviors and serious incidents.

In 1996, Rotter and colleagues obtained an Occupational Safety and Health Administration (OSHA) grant as part of a workforce development initiative with the hypothesis that increased staff awareness of the incarceration experience and specialized treatment of patients with incarceration histories may benefit from the therapeutic atmosphere, which is likely to improve safety on a psychiatric inpatient ward.

To develop some empirical underpinnings for this program, initially a series of focus groups was developed with inpatient, outpatient, and corrections-based mental health providers to identify behaviors that they believed distinguished the population of offenders struggling with mental health issues. Concurrently, the authors videotaped patient interviews that were structured to draw out offenders' experiences in jail and prison and their reactions to their current clinical environment.

Further, a behavioral observation scale was developed that staff could use to rate an individual patient's attitudes and behaviors. Its elements were drawn from six behavioral categories: (1) intimidation, (2) snitching, (3) stonewalling, (4) using coercion and jail language, (5) conning, and (6) clinical scamming. The scale was administered to 30 inpatients with a history of incarceration and to 15 inpatients without such a history. Categories more prevalent among patients with incarceration histories included intimidation, stonewalling, and snitching.

Individuals adapt to the culture of incarceration by adopting the inmate code. While adaptive in a correctional setting, these beliefs and behaviors may obstruct engagement in treatment and residential programs. The table (over) illustrates the transference of inmate code to the therapeutic setting, where these behaviors become maladaptive. In the clinical sense, staff may misinterpret these behaviors as resistance to treatment and/or as acute symptoms of mental illness (e.g., depression-related passivity or guardedness secondary to paranoia).

In 2002, Project Renewal in New York City, introduced SPECTRM provider training and the Re-Entry After Prison/Jail (RAP) program in two shelters (one men's and one women's shelter) for single adults who were homeless and had serious mental illness. The duration of the program was four months, and participants were surveyed before and after the program. Ten men began the RAP program, and seven completed; fifteen women began the program and eight completed. Throughout the training program, it was discovered that both men and women developed a greater sense of trust in staff and peers, despite the fact that they described the environment of the shelter as similar to jail or prison. Men who completed the RAP program found that discussing the experience of incarceration with those who shared the same experience was relieving, and that they experienced reduced concerns about vulnerability, especially in regard to the effects of medication.

Inmate Code *Adaptations dictated by inmate code and environmental factors*	**Behaviors in a Therapeutic Setting** *The same behaviors are interpreted by staff as resistance in the therapeutic setting*
Do your own time	Lack of treatment involvement
Don't be a snitch/rat	Don't talk to staff
Don't trust anyone	Don't engage with staff or other patients
Respect	Violent or threatening behaviors
Strength and Weakness	Medication refusal, Violent or threatening behaviors
Fear and Vigilance	Medication refusal, Violence as a response to threat
Freedom Limited	I did my time, Hospital or Prison
Extortion, Gambling, Drug Trafficking and Use	Treating the hospital or residence program as an extension of prison; e.g., trading cigarettes and commissary
Transiency	Lack of treatment involvement; does not engage with staff or other clients
Lack of Privacy	No eye contact; strict demands regarding personal space

(Rotter, Larkin, Schare, Massaro, & Steinbacher, 1998).

Features

The provider training component of SPECTRM reviews potential behaviors that are considered adaptive in jail and prison and uses a cultural competence approach to address them. Through teaching treatment providers about the incarceration experience and showing them how behaviors adapted therein are traditionally misinterpreted in community treatment settings, staff are better able to understand their clients and engage them in treatment more effectively and efficiently.

The Re-Entry After Prison/Jail (RAP) Program is designed to assist providers in working with people with serious mental illness who have histories of correctional incarceration. The purpose of this program is to help participants make a successful transition from correctional settings to therapeutic settings and the community. It provides participants with the skills necessary to better engage in therapeutic services and to help avoid further hospitalization and/or incarceration.

Based on a cultural competence model, the program is based in cognitive behavioral theory and utilizes psycho-educational and reframing techniques. It helps participants to relinquish behaviors learned or reinforced in the cultures of jail and prison that interfere with successful readjustment and to replace them with skills that will help them better achieve their own personal goals.

Conclusion

Cultural competence requires that agencies be able to identify and understand the help seeking needs of the population they serve and deliver services tailored to their unique needs. Meeting the needs of individuals with mental illness who have histories of incarceration is challenging, and compounded by providers' unwillingness to treat this poorly understood and estranged clinical population. SPECTRM is an approach to increase the mental health workforce capacity to provide quality clinical work in therapeutic settings and add a best practice dimension to cultural competence by recognizing the need for a special clinical emphasis on adaptations to incarceration. Simultaneously, individuals with incarceration histories and now receiving services in civil and community treatment settings may be better able to take advantage of community rehabilitation.

To learn more about the SPECTRM training, contact Dr. Merrill Rotter (Bronx Psychiatric Center, Bronx, NY / Albert Einstein College of Medicine, Yeshiva University, Bronx, NY 10461) at Brdomrr@omh.state.ny.us. ■

Resources

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Cross-Systems Mapping & Taking Action for Change

Appendix D: A Best Practice Approach to Community Re-Entry from Jails for Inmates with Co-Occurring Disorders: The APIC Model

A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model

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Abstract

Almost all jail inmates with co-occurring mental illness and substance use disorders will leave correctional settings and return to the community. Inadequate transition planning puts people with co-occurring disorders who enter jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness, and re-arrest. While there are no outcome studies to guide evidence-based transition planning practices, there is enough guidance from the multi-site studies of the organization of jail mental health programs to propose a best practice model. This manuscript presents one such model—APIC. The APIC Model is a set of critical elements that, if implemented, are likely to improve outcomes for persons with co-occurring disorders who are released from jail.

Introduction

Approximately 11.4 million adults are booked into U.S. jails each year (Stephan, 2001), and at midyear 2000, 621,000 people were detained on any given day (BJS, 2000). Current estimates suggest that as many as 700,000 of adults entering jails each year have active symptoms of serious mental illness and three-quarters of these individuals meet criteria for a co-occurring addictive disorder (GAINS, 2001).

While jails have a constitutional obligation to provide minimum psychiatric care, there is no clear definition of what constitutes adequate care (APA, 2000). In a review of jail services, Steadman and Veysey (1997) identified discharge planning as the least frequently provided mental health service within jail settings. In fact, the larger the jail, the less likely inmates with mental illness were to receive discharge planning. This occurs in spite of the fact that discharge planning has long been viewed as an essential part of psychiatric care in the community, and one of the country's largest jail systems, New York City, was recently required by court order to provide discharge planning services to inmates with mental illness. (Brad H. v. City of New York).

There are important differences in how transition planning can and should be provided for inmates with mental illnesses completing longer-term prison stays versus short-term jail stays (Griffin, 1990, Hartwell and Orr, 2000, Hammett, et al., 2001, Solomon, 2001). Jails, unlike prisons, hold detained individuals who are awaiting appearance in court, and unsentenced people who were denied or unable to make bail, as well as people serving short-term sentences of less than a year (although as prisons become more crowded, jails increasingly are holding people for extended periods of time). Short episodes of incarceration in jails (often less than 72 hours) require rapid assessment and planning activity, and while this challenge may be offset by the fact that jail inmates are less likely than prisoners to have lost contact with treatment providers in the community, short stays and the frequently unpredictable nature of jail discharges can make transition planning from jails particularly challenging (Griffin, 1990).

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Nowhere is transition planning more valuable and essential than in jails. Jails have, in many parts of the country, become psychiatric crisis centers of last resort. Many homeless people with co-occurring disorders receive behavioral health services only in jail, because they have been unable to successfully access behavioral health services in the community, and lack of connection to behavioral health services in the community may lead some people to cycle through jails dozens or even hundreds of times. Inadequate transition planning puts people with co-occurring disorders who entered the jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, hospitalization, relapse to substance abuse, suicide, homelessness, and re-arrest.

While there are no outcome studies to guide evidence-based transition planning practices, there is enough guidance from the multi-site studies of the organization of jail mental health programs by Steadman, McCarty, and Morrissey (1989); the American Association of Community Psychiatrists continuity of care guidelines (2001); and the American Psychiatric Associations' task force report on psychiatric services in jails and prisons (2000), to create a best practice model that has strong conceptual and empirical underpinnings and can be expeditiously implemented and empirically evaluated. The APIC Model presented in Table 1 is that best practice model.

Jail Size As a Factor

Just as critical differences exist between jail and prison practice, almost every facet of jail practice is influenced directly by the size of the jail. What is necessary and feasible in the mega jails of New York City or Los Angeles is quite different from what can or should be done in the five- or ten-person jails in rural Wyoming or even the 50-person jails in the small towns of the Midwest. We have designed the APIC Model to provide a model of transition planning that contains core concepts equally applicable to jails and communities of all sizes. The specifics of how the model is implemented and on what scale will vary widely. Nonetheless, we believe that the basic guidance the model offers can be useful to all U.S. jails.

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Tilling the Soil for Re-entry: System Integration

Efforts in the past to help people with co-occurring disorders in the criminal justice system have taught us that the results of these efforts will only be as good as the correctional-behavioral health partnership in the community. Transition planning can only work if justice, mental health, and substance abuse systems have a capacity and a commitment to work together. As a result, the APIC model depends on, and could perhaps drive, active system integration processes among relevant criminal justice, mental health and substance abuse treatment systems. In order to mobilize a transition planning system, key people in all of these systems must believe that some new response to jail inmates with mental illness is necessary and that they can be more effective in addressing the needs of this population by combining their efforts with other agencies in a complementary fashion (GAINS Center, 1999).

Good transition planning for jail inmates with co-occurring disorders requires a division of responsibility among jails, jail-based mental health and substance abuse treatment providers, and community-based treatment providers. Jails should be charged with the screening and identification of inmates with co-occurring disorders, crisis intervention and psychiatric stabilization; such functions are not only constitutionally mandated, but also facilitate better management of jails and supply enough information to alert discharge planners to inmates needing transition planning services. After those functions, a jail's principle discharge planning responsibility should be to establish linkages between the inmates and community services. The goal of these linkages is to reduce disruptive behavior in the community after release and to decrease the chances that the person will re-offend and reappear in the jail.

The APIC Model

Assess	***A***ssess the inmate's clinical and social needs, and public safety risks
Plan	***P***lan for the treatment and services required to address the inmate's needs
Identify	***I***dentify required community and correctional programs responsible for post-release services
Coordinate	***C***oordinate the transition plan to ensure implementation and avoid gaps in care with community-based services

Table 1.

In general, integration of criminal justice, mental health and substance abuse systems can reduce duplication of services and administrative functions, freeing up scarce resources that can be used to provide transition planning and assist inmates with co-occurring disorders in their re-entry to community from jail. Mechanisms for creating this interconnected network will include the following: new relationships among service organizations to coordinate the provision of services, the accurate recording of service provision, management information systems (with information sharing as permitted by confidentiality requirements), and staff training. Working partnerships among probation, neighborhood businesses, and service providers can also develop opportunities for the ex-inmate to participate in restorative and therapeutic activities and community service projects.

A coordinating committee comprising all stakeholders at the local level can be a key element in systems integration. This coordinating committee will work with staff providing transition planning to identify and remove barriers to successful re-entry. System integration is not an event, a document, or position. It is an ongoing process of communicating, goal setting, assigning accountability, evaluating, and reforming.

Throughout this article, we follow the suggestion of the American Association of Community Psychiatrists (AACP) by using the term “transition planning,” rather than “discharge planning” or “re-entry planning.” (AACP, 2001). The AACP recommends “transition planning” as the preferred term because *transition* both implies bi-directional responsibilities and requires collaboration among providers. It is understood that some ex-inmates will return to custody, and, thus re-entry can be seen as part of a cycle of care.

The APIC model for jail transition to community is described in the following pages. The critical elements have been organized to allow for a hierarchical approach that prioritizes elements for “fast-track” (i.e., less than 72 hours) inmates. Earlier elements in each section apply to all inmates; the latter elements should be conducted as allowed by time, the court, and the division of resources between correctional staff and community providers.

Transition planning can only work if justice, mental health, and substance abuse systems have a capacity and a commitment to work together … [T]he results … will only be as good as the … partnership in the community.

1. ***Assess*** the clinical and social needs, and public safety risks of the inmate

Assessment catalogs the inmate's psychosocial, medical, and behavioral needs and strengths. The nature of behavioral health problems is described, their impact on level of functioning is reviewed, and the inmate's motivation for treatment and capacity for change is evaluated (Peters and Bartoi, 1997). The time for assessment is dependent on the time the individual spends in jail. "Fast-track" strategies will be required for inmates spending less than 72 hours. A hierarchy of assessment strategies should be employed to ensure, even for short-stay inmates, basic needs are identified and linkage to resources is achieved. For longer stay inmates, longitudinal assessment strategies can be developed that are informed by continual observation and the collection of relevant records and opinions.

Transition planning is an essential component of the treatment plan and should begin as soon as any behavioral disorder is identified after incarceration (Jemelka et al., 1989). While uniform methods should be developed for screening and identification of people with behavioral disorders, a valid, reliable, and efficient screening tool is yet to be available (Veysey et al., 1998). Standardized screening tools with follow-up assessment strategies should be employed. Because of the high rates of co-occurring disorders among jail inmates, the detection of either a substance use disorder or a mental illness should trigger an evaluation for co-occurring conditions.

A specific person or team responsible for collecting all relevant information—from law enforcement, court, corrections, correctional health, and community provider systems—must be clearly identified. If the inmate has been previously incarcerated at the detention center, previous treatment records and transition planning documents should be obtained. This person or team will be responsible for utilizing all available information to create a fully informed transition plan. Mechanisms for getting all relevant information to the person/team must be established.

Assessment involves...

- √ *cataloging the inmate's psychosocial, medical, and behavioral needs and strengths*
- √ *gathering information—from law enforcement, court, corrections, correctional health, families and community provider systems—necessary to create a fully informed transition plan*
- √ *incorporating a cultural formulation in the transition plan to ensure a culturally sensitive response*
- √ *engaging the inmate in assessing his or her own needs*
- √ *ensuring that the inmate has access to and means to pay for treatment and services in the community*

Pre-trial services and the court system should provide adequate time to the releasing facility to develop a comprehensive community-based disposition plan or assign responsibility for comprehensive assessment to community providers; courts should coordinate with transition planners to ensure that plans can be completed and implemented without delaying release of inmates. Action protocols should be developed for correctional staff to identify and respond to potential behavioral health and medical emergencies. While the responsibility for assessing risks to public safety is traditionally the role of the court, communication between behavioral health providers and an inmate's defense attorney may provide useful information that the attorney can use in advocating for appropriate community treatment and court sanctions (Barr, 2002).

Special needs of the inmate must also be considered; with very high percentages of jail inmates in many jurisdictions being people of color, it is critical to incorporate a cultural formulation in the transition plan to ensure a culturally sensitive response. If the inmate does not speak English as their primary language, the transition plan must also determine and accommodate any need for language interpretation. Attention must also be paid to gender and age to ensure that the transition plan links the inmate with services that not only will accept the person but will connect him or her with a compatible peer group.

The most important part of the assessment process is engaging the inmate in assessing his or her own needs. The person or team responsible for transition planning must involve the inmate in every stage of the transition planning process, not only to gather information from the inmate that will lead to a plan that meets the inmate's own perceptions of what s/he needs, but also to build trust between the staff member and the inmate. One of the barriers to even the best transition plan being implemented can be an inmate's perception that transition planning is an effort by the jail to restrict his or her freedom after release from the jail or even an on-going punishment. The primary way this barrier can be overcome is by engaging the inmate, from the earliest stage possible, in considering and identifying his or her own transition needs, and then building a transition plan that meets those needs.

The transition plan must consider special needs related to

- *cultural identity*
- *primary language*
- *gender*
- *and age*

to ensure that the inmate is linked with services that will accept the person and connect him or her with a compatible peer group

Another critical aspect of re-entry planning is ensuring that the inmate has access to and a means to pay for treatment and services in the community. An essential step in transition planning is assessing insurance and benefit status (including Medicaid, SSI, SSDI, veterans benefits, and other government entitlement programs) and eligibility. Very few communities have policies and procedures for assisting inmates in maintaining benefits while incarcerated or obtaining benefits upon release. Assessment for eligibility should be performed as early after admission as possible. People who were receiving SSI or SSDI payments when arrested have these benefits suspended if they are incarcerated for more than 30 days, but some jails have agreements with the local Social Security Administration field offices that facilitate swift reactivation of these benefits (Bazelon, 2001); creation of such agreements should be encouraged and transition planning staff should be trained to make use of such agreements. If the inmate is likely to be eligible for public benefits and insurance or private insurance then application for benefits should be incorporated into the planning phase. If the inmate is likely to have limited access to care because of inability to pay for services upon release, this should be documented and an alternative mechanism for the person to obtain treatment found.

2. ***Plan*** for the treatment and services required to address the inmate's needs

Transition planning must address both the inmate's short-term and long-term needs. Special consideration must be given to the critical period *immediately* following release to the community—the first hour, day and week after leaving jail. High intensity, time-limited interventions that provide support as the inmate leaves the jail should be developed. The intensive nature of these interventions can be rapidly tapered as the individual establishes connections to appropriate community providers. Again, the most important task of the transition planner is to listen to the inmate. Many inmates have been to jail before, and some have passed through the same jail and the same transition back to the community dozens of times; the single most important thing a transition planner can do during the planning process is learn from the inmate what has worked or, more likely, not worked during past transitions, and plan accordingly.

Planning involves...

- √ *addressing the critical period immediately following release—the first hour, day and week after leaving jail—as well as the long-term needs*
- √ *learning from the inmate what has worked or not worked during past transitions*
- √ *seeking family input*
- √ *addressing housing needs*
- √ *arranging an integrated treatment approach for the inmate with co-occurring disorders—an approach that meets his or her multiple needs*
- √ *ensuring that the inmate...*
  - *is on an optimal medication regimen*
  - *has sufficient medication to last at least until follow-up appointment*
- √ *connecting inmates who have acute and chronic medical conditions with community medical providers*

Inmate input into the release plan must occur from the beginning, and should not be limited to sharing information with the planner. For example, the inmate can be enlisted, with supervision, in making phone calls to set up aftercare appointments. As the inmate's psychiatric condition improves during the course of treatment, s/he should be encouraged to assume an increasingly greater share of the responsibility for the plan that will assure ongoing and continuing care following release.

Family

Family input into the release plan should occur to the extent the inmate identifies and wishes for a family member(s) to be involved. All potential sources of community-based support should be enlisted to help the transition back to the community. The family or other primary support system should be notified of the inmate's release in advance, with inmate consent.

Housing

When faced with a behavioral health consumer in crisis in a community with inadequate supports, police often resort to incarceration for both public safety and humane concerns. Teplin and Pruett (1992) have noted that arrest is often the only disposition available to police in situations where people are not sufficiently ill to gain admission to a hospital, but too ill to be ignored. According to the National Coalition for the Homeless, "In a country where there is no jurisdiction where minimum wage earners can afford the lowest Fair Market Rent, and where rates of homelessness are rapidly growing, it is increasingly difficult to avoid jail as a substitute for housing." (National Coalition for the Homeless, 2002)

Inmates with co-occurring disorders who are homeless or at risk of homelessness should be prioritized for community low-income and supportive housing resources because the stability of these individuals is both a clinical and a public safety concern. For inmates who are homeless, referral to a shelter following release does not constitute an adequate plan. Barriers to housing, such as discriminatory housing policies, should be communicated to and resolved by a criminal justice/behavioral health oversight group (see *Coordinate*). People arrested for drug related offenses with inadequate housing should be prioritized for substance abuse treatment so that public housing restrictions can be avoided.

Planning involves

continued...

√ *initiating benefit applications/reinstatements for eligible inmates—for Medicaid, SSI/SSDI, Veterans, food stamp, and TANF—during incarceration*

√ *ensuring that the inmate has...*

- *adequate clothing*
- *resources to obtain adequate nutrition*
- *transportation from jail to place of residence and from residence to appointments*
- *a plan for childcare if needed that will allow him or her to keep appointments*

Housing providers are understandably reluctant to take in tenants with histories of violence. Conviction for arson or sex offenses makes it nearly impossible to find an individual housing upon release. Mechanisms for sharing the liability of housing high-risk ex-inmates should be developed among housing providers, public behavioral health agencies, and correctional authorities, because it is in no one's interest for these individuals to be homeless and isolated from services and treatment.

Integrated treatment for co-occurring disorders

Given the high prevalence rates of co-occurring disorders within jails, and the high morbidity and mortality associated with these disorders, the identification of effective interventions has gained great attention and a growing body of knowledge adequate to guide evidence-based practices. For the past 15 years, extensive efforts have been made to develop integrated models of care that bring together mental health and substance abuse treatment. Recent evidence from more than a dozen studies shows that comprehensive integrated efforts help people with dual disorders reduce substance use and attain remission. Integrated approaches are also associated with a reduction in hospital utilization, psychiatric symptomatology, and other problematic negative outcomes, including re-arrest (Osher, 2001). Unfortunately, in spite of these findings, access to integrated programs across the country remains limited. Nonetheless, judicial awareness of the utility of integrated care can be a stimulus for its development. Developing a transition planning system can demonstrate to judges, on both a case-by-case and system-wide level, how treatment programs that fail to meet the multiple needs of inmates with co-occurring disorders significantly reduce the liklihood of successful re-entry.

Medication

The evidence for the effectiveness of pharmacological treatment of mental illness is overwhelming (U.S. Department of Health and Human Services, 1999). Previous medication history should be accessed to assure continuity of care during incarceration, and clinicians within the jail should work with the inmate to ensure that by the time of release s/he is on an optimal medication regimen from the perspectives of improving functioning and minimizing side effects. Medication adherence is critical to successful community integration, and mechanisms should be developed to encourage and

Many inmates ... have passed through the same jail dozens of times ... the single most important thing a transition planner can do ... is learn from the inmate what has worked or ... not worked during past transitions and plan accordingly.

monitor medication compliance. A plan to assure access to a continuous supply of prescribed medications must be in place prior to the inmate's release. Packaged medications should be provided for an adequate period of time (depending on where and when the follow-up is scheduled). Prescriptions can be provided as well, assuming a payment mechanism has been established.

Other behavioral health services

Depending on the individualized assessment, a range of other support services may be required upon release. Treatment providers must be familiar with the unique needs of ex-inmates with co-occurring disorders. Specialized cognitive and behavioral approaches may be required. Established criminology research findings suggest that an understanding of situational, personal, interpersonal, familial, and social factors is necessary to prevent re-arrest (Andrew, 1995). Outreach and case management services are frequently useful in the engagement of people with serious mental disorders. Psychiatric rehabilitation services, including behavioral or cognitive therapy, illness management training, peer advocacy and support, and vocational training, can help ex-inmates move toward recovery.

The importance of work as both an ingredient of self-esteem and a way to obtain critical resources cannot be overestimated. Newer models of supported employment and vocational rehabilitation have provided higher percentages of people with serious mental illness the opportunity to work then previously thought possible (Becker, et al., 2001). Family psycho-educational interventions may also be appropriate when family members can be incorporated into an ex-inmate's recovery.

Medical care

People released from jail often have significant medical co-morbidities. Because, unlike the rest of society, inmates have a constitutional right to health care, jails for many inmates may be a place where illnesses and medical conditions are first diagnosed and treated. Linkage to ongoing community-based care following release from jail is essential if these inmates are to achieve control over or eradicate their medical conditions. Transition planning should connect inmates with specific providers for acute and chronic medical needs, as necessary.

Recent evidence from more than a dozen studies shows that comprehensive integrated efforts help people with co-occurring disorders reduce substance abuse and attain remission. Integrated approaches are also associated with a reduction in hospital utilization, psychiatric symtomatology, and ... re-arrest (Osher, 2001).

Income supports and entitlements

As noted above, access to behavioral health and addiction treatment and to the income support that can pay for housing and other essential services is, for most jail inmates with serious psychiatric disabilities, available only through public benefits. For inmates who are eligible but not enrolled, Medicaid, SSI/SSDI, veterans, food stamp, and TANF benefit applications should be initiated during incarceration. The courts, probation department and jail behavioral health providers should work with local departments of social services and other agencies that manage indigent health benefits to avoid termination of benefits when an individual enters jail. Instead, a suspension of benefits should occur, with immediate reinstatement upon release. State policy can and should be amended to prevent people who are briefly incarcerated from being removed from state-run health and benefit plans (GAINS, 1999). Jails should enter into pre-release agreements with local Social Security offices to permit jail staff to submit benefit applications for inmates and help inmates obtain SSI and SSDI benefits as soon as possible after release.

Food and clothing

No one should be released from a jail without adequate clothing and a plan to have adequate nutrition. Inadequate food and clothing is an obvious, frequent and easily preventable cause of immediate recidivism among released jail inmates. Inmates should be assessed for eligibility for food benefits, linked with those benefits, and provided a means to obtain food until those benefits become available.

Transportation

A plan for transportation that will allow the individual to travel from the jail to the place s/he will live, and from the residence to any scheduled appointments, should be in place prior to release. This is a critical and often overlooked need, especially in non-metropolitan areas with spotty or nonexistent public transportation. Ex-inmates whose psychiatric symptoms make it difficult for them to travel may need to be escorted.

Child care

A plan for childcare (as needed) that will allow the ex-inmate to keep appointments should be in place prior to release. This is an especially acute need for women, who are much more likely than men to be responsible for children.

Psychiatric rehabilitation services, including behavioral or cognitive therapy, illness management training, peer advocacy and support and vocational training, can help ex-inmates move toward recovery.

3. ***Identify*** required community and correctional programs responsible for post-release services

A transition plan must identify specific community referrals that are appropriate to the inmate based on the underlying clinical diagnosis, cultural and demographic factors, financial arrangements, geographic location, and his or her legal circumstances. If jail behavioral health staff do not double as community providers, they should participate in the development of service contracts with community providers to assure appropriateness of community-based care (APA, 2000). Cultural issues, including the inmate's ethnicity, beliefs, customs, language, and social context, are all factors in determining the appropriateness of community services. Other factors in identifying appropriate services are the preferences of the inmate, including what type of treatment s/he is motivated to participate in and any positive or negative experiences s/he has had in the past with specific providers.

The appropriateness of specific placements should be determined in consultation with the community team. A complete discharge summary, including diagnosis, medications and dosages, legal status, transition plan, and any other relevant information should be faxed to the community provider prior or close to the time of release. Jails should ensure that everyone who has entered jail with a Medicaid card or other public benefit cards or identification receives these items and the rest of their property back when released. Special efforts should be made to engage the Veterans Benefits Administration in determining eligibility and providing services to qualified veterans. Every ex-inmate should have a photo ID; those who did not have one prior to arrest should be assisted in obtaining one while in jail.

Conditions of release and intensity of community corrections supervision should be matched to the severity of the inmate's criminal behavior. Intensity of treatment and support services should be matched to the inmate's level of disability, criminal history, motivation for change, and the availability of community resources. Inmates with co-occurring disorders should not be held in jail longer than warranted by their offense simply because community resources are unavailable, and people who have committed minor offenses

Identifying involves...

- √ *naming in the transition plan specific community referrals that are appropriate to the inmate based on*
  - *clinical diagnosis*
  - *demographic factors*
  - *financial arrangements*
  - *geographic location*
  - *legal circumstances*
- √ *forwarding a complete discharge summary to the community provider*
- √ *ensuring that every inmate's belongings—including benefit card(s)—are returned upon release and that the inmate has a photo ID*
- √ *ensuring that treatment and supportive services match the ex-inmate's level of disability, motivation for change, and availability of community resources*

should not be threatened with disproportionately long sentences to induce them to accept treatment. Ex-inmates with low public safety risk should not be intensively monitored by the criminal justice system. Ex-inmates who need services but are not subject to substantial criminal justice sanctions should have voluntary access to intensive case management services or other services designed to engage them voluntarily. The differences between inmates with court ordered sanctions and those without must be incorporated into transition planning. Probation and parole officers working with ex-inmates with co-occurring disorders should have relatively small caseloads.

Issues of confidentiality and information sharing need to be addressed as part of any re-entry process. Responsibility to discuss and clarify issues of confidentiality and information sharing should be jointly assumed by staff within the jail and the treatment provider/ case manager in the community. The community provider's role (with regard to limits of confidentiality) vis-à-vis other social service agencies, parole and probation, and the court system also needs to be addressed and clarified with the inmate. If probation or parole is involved, specific parameters need to be set about what information the officer will and will not receive, and these parameters should be explained to the inmate. The treatment provider should discuss the potential benefits and problems for the individual in signing the "Release of Information" form, and should negotiate with probation or parole to agree upon a release that will permit enough information to be exchanged to involve the officer in treatment without compromising the therapeutic alliance. For people at risk of acute decompensation, advanced directives specifying information to be shared, treatment preferences, and possible alternatives to incarceration or hospitalization, or healthcare proxies naming an alternate individual to make treatment decisions, may be advisable.

The transition treatment plan must be included in the chart of the jail behavioral health service as well as the chart at the community behavioral health agency. Documentation should include the site of the behavioral health referral and time of the first appointment; the plan to ensure that the ex-inmate has continuous access to medication and a means to pay for services, food and shelter; precisely where the ex-inmate will live and with whom; the nature of family involvement in post-release planning or at least efforts that

Identifying involves

continued...

- √ *supporting conditions of release and community corrections supervision that match the severity of the inmate's criminal behavior*
- √ *addressing the community treatment provider's role (with regard to limits of confidentiality) vis-à-vis other social service agencies, parole and probation, and the court system*

have been made to include them; direct or telephone contacts with follow-up personnel; and the "transition summary."

4. ***Coordinate*** the transition plan to ensure implementation and avoid gaps in care

Due to the complex and multiple needs of many inmates with co-occurring disorders, the use of case managers is strongly encouraged (Dvoskin and Steadman, 1994). In spite of the face validity of this concept, few jails provide case management services for inmates with co-occurring disorders on release (Steadman et al., 1989). The form of case management may vary between sites, but the goals remain the same: to communicate the inmate's needs to in-jail planning agents; to coordinate the timing and delivery of services; and to help the client span the jail-community boundary after release. For inmates needing case management services, a specific entity that will provide those services should be clearly identified in the transition plan. A clinician, team or individual at the community treatment agency should be identified as responsible for the coordination/provision of community care following release. They should be contacted, kept informed, and actively involved in the transition plan. Alternatively, the community treatment agency, probation, the courts and the jail could establish a jointly funded team of caseworkers to carry out this transitional service. The development of Assertive Community Treatment (ACT) teams focused on people with serious mental illness coming out of jail has demonstrated effectiveness in reducing recidivism (Lamberti, 2001)

Case assignment to a community treatment agency must be made cooperatively by the inmate, the jail providers and the agency itself. Responsibility to assume care of the individual between the time of release and the first follow-up appointment must be explicit and clearly communicated to the individual, to the family, and to both the releasing facility and the community agency. This responsibility includes ensuring the individual

- knows where, when, and with whom the first visit is scheduled
- has adequate supplies of medications to last, *at the very least*, until the first visit
- knows whom to contact if there are problems with the prescribed medication and/or the pharmacist has a question about the prescription

Coordinating involves...

- √ *supporting the case manager entity—in coordinating the timing and delivery of services and in helping the client span the jail-community boundary after release*
- √ *case assignment to a community treatment agency must be made cooperatively—by the inmate, the jail providers and the community agency itself*
- √ *explicitly communicating—to the individual, the family, the releasing facility and the community treatment agency—the name(s) and contact information of the person(s) who will be responsible for care of the ex-inmate between the time of release and the first follow-up appointment*

- knows whom to contact if there are problems (medical or social-service related) between discharge and their first follow-up appointment
- knows whom to call if it is necessary to change the appointment because of problems with transportation, daycare, or work schedule.

Incentives should be created for community providers to do "inreach" to the jails and begin the engagement process prior to release. The inmate should, prior to release, know a person from the community treatment agency that accepts responsibility for community-based treatment and care, preferably via face-to-face contact. Ideally, caseworkers from the community's core service agencies should accompany the individual to housing or shelter and conduct assertive follow-up to insure continuity of care. Efforts should be made to make it as easy as possible for community providers to enter the jail in their efforts to maximize continuity of care. Wait time at the jail prior to seeing inmates should be reduced to a minimum; hours for their visits should be extended as much as possible; and, to the extent consistent with effective security, the search procedure upon their entering the jail should be streamlined.

At the same time, community behavioral health providers must understand and respect the need to maintain jail security. The jail staff should be willing to train community providers on how their security policies and practices work in order to facilitate the providers' adherence to jail procedures and expedite admission to the facility.

A mechanism to track ex-inmates who do not keep the first follow-up appointment should be in place (i.e., responsibility needs to be assigned to a specific person or agency such as the releasing facility, community treatment agency, or case manager entity). The ex-inmate should be contacted, the reason for failure to appear should be determined, and the appointment should either be rescheduled or the plan for follow-up should be renegotiated with the ex-inmate.

Coordinating involves

continued...

√ *confirming that the inmate....*

- *knows details regarding the first follow-up visit*
- *has adequate medications*
- *knows whom to contact if*
  – there are problems with medication
  – there are medical or social service-related problems
  – it is necessary to change the follow-up appointment

√ *establishing a mechanism to track ex-inmates who do not keep the first follow-up appointment (appointment should be rescheduled or the plan renegotiated with the ex-inmate)*

The court system, with the participation of probation and parole officers and community providers, should utilize graduated sanctions and relapse prevention techniques, including hospitalization, in lieu of incarceration for the ex-inmate with co-occurring disorder who has violated conditions of release. Probation and parole officers should be encouraged to work with behavioral health providers to develop clinical rather than criminal justice interventions in the event of future psychiatric episodes. Probation and parole agencies should have specialized officers with behavioral health expertise; these officers should be cross-trained with behavioral health clinicians to facilitate collaboration between the clinicians and law enforcement. Law enforcement officials should have easy access to clinical consultations with behavioral health professionals. “No refusal” policies should be incorporated into contracts with community providers to ensure that ex-inmates with co-occurring disorders are not denied services that are otherwise available within the community.

An oversight group with appropriate judicial, law enforcement, social services and behavioral health provider representation should be established to monitor the implementation of release policies. Collaborative efforts bringing together correctional systems and community-based organizations are particularly promising (Griffin, 1990, Hammett, 1998). A mechanism for rigorous quality assurance must be established. The jail and community providers should collaborate in establishing standards for post-release treatment planning and documentation and a mechanism to monitor implementation of the plan. A joint committee of representative jail providers and community behavioral health providers should meet regularly to monitor the process, resolve problems, and hold staff to the standards established by the committee.

The jail and community providers should collaborate in establishing standards for post-release treatment planning and documentation and a mechanism to monitor implementation of the plan. A joint committee of representative jail providers and community behavioral health providers should meet regularly to monitor the process, resolve problems, and hold staff to the standards established by the committee.

Conclusion

The APIC model is a set of critical elements that, if implemented in whole or part, are likely to improve outcomes for people with co-occurring disorders who are released from jail. Which of these elements are most predictive of improved outcomes awaits empirical investigation. The National Coalition for Mental and Substance Abuse Health Care in the Justice System noted that any comprehensive vision of care for people with co-occurring disorders re-entering community must "build lasting bridges between mental health and criminal justice systems, leading to coordinated and continual health care for clients in both systems" (Lurigio, 1996). Successful development of these "bridges," jurisdiction by jurisdiction, will ultimately create an environment where ex-inmates with co-occurring disorders have a real opportunity for successful transition.

The National Coalition for Mental and Substance Abuse Health Care in the Justice System noted that any comprehensive vision of care for people with co-occurring disorders re-entering community must "build lasting bridges between mental health and criminal justice systems, leading to coordinated and continual health care for clients in both systems" (Lurigio, 1996).

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Cross-Systems Mapping & Taking Action for Change

Appendix E: Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems

Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems

John Petrila, JD, LLM[1]

The CMHS National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness February, 2007

Recently, police arrested an individual with a long arrest record. During the arrest, he was injured and police took him to an area hospital for care. When the police came to check on him the next day, he had been released. The hospital spokesperson said that the Health Insurance Portability and Accountability Act (HIPAA) made it impossible for the hospital to communicate with the police regarding the individual's release.

This 2006 newspaper story is notable for two reasons. First, it illustrates one of the many types of interactions between law enforcement officials and health care providers that occur every day across the United States. Second, it illustrates the many misunderstandings regarding HIPAA that continue to exist years after its enactment.

These misunderstandings are sometimes so deeply ingrained that they have assumed the status of myth. These myths have serious negative consequences for persons with mental illness who are justice-involved. They can bring efforts at cross-system collaboration to a halt and they can compromise appropriate clinical care and public safety. In fact, these myths are rarely rooted in the actual HIPAA regulation. HIPAA not only does not create a significant barrier to cross-system collaboration, it provides tools that communities should use in structuring information sharing arrangements.

Contrary to myth, HIPAA covered entities do not include the courts, court personnel, accrediting agencies such as JCAHO, and law enforcement officials such as police or probation officers.

What is HIPAA?

Congress enacted HIPAA in 1996 to improve the health care system by "encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information."

The HIPAA "Privacy Rule" (which establishes standards for the privacy of information and took effect on April 14, 2003) has received most of the attention from those concerned about the impact of HIPAA. However, as important, the Department of Health and Human Services adopted the Rule on Security Standards in 2003, to govern the security of individually identifiable health information in electronic form. An Enforcement Rule was also adopted, effective March 2006. Most of the myths about HIPAA concern the Privacy Rule, while too often ignoring the potentially more troublesome area of electronic security.

Who does the HIPAA Privacy Rule cover?

The Privacy Rule establishes standards for the protection and disclosure of health information. The Privacy Rule only applies to "covered entities," which are health plans (such as a group health plan, or Medicaid); health care clearinghouses (entities that process health information into standard data elements); and health care providers. Other entities may be

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affected by HIPAA if they are "business associates" (discussed briefly, below).

Contrary to myth, HIPAA-covered entities do *not* include the courts, court personnel, accrediting agencies such as JCAHO, and law enforcement officials such as police or probation officers. There are special rules for correctional facilities, discussed briefly below.

What does the Privacy Rule require before disclosure of protected health information?

The Privacy Rule permits disclosure of health information in many circumstances *without requiring the individual's consent to the disclosure*. These circumstances include the following:

- Disclosures or uses necessary to treatment, payment, or health care operations. This means, for example, that a care provider may release information to another treatment provider at discharge, because the disclosure is necessary for treatment. In addition, "health care operations" is defined broadly and includes quality improvement, case management, and care coordination among other things.

- HIPAA also permits other disclosures without the individual's consent. Those relevant here include disclosures for public health activities; judicial and administrative proceedings; law enforcement purposes; disclosures necessary to avert a serious threat to health or safety; and disclosures mandated under state abuse and neglect laws.

  In the example provided at the beginning of this fact sheet, the hospital properly could have notified law enforcement of the presence of the arrestee in the hospital under the provision of HIPAA that permits a covered entity to disclose protected health information to a law enforcement official's request for "information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person" (164.512(f) (2). While this section limits the type of information that may be disclosed for this purpose, it is clear that identifying information can be disclosed.

- In the case of correctional facilities, HIPAA permits health information to be shared with a correctional institution or law enforcement official with custody of the individual, if the information is necessary for the provision of health care to the individual; the health and safety of the inmate, other inmates, or correctional officials and staff; the health and safety of those providing transportation from one correctional setting to another; for law enforcement on the premises of the correctional facility; and for the administration and maintenance of the safety, security, and good order of the facility. This general provision does not apply when the person is released on parole or probation or otherwise released from custody.

HIPAA not only does not create a significant barrier to cross-system collaboration, it provides tools that communities should use in structuring information sharing arrangements.

Does this mean that consent is never required in these circumstances?

While HIPAA permits disclosure without consent in many situations, it does not mean that unlimited disclosure is permissible or that obtaining consent is unnecessary or inappropriate. First, confidentiality and privacy are important values in health care. Obtaining consent may be a way of demonstrating respect for the individual's autonomy, whether or not it is legally required. Second, other laws may mandate that consent precede disclosure even if HIPAA does not. If a state law provides more stringent protection of privacy than HIPAA, then the state law must be followed. The same is true of the Federal rules

on the confidentiality of alcohol and drug abuse patient records (commonly referred to as Part 2). These rules, enacted more than 30 years ago, have strict requirements for the release of information that would identify a person as an abuser of alcohol or drugs. Another example illustrates this point: HIPAA permits disclosure of information in response to judicial and administrative subpoenas that many state laws limit. If state law has more procedural protection for the individual in that circumstance, then state law applies. Finally, HIPAA incorporates the principle that in general disclosures should be limited to the "minimal necessary" to accomplish the purpose for which disclosure is permitted.

Are there tools that can be used in cross-system information sharing?

There are several tools systems can adopt in creating an integrated approach to information sharing.

- *Uniform consent forms*. While HIPAA does not require prior consent to many disclosures, consent may still be necessary for legal (i.e., other state law) reasons, or because it serves important values. One barrier to collaboration is that most agencies use their own consent forms and consent is obtained transaction by transaction. In response, systems can adopt uniform consent forms that comply with Federal and state law requirements.

  Such forms have several features. First, they permit consent to be obtained for disclosure throughout the system at whatever point the individual encounters the system. Second, the forms can be written to include all major entities in the collaborative system; the individual can be given the option to consent to disclosure to each entity in turn, by checking the box next to that entity, or consent can be presumed with the individual given the option of withholding information from a particular entity.

- *Standard judicial orders*. Courts and court officers (state attorneys, public defenders) are not covered entities under HIPAA. However, in some jurisdictions care providers have been reluctant to share health information with the courts, or with probation officers, on the ground that HIPAA prohibits it. In response, some judges have created judicial orders with standard language mandating the sharing of information with certain entities, for example probation officers. Such orders do not concede that courts or court officers are covered by HIPAA; rather they are designed to eliminate mistaken assumptions that care providers may have regarding HIPAA.

- *Business associate agreements*. A "business associate" is a person or entity that is not a covered entity but that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. Examples include the provision of accounting, legal, or accreditation services; claims processing or management; quality assurance; and utilization review. Entities or persons providing these and other services described in the regulation must sign a business associate agreement with the covered entity for which the services are provided.

HIPAA does not discuss uniform consent forms or standard judicial orders, but it is evident that both will assist in easing sharing of information within and across systems. HIPAA does require the use of business associate agreements in some circumstances, and so knowledge of the requirements for such agreements is important. 42 CFR Part 2, on the confidentiality of alcohol and substance use information, has an analogous though not identical provision permitting the sharing of information with "qualified services organizations."

Will HIPAA violations lead to severe penalties?

The fear of liability far outstrips the actual risk of liability in providing mental health care. This is true generally, and particularly true with confidentiality, where there have been few

lawsuits in the last three decades alleging a breach of confidentiality.

There is also great fear regarding the possibility of punishment for violating HIPAA. Certainly, HIPAA provides for significant penalties, including civil and criminal fines and incarceration. However, there are two reasons that penalties for minor HIPAA violations, in particular, are unlikely. First, if an individual's health information is disclosed inappropriately under HIPAA, that individual cannot bring a lawsuit for the violation. Rather, enforcement of HIPAA is done entirely through regulatory agencies, with primary enforcement the responsibility of the Office of Civil Rights of the Federal Department of Health and Human Services. Second, although, there had been 22,664 complaints received by OCR through September 30, 2006, not a single penalty has been imposed.

... through September 30, 2006, not a single [HIPAA violation] penalty has been imposed.

In fact, only 5,400 (or 23%) complaints required further investigation, and these were resolved either by informal action (for example, a letter) or no further action. Therefore, the actual, as opposed to perceived, risk for being severely punished for a HIPAA violation is remote.

A note on the Rule on Security Standards

As noted above, this rule was adopted in 2003 but has received comparatively little attention in discussions of cross-system collaboration. Yet while concerns regarding the Privacy Rule have been exaggerated in many jurisdictions, security issues may sometimes receive too little attention. For example, while protected health information may be shared in most circumstances, if it is done electronically steps must be taken to secure the information, for example by encrypting email exchanges. As systems get beyond the myths regarding sharing of information under HIPAA, it will be important to focus on the requirement of the Security Standards, particularly since the most egregious violations of individual privacy over the last few years have resulted from intrusions into electronic data.

Summary

HIPAA has become the reason many conversations regarding cross-system collaboration have come to a stop. Yet HIPAA provides no significant barrier to sharing information within and across systems. While confidentiality and privacy of health information are important and legally protected values, HIPAA has become subject to myths that have no foundation in the text of the regulation. It is important that all parties involved in efforts to create integrated systems for people with mental illnesses in the criminal justice system put HIPAA aside as a reason these efforts cannot succeed. ■

Useful Resources

www.hhs.gov/ocr/hipaa

This is the home page for the Office of Civil Rights of the US Department of Health and Human Services. OCR has primary enforcement authority for HIPAA. This page has a wealth of information regarding HIPAA — it's the first place to go with questions.

www.hipaa.samhsa.gov/download2/SAMHSAHIPAAComparisonClearedPDFVersion.pdf

This page links to a document prepared by SAMHSA that compares Part 2 (the Federal regulations on the confidentiality of substance use and alcohol information) with the HIPAA Privacy Rule.

www.hhs.gov/ocr/combinedregtext.pdf

This link provides the full text of the Privacy Rule and Security Standards for the Protection of Electronic Protected Health Information.

www.gainscenter.samhsa.gov/html/resources/presentations.asp

This page includes an audio replay and materials from a CMHS TAPA Center for Jail Diversion net/tele-conference: *HIPAA and Information Sharing*. A sample uniform consent form is included.

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Appendix F: Illness Management and Recovery

Illness Management and Recovery in Criminal Justice

Kim Mueser, PhD[1] and Sally MacKain, PhD[2]

CMHS National GAINS Center May 2006 *Updated August 2008*

Illness Management and Recovery (IMR) is a set of specific evidence-based practices for teaching people with severe mental illness how to manage their disorder in collaboration with professionals and significant others in order to achieve personal recovery goals. Learning about the nature and treatment of mental illness, how to prevent relapses and rehospitalizations, and how to cope effectively with symptoms gives consumers greater control over their own treatment and over their lives. The practices included in IMR are often referred to by a variety of other names, such as *wellness management and recovery* and *symptom self-management*.

Evidence Supporting IMR

Research reviews have identified five specific evidence-based practices included in IMR, each supported by multiple controlled studies.

Psychoeducation is teaching information about mental illness and its treatment using primarily didactic approaches, which improves consumers' understanding of their disorder and their capacity for informed treatment decision-making.

Behavioral tailoring is helping consumers fit taking medication into daily routines by building in natural reminders (such as putting one's toothbrush by one's medication dispenser), which improves medication adherence and can prevent relapses and rehospitalizations.

Relapse prevention training reduces the chances of relapse and rehospitalization by teaching consumers how to recognize situations that trigger relapses and the early warning signs of a relapse, and developing a plan for responding to those signs in order to stop them before they worsen and interfere with functioning.

Coping skills training bolsters consumers' ability to deal with persistent symptoms by helping them identify and practice coping strategies, which can decrease distress and the severity of symptoms.

Social skills training helps consumers strengthen their social supports and bonds with others by practicing interpersonal skills in role plays and real life situations, resulting in more rewarding relationships and better illness management.

Illness Self-Management Programs

A variety of standardized programs have been developed to help consumers learn how to manage their mental illness more effectively. These programs overlap with one another, but each contains unique features, and consumers may benefit from participating in more than one program:

- Illness Management and Recovery (IMR) is a standardized individual or group format program based on the evidence-based practices described above. Teaching involves a combination of motivational, educational, and cognitive-behavioral strategies aimed at helping consumers make progress towards personal recovery goals. The materials for implementing the IMR program are free, including introductory and clinical training videos.
- The Social and Independent Living Skills (SILS) program is a series of teaching modules, based on the principles of social skills training, that helps consumers learn how to manage their mental illness and improve the quality of their lives. Module topics include Symptom Management, Medication Management, Basic Conversational Skills, Community Re-entry, and Leisure for Recreation.
- Wellness Recovery and Action Plan (WRAP) is a peer-based program aimed at helping consumers develop a personalized plan for managing their wellness and getting their needs met, both individually and through supports from significant others and the mental health system.

Evidence Base for IMR-Related Programs in Criminal Justice Settings

Although evidence supports teaching illness self-management in hospitals and communities, little is known about the effects of such programs in the criminal justice system. Four published studies in the mental health or criminal justice literature identify programs that utilized IMR evidence-based practices. Two programs, one at the California Medical Facility at Vacaville (MacKain & Streveler, 1990) and one at Brown Creek Correctional Institution in North Carolina (MacKain & Messer, 2004) used the SILS modules as a primary focus of treatment. The programs were delivered on acute care and day treatment units that provided multi-level, continuous care. Inmates who received at least 18 sessions of medication management training scored higher on a test of knowledge and skill than those with less exposure to the modules. The inmates at Brown Creek showed improvement in knowledge about their own medications and in their understanding of information and skills taught in the module. The gains in personal medication knowledge were maintained after transfer to other prison units, but the more generalized medication management knowledge and skills deteriorated following transfer, perhaps due to the lack of opportunities for continued practice.

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Adapting IMR for a Jail Diversion Program: The Bronx Mental Health Court

The Bronx Mental Health Court started in 2001 using a deferred sentence model for diverting individuals with serious mental illness who had committed felonies to community-based treatment. In 2005 when the court was preparing to add a track for misdemeanor charges, it engaged experts in IMR to help adapt the practice for justice-involved individuals. The practice was modified to fit with the court-ordered treatment plans of the mental health court participants and additional modules were developed to address the effects of prison and jail cultures on thinking and behavior. The clinical modifications resulted in modules added to the front end of the curriculum as a means of preparing participants for general modules (i.e., building social support, coping with stress). These add-on modules addressed:

- Processing jail/prison experiences
- Counterproductive adaptations to incarceration
- Thinking styles
- Difficulty with negative emotions (Rotter and Boyce, 2007)

The Mental Health Program at McNeil Island Corrections Center in Washington offers psychoeducational classes such as symptom recognition and relapse prevention (Lovell et al., 2001a). In one study, comparisons of pre-program and post-program behavior in inmates with at least 3 months of treatment showed reductions in symptom severity, behavioral infractions, and assignments to higher levels of care (Lovell et al., 2001b). Former participants also had higher rates of job and school assignments and lower levels of symptom severity when transferred or released, compared to their level at treatment entry. At follow-up, 70 percent of the transferred inmates maintained their level of functioning and were housed among the general population of inmates.

Implementing IMR-Related Programs in Criminal Justice Settings

Despite the lack of controlled research on IMR-related programs in criminal justice settings, evidence supporting their use in other contexts suggests that they can be adapted to an offender with mental illness in a variety of settings. Different illness self-management programs complement one-another in focus and approach. Components of IMR, SILS, and WRAP can all be adapted to meet the unique demands across institutional and community settings:

Jails. Considering the brief to intermediate length of time individuals may spend in jail, this setting is most appropriate for mental health screening, educating consumers about the basic facts of mental illness and its treatment, and fostering motivation for learning illness self-management skills. Subsequent work on formulating personal recovery goals and competence at illness self-management can be accomplished in either outpatient mental health or prison settings.

Prisons. IMR-related programs can be implemented in prison settings, with the combined focus on articulating personal long-term goals and learning the rudiments of illness self-management. As described in the previous section on the evidence base for IMR-related programs in criminal justice settings, longer sentences in prison and the ready access to consumers facilitate the engagement of inmates in group or individual work aimed at improving illness self-management skills.

Community Corrections/Community Mental Health. IMR-related programming can be implemented with individuals or groups in these settings, other transitional programs, or FACT teams. Topic areas emphasizing skills such as building social support, using medications effectively, coping with stress, and getting one's needs met in the mental health system are most relevant when offered within the consumer's own residence or community. Peers are important partners in helping consumers with criminal justice system involvement develop the motivation and IMR-related skills to avoid incarceration or for those leaving jail or prison to adjust to life outside institutions and avoid re-incarceration. ■

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Social and Independent Living Skills (SILS) program materials website: http://www.psychrehab.com.

Wellness Recovery and Action Plan (WRAP) program materials website: http://www.mentalhealthrecovery.com.

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Appendix G: Integrating Mental Health and Substance Abuse Services for Justice-Involved Persons with Co-Occurring Disorders

Integrating Mental Health and Substance Abuse Services for Justice-Involved Persons with Co-Occurring Disorders

Fred C. Osher, MD[1]

The National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness May, 2006

Even the highest estimates of co-occurring disorders (COD) in the general population are small compared to COD prevalence in jails and prisons. The factors that contribute to overrepresentation of COD in justice-involved persons include:

- high rates of substance use, abuse, and dependence among persons with mental illnesses (Grant et al., 2004) coupled with increased enforcement of illegal drug use, possession, and/or sales statutes leading to arrest;
- increased application of mandatory minimum sentencing guidelines for drug-related offenses resulting in longer jail and prison periods of incarceration;
- association of COD and homelessness (Drake et al., 1991) and homelessness and incarceration (Michaels et al., 1992) that brings a subset of impoverished persons with COD in contact with the justice system who often become "revolving door" clients; and
- destabilizing effects of two sets of interacting disorders that impair cognition, lead to behavioral disturbances, and result in both the commission of crimes and the inability to avoid arrest and subsequent sentencing.

The History and State of COD Treatment

The history of treatment approaches to persons with COD reflects the division of mental health and substance abuse treatment systems. Separate regulations, financing, provider education, licensing and credentialing, and eligibility for services have existed for decades. Service delivery mirrors the separation in administration and funding. As a result, persons with COD are often barred from service and shuffled between providers, seldom receiving comprehensive screening and assessment, let alone an effective package of integrated services. Compounding the administrative barriers, the stigma, shame, and discrimination experienced by some consumers can prevent them from seeking care.

These factors are reflected in the finding of the National Survey on Drug Use and Health that almost one-half of persons with COD received neither mental health nor substance abuse services in the year preceding the survey (SAMHSA, 2004). For those that do get service, the majority do not receive integrated care, but rather receive treatment within sequential and parallel treatment models (Mueser et al., 2003) that appear to have little positive effect on outcomes (Havassy et al., 2000).

Services Integration for COD as an EBP

Services integration occurs at two distinct levels — integrated treatment and integrated programs. Critical components of integrated programs consist of both structural elements (e.g., multi-disciplinary teams) and treatment elements (e.g., medications), each of which may have its own body of research evidence to support its effectiveness for specific populations to achieve specific outcomes (Mueser et al., 2003). It is not the use of these components that makes a program integrated, but rather the coordination of appropriate components within a single program that determines the degree of program integration.

Integrated treatment occurs at the interface of providers and the persons with COD. It is the application of knowledge, skills, and techniques by providers to comprehensively address both mental health and substance abuse issues in persons with COD. It is not the use of specific treatment techniques that make a treatment integrated, but the selection and blending of these techniques by the provider and the manner in which they are presented to the consumer that defines integration. Ideally, the providers of integrated treatment would have access to all relevant mental health and substance abuse interventions to blend in an individualized treatment plan.

Treatment planning is a collaborative process that requires an individual and his or her service team to consider the assessment information, to establish individual goals, and to specify the means by which treatment can help the individual reach those goals. Treatment for people with dual disorders is more effective if the same clinician or clinical team helps the individual with both substance abuse and mental illness; that way the individual gets one consistent, integrated message about treatment and recovery (SAMHSA, 2003).

Integrated Treatment Programs for Justice-Involved Persons with COD

While coercion is a consideration in the application of all EBPs to justice-involved persons, its role in COD services is critical. Approaches to the effective use of coercive interventions within the context of integrated treatment have been proposed (CSAT, 2005; Mueser et al., 2003). The appropriate application of coercive strategies by providers is one of the adaptations to COD integrated services required to work with justice-involved persons. Ultimately, the challenge for the client will be to move beyond coercion as the external motivating factor for change to other internal and voluntary motivations.

Several program models such as modified therapeutic community, integrated dual disorder treatment, and assertive community treatment have the potential to achieve positive outcomes with justice-involved persons with COD:

- The modified therapeutic community (MTC) is an integrated residential treatment program with a specific focus on public safety outcomes for persons with COD (DeLeon, 1993). It is a derivative of the therapeutic community and has demonstrated lower rates of

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reincarceration and a reduction in criminal activity in MTC participants (Sacks et al., 2004).

- The Integrated Dual Disorder Treatment (IDDT) model combines program components and treatment elements to assure that persons with COD receive integrated treatment for substance abuse and mental illness from the same team of providers (SAMHSA, 2003). While routinely applied to justice-involved persons with COD, the model has not yet been studied for its specific effects on criminal justice outcomes.
- Assertive Community Treatment (ACT) and its adaptations for justice-involved persons has been previously reviewed (Morrissey & Piper, 2005). As an evidence-based program (EBP), ACT is a blend of program components and treatment elements of which several are specific to COD.

COD Across the Continuum of Criminal Justice Settings

It is important to remember that in applying service integration strategies for justice-involved persons with COD, it is necessary to look at both the program modifications that are required within the various points of contact with the justice system, and the unique aspects of linking justice-involved persons from a point of contact to community providers. Tailored responses within police, court, jail, prison, and community corrections contexts are required.

- The earliest point of contact with the justice system is typically at the point of arrest. Innovation in police responses has led to the development of numerous models (Reuland & Cheney, 2005) aimed at reducing the number of persons with mental illness going to jail, improving officer and civilian safety, and increasing the officers understanding of behavioral disorders.
- A growing number of persons with co-occurring mental and substance use disorders appear before the court. It is critical that court staff understands, identifies, and accommodates the court process to the unique features of defendants with co-occurring disorders. For the courts, further efforts are required to establish the relationship between these clinical disorders and the criminal charges.
- Jails and prisons are constitutionally obligated to provide general and mental health care (Cohen, 2003). In fact, incarcerated individuals are the only U.S. citizens with legally protected access to health care. Jails may be the first opportunity for COD problem identification, treatment, and community referral (Peters & Matthews, 2002).
- The inadequacy of discharge or transition planning activities for inmates released from jail and prison have been well documented (Steadman & Veysey, 1997). Clearly the identification of COD within the inmate population is a critical step to release planning and community linkage. For persons without conditions of release, access to integrated services will be at least as difficult as that of other citizens. For people with probation or parole terms, community supervision affords an opportunity to engage and monitor the person with COD in integrated settings.

Future Directions

The majority of care is likely to be delivered in less structured programs and by clinicians who will hopefully embrace the principles of integrated care. As recommended by SAMHSA in the 2002 Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders, sustained attention should be paid to the development of training the workforce and keeping specific clinical competencies in the forefront.

It is important to provide incentives to address COD in the criminal justice system. This can be achieved in part by documenting the high prevalence of COD within justice settings and the consequences, in terms of poor outcomes, of not providing optimal care.

Justice settings should provide routine screening for CODs (Peters & Bartoi, 1997). Law enforcement, court, and corrections personnel should receive training in the application of effective EBPs to respond to the needs of persons with COD. In addition, behavioral health providers should become familiar with the goals and objectives of these criminal justice programs.

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Cross-Systems Mapping & Taking Action for Change

Appendix H: Addressing Histories of Trauma and Victimization through Treatment

GAINS The National GAINS Center for People with Co-Occurring Disorders in the Justice System

Addressing Histories of Trauma and Victimization through Treatment

4 of 8
SAMHSA Substance Abuse and Mental Health Services Administration

Colleen Clark, PhD

September 2002

Justice-Involved Women with Co-occurring Disorders and Their Children Series

In 1998, women comprised 22% (3.2 million) of annual arrests in the U.S. Between 1990 and 1998, the number of women in prison increased by 88%, on probation by 40% and on parole by 80% (Chesney-Lind, 2000). Today, women account for 11% of the U.S. jail population (Beck & Karberg, 2001). The facts are compelling; women are a rapidly increasing presence in a male oriented justice system. Women offenders present multiple problems: mental illness and substance use disorders, child-rearing, parenting and custodial difficulties, health problems, histories of violence, sexual abuse and corresponding trauma (Veysey,1998). Among women entering jails, 12.2% are diagnosed with serious mental illnesses, almost double the rate of males at intake (Teplin, 2001), and 72% present a co-occurring substance use disorder. Many women in jail have been victims; a staggering 33% are diagnosed with post-traumatic stress disorder (Teplin et al., 1996). In a recent jail survey, 48% of women reported a history of physical or sexual abuse and 27% reported rape (BJS, 2001).

Women entering jail may be pregnant, post-partum or leave children in the community. More than 100,000 minor children have a mother in jail (Bloom & Owen, 2002). History of abuse is known as a correlate of behavior leading to contact with the justice system; the cycle of intergenerational violence is well documented. Early identification of this history is critical in treatment decisions, planning for community re-entry and the return of the ex-offender mother to a parenting role.

Though many correctional facilities recognize that women bring different health and relationship issues to their period of incarceration, operationally most have not adjusted practices already established for male inmates. Jails present a challenge to service provision due to their 'short-term' nature where lengths of stay may range from overnight detention to a sentence of up to one year. This series discusses topical issues relating to women in jails and highlights promising programs from around the nation.

Women in jail have often been the victims of physical or sexual abuse in childhood and/or adulthood (ACA, 2001). Consistent with the finding that most women with co-occurring mental and substance use disorders have histories of abuse (Alexander, 1996), trauma histories can be considered the norm among women with co-occurring disorders in jail.

The impact of this violence can affect all areas of a woman's life and the lives of her children and contributes to the development of, and impairs the recovery from, mental and substance use disorders. In the last few years, survivors, clinicians and other service providers have worked together to develop principles, procedures and techniques to assist women in their recovery from trauma, even in the face of coexisting mental health, substance abuse and criminal justice issues.

Trauma-Sensitive Treatment

Trauma-sensitive treatment (Harris, 1998) refers to incorporating an awareness of trauma and abuse into all aspects of treatment and the treatment environment. This awareness can be used to modify procedures for working with women in jail.

Just as drug treatment best occurs in a drug-free environment, trauma treatment is best accomplished in as trauma-free environment as possible. Some abuse survivors, especially those with histories of severe or prolonged abuse, may experience angry outbursts, self-destructive or self-mutilating behaviors or other apparently irrational behaviors that can be considered disruptive in jail. Traditional responses include seclusion, at times with little clothing to prevent further harm; direct physical restraint; intense observation; use of straps or cloth limb restraints; or heavy dosages of major tranquilizers. These approaches may mimic traumatic assaults or abuses experienced under different circumstances. A previously incarcerated woman described her experience as follows: *"Very, very rarely did I have, for instance, women physicians and women guards. And I think that in terms of somebody who is scared, that makes a big difference. A lot of the staff that I interacted with seemed to be directly out of the military. … I mean, a medical exam was not a safe situation ..."* (National GAINS Center, 1998).

A trauma-sensitive approach suggests alternative procedures that are not only less likely to exacerbate symptoms, but are also more effective as behavioral management techniques. The TAMAR project in Maryland is designed to increase the awareness of trauma for those

working with incarcerated women and to provide trauma-sensitive and trauma-specific services in criminal justice settings. They offer alternative approaches, such as talking the detainee through a "pat down" to explain when, how and why there will be physical contact during the procedure.

In a review of jail practices and female detainees with abuse histories, Veysey, De Cou and Prescott (1998) point out that procedures developed for practical security and treatment purposes have historically not accommodated gender-differences. A gender-and trauma-sensitive environment may include the use of female staff; minimizing procedures that require removal of clothing; incorporating trauma issues into other treatment modalities; and maximizing access to trauma-specific therapies. Training should be provided to all staff involved with the incarcerated women, including correctional and social services staff (TAMAR, 1998). As one trauma survivor replied when asked what helps, *"... someone who can help me to see I have choices—who can help me to stay in the present, keep me from going way down. There is a lot of knowledge about how to do this. It needs to be shared."* (Maine DMH, 1997)

Did you ever receive punishment that resulted in bruises, cuts, burns, or other injuries?
☐ 1- *Yes* ☐ 2- *No* *At what age:* ___

If Yes, do you want to discuss it?
☐ 1- *Yes* ☐ 2- *No*

Generally, it is recommended that terms such as "physical abuse," "sexual abuse" and "perpetrator" be avoided in traumatic assessment interviews as they are not words that the individual likely uses to describe or understand their experiences—and may be misinterpreted. A basic history usually includes questions about the experience of physical, sexual, and emotional abuse in childhood and adulthood as well as the witnessing of such acts. Separate questions are usually asked regarding "domestic violence" and rape in adulthood.

Very, very rarely did I have ... women physicians and women guards. And I think [for] somebody who is scared, that makes a big difference … I mean, a medical exam was not a safe situation.

A trained intake worker can conduct a basic trauma assessment—an advanced professional degree is not required. Staff training, however, is important to increase staff comfort and competence in conducting assessments and in eliciting informative trauma histories. Effective staff training addresses concerns, provides evidence that asking about violence is helpful to clients, addresses client reticence to discuss violence, and emphasizes client choice in answering questions. Training in sensitivity to cultural issues is also important; for example, cultural norms may inhibit willingness to reveal victimization to people outside the family (Fearday et al., 2001).

If clinical services or a professional clinician are available, the basic history should be followed by a more detailed examination that covers issues such as the duration and intensity of the violence and whether the woman would like to talk more about her abuse. It can also be helpful to determine if the woman experiences symptoms that are often the result of trauma and signs of post-traumatic stress disorder (PSTD), such as flashbacks, nightmares, insomnia, fearfulness, or numbness. If there are no trauma-specific services available in the jail, information from a woman's history can still be helpful in creating a trauma-sensitive environment and for discharge planning.

Service providers sometimes express reluctance to ask about abuse and violence. Reasons may include fear of re-traumatizing clients or being intrusive, or knowing the staff/program is unequipped to offer follow-up support. Trauma survivors often appreciate being asked about their history when it is done in a respectful manner, but women should always be given the option of not answering these or any other personal questions. With few exceptions, the emotional responses elicited by such an assessment require the same basic counseling skills needed for any mental health or substance abuse assessment.

Identifying Trauma

Assessing a woman's history of abuse can be very straightforward and should be included in all routine mental health and substance abuse assessments. Women with adequate reading skills can complete a simple checklist or a questionnaire can be completed by interview. Questions should be worded in a concrete, behaviorally-anchored fashion to avoid misunderstanding, as might arise from people's differing definitions of abuse. For example, in seeking to learn if a respondent has been physically abused, the question is best posed as follows:

Trauma-Specific Service Planning and Program Development

Trauma -responsive planning has evolved in the context of therapeutic community-based programs and shelters serving women in crisis, at risk, or presenting mental illnesses or substance use disorders. The SAMHSA Women, Co-Occurring Disorder and Violence KDA Study identified eight program components critical to the development of successful trauma-focused models (Salasin, 2000).

These components are also applicable within the context of a jail setting:

- outreach and engagement
- screening and assessment
- parenting skills
- peer-run services
- treatment
- crisis interventions
- trauma-specific services.

Trauma-Specific Therapies and Treatment Approaches

Full recovery from trauma and its sequelae can be a lengthy process that occurs over several years. Interventions are being developed that address initial goals of establishing safety in relationships and the home environment as well as understanding symptom experience related to trauma. An evidence-base for gender sensitive treatment is being established—along with some "user-friendly" clinical manuals that will facilitate their translation from research to practice settings. Examples of ongoing work in this area are outlined below.

Seeking Safety is a present-focused 25-topic manualized intervention that integrates the treatment of PTSD and substance abuse (Najavits, 2001).

Trauma Recovery and Empowerment (TREM) (Harris, 1998) offers (30-plus) manualized sessions that integrate recovery from trauma with mental illness and substance abuse treatment.

Treating concurrent PTSD and Cocaine Dependence (Brady et al., 2001) uses manual-guided imaginal and in-vivo exposure with cognitive behavioral relapse prevention techniques.

Substance Dependence Posttraumatic Stress Disorder Therapy (Triffleman et al., 1999) is a 5 month, twice weekly manualized cognitive behavioral intervention.

Triad Women's Project (C. Clark, PI) has developed a 16-session manualized psychoeducational intervention that builds skills to facilitate recovery from trauma and mental illness.

Importantly, these interventions were designed to be implemented by front-line counselor-level staff in jail and community-based treatment settings. To address the experience of abuse and violence, counseling staff must recognize that trauma can result in a range of behavioral, emotional, physical, and cognitive disorders. Most trauma-informed interventions cover three primary areas:

1) Identifying the *nature and extent of the trauma*, including symptom development; strengths used for survival; distortion of feelings and behavior due to trauma; and how ongoing-symptom experiences (dissociation, substance abuse) may function to numb the pain of abuse history.

2) The creation of a *safe haven* for trauma survivors can be the most healing aspect of any intervention. Certain basic rules help to establish this environment, including confidentiality; opportunity to speak or "pass"; and a group norm disallowing advice-giving, criticism, or confrontation. Common responses among women experiencing such an environment include increased self esteem at knowing what they have to say is heard and valued, relief at finding they are not alone or "crazy" or "bad" because of their experiences, and increased empowerment.

3) Women with trauma histories are encouraged to *develop skills needed to recover* from traumatic experiences and build healthy lives. These may include cognitive, problem-solving, relaxation, stress coping, relapse prevention and short- or long-term safety planning skills.

Re-entry

To effectively plan the transition from jail to community-based treatment, community treatment programs should be reviewed for "trauma awareness." This program review should identify whether the program offers trauma-specific treatment, incorporates trauma awareness into substance abuse and mental health treatment, provides staff training in trauma sensitivity and offers women-only programs.

For any given woman, more detailed examinations may be necessary to determine a program's capability to address issues identified but not addressed in jail. For example, there is no standard protocol for medication of trauma-related disorders, and the added complexity of medication management for women with mental illnesses and substance abuse histories can make this a very difficult task. Even when an appropriate psychiatrist in the community is identified, questions of access and paying for treatment remain. Community programs that either initiate contact while the women are incarcerated or provide groups within the jails that are also provided in the community are ideal for developing trust and providing continuity (TAMAR, 1998; Triad, 2000).

Consistent with in-jail interventions, the most important discharge planning consideration is establishing safety. No trauma treatment can truly be effective if a woman returns to or remains in an abusive or violent environment. If safe placement is not immediately possible, priority attention should be placed on giving women information on options and resources, such as domestic violence shelters. Obtaining the woman's permission to communicate information about her trauma history with the follow-up providers can be very beneficial. This alerts the community provider to issues they may not regularly assess and helps the woman not have to repeat the telling of her history.

Over the next several years, it seems likely that most in-jail and community-based programs will increase their emphasis on trauma-sensitive and gender-specific treatment interventions.

Promising program…

TIR (**T**raumatic **I**ncident **R**eduction) The Department of Women's Justice Services of the Cook County Sheriff's Office was formed in 1999 to administer gender and culturally appropriate services to female drug offenders in Cook County, Illinois. The three phase program consists of a pre-treatment, treatment education, and a relapse prevention component, each lasting 20-30 days. Services include mental health, education, life skills, training, and community reintegration components. The Cook County Sheriff's Office subcontracts with TIR, a nonprofit educational foundation composed of community partners, a mental health practitioner, university faculty and researchers. TIR is committed to providing effective treatment for those suffering from the effects of trauma. TIR employs a systematically focused memory recovery technique for permanently reducing or eliminating the effects of traumatic events.

For more information: rie@wwa.com

Tools & Resources

1) **TAMAR Project, MD***
   Program information
   Joan Gillece: gillecej@dhmh.state.md.us
2) **TRIAD Women's Project, FL***
   Group Facilitator's Manual (2000)
   Integrated Biopsychosocial Assessment Instruments for (non)/clinical settings (includes trauma questions)
   Colleen Clark: cclark@fmhi.usf.edu
3) **TREM: Community Connections**
   Approaches to Trauma Services (1997)
   Maxine Harris: mharris@ncemi.org
4) **Maine Trauma Advisory Group: Report (1997)**
   Dept. of Mental Health, Office of Trauma Services: (207) 287-4250
5) **Trauma Assessment and Resource Book**
   NYS OMH:Trauma Initiative Design Center*
   Fax requests to: (518) 473-2684

* Sample screening forms available upon request.

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Cross-Systems Mapping & Taking Action for Change

Appendix I: Extending Assertive Community Treatment to Criminal Justice Settings

Extending Assertive Community Treatment to Criminal Justice Settings

Joseph Morrissey, PhD, and Piper Meyer, PhD[1]

CMHS National GAINS Center May 2006 *Updated August 2008*

Assertive Community Treatment (ACT) is a service delivery model in which treatment is provided by a team of professionals with services determined by consumer needs for as long as needed (Phillips et al., 2001). ACT combines treatment, rehabilitation, and support services in a self-contained clinical team made up of a mix of disciplines, including psychiatry, nursing, addiction counseling, and vocational rehabilitation (Stein & Santos, 1998; Dixon, 2000). The ACT team operates on a 24/7 basis, providing services in the community to offer more effective outreach and to help the consumer generalize the skills to real life settings (Phillips et al., 2001). ACT is intended for consumers who have severe (a subset of serious with a higher degree of disability) mental illness, are functionally impaired, and at high risk of inpatient hospitalization.

Evidence-Base for ACT

The effectiveness of ACT has been well established with over 55 controlled studies in the US and abroad. In one recent review (Bond et al., 2001), ACT was found to be most effective in reducing the use and number of days in the hospital, but *not* consistently effective in reducing symptoms and arrests/jail time or improving social adjustment, substance abuse, and quality of life (See also Burns & Santos, 1995; Dixon, 2000; Marshall & Lockwood, 2004; Ziguras & Stuart, 2000). When tested against other forms of case management, ACT teams have proven to be more effective *only* in reducing psychiatric hospitalizations and improving housing stability (Bond et al, 2001; Ziguras & Stuart, 2000; LewinGroup, 2000).

The lack of effectiveness in preventing arrests/jail detentions and reducing substance abuse in these studies is disappointing. However, very low base rates of arrest and the consequent lack of statistical power hamper drawing clear conclusions about these outcome indicators. A relevant question becomes: Can we keep persons with severe mental illness out of jail by assigning them to special ACT teams that focus on forensic populations and incorporate new specialists within the team with criminal justice system know-how?

FACT Adaptations

A number of ACT-like programs have grown up in communities around the country that focus on keeping people with severe mental illness out of jails and prisons. The name "forensic ACT" or FACT is the emerging designation for these hybrid teams. Little standardization of program practices and staffing exists for FACTs. Among the core elements that distinguish FACT from ACT are: (1) the goal of preventing arrest and incarceration; (2) requiring that all consumers admitted to the team have criminal justice histories; (3) accepting the majority of referrals from criminal justice agencies; and (4) the development and incorporation of a supervised residential treatment component for high-risk consumers, particularly those with co-occurring substance use disorders (Lamberti et al., 2004).

Can ICM Substitute for ACT?

Intensive Case Management (ICM) is a model that has some distinct differences from ACT and requires less funding than a full-fidelity ACT team. ICM often mirrors ACT with regard to assertive, in-vivo, and time-unlimited services, but it uses case managers with individual caseloads, has no self-contained team, lacks 24/7 capacity, and brokers access to psychiatric treatment rather than providing it directly. Brokered case management is much less intensive due to larger caseloads, often office-based services, and less frequent client contact. Evidence indicates that brokered case management is ineffective (Marshall et al., 1998) whereas strengths case management appears to be effective in a small number of trials (Rapp, 2004). We have located 26 programs in 12 states that have described their ACT or ICM program as one that serves a forensic population.

FACT Evidence-Base

Published evidence on FACT teams is limited to two recent studies (McCoy et al., 2004 ; Weisman et al, 2004). In a pre-post study (no control group), consumers who completed one year of Project Link in Rochester, NY (Lamberti et al., 2001), compared to the year prior to program admission, had significant reductions in jail days, arrests, hospital days, and hospitalizations. A preliminary pre-post cost analysis also found that Project Link reduced the average yearly service cost per client (Weisman et al., 2004). Improvements were also noted in psychological functioning and engagement in substance abuse treatment. In two pre-post studies (no control group) after one year at the Thresholds State County Collaborative Jail Linkage Project (CJLP) in Chicago, consumers had a decrease in days in jail and days in the hospital and reduced jail and hospital costs (McCoy et al. 2004).

FICM Evidence-Base

The evidence base for FICM effectiveness comes from published studies (Cosden et al., 2003; Godley et al., 2000; Solomon & Draine, 1995; Wilson et al., 1995) and from the nine-site SAMHSA Jail Diversion Demonstration, where sites used FICM in a service linkage model (Broner et al., 2004; Steadman & Naples, 2005).

The first study (Broner et al., 2004; Steadman & Naples, 2005) involved a non-random comparison group design that used FICM to divert detainees to community treatment services at diverse sites around the country. Diverted individuals reported more days in the community, more service use, and fewer jail days than did the non-diverted comparison groups, but there

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were no consistent differences on symptoms or quality of life. In other words, FICM improved jail incarceration outcomes, but it had little or no effect on public mental health outcomes. Steadman and Naples argue that the absence of mental health effects in the SAMHSA jail diversion study was due to the treatment services to which diverted individuals were referred. None of them provided evidence-based treatments such as ACT, so the referral was equivalent to assigning people with severe mental illness and co-occurring substance abuse disorders to usual care.

Two random clinical trials have been reported here as well (Cosden et al., 2003; Solomon & Draine, 1995). The Solomon and Draine study compared FICM with FACT and with usual care services, finding no significant differences in social or clinical outcomes after one year of services but a higher re-arrest rate for FACT (attributed to having probation officers on the team). The Cosden et al. study compared a combined mental health court and FICM model (that also had probation officers as team members) with usual care; at 12 months, both groups exhibited improvements in life satisfaction, psychological distress, independent functioning, and drug problems. No differences were found for time in jail or number of arrests, but consumers in the intervention arm were more likely to be booked and not convicted, and to have been arrested for probation violations. The usual care group were more likely to be convicted of a new crime.

Conclusions

FACT teams are relatively new adaptations of the ACT model, yet implementation is outpacing knowledge of FACT's effectiveness (Cuddeback et al., 2008). When adhering to the core ACT model, they show promise for reducing inpatient hospitalizations. Paired with interventions effective for justice involvement, they can be expected to reduce recidivism and maintain certain clients in the community. Nonetheless, they are a high intensity, high cost intervention that fits the most disabled segment, perhaps 20 percent, of the persons being diverted or reentering from the criminal justice system. The community management models of choice for the other 80 percent or so of less disabled individuals are multiple, less costly forms of criminal justice-informed case management that rely on brokering services from mainstream providers rather than providing all services via a FACT team. While brokered case management models are still a challenge for many communities with limited resources, they are sustainable in areas where services are more ample. The development of a clinical model for FACT that allows for fidelity measurement is essential for establishing an evidence base. ▮

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Cross-Systems Mapping & Taking Action for Change

Appendix J: The EXIT Program: Engaging Diverted Individuals Through Voluntary Services

The EXIT Program: Engaging Diverted Individuals Through Voluntary Services

Gerald Foley[1] and Elisa Ruppel[2]

The CMHS National GAINS Center **May, 2008**

Among justice-involved people with serious mental illness and co-occurring substance use disorders, those who repeatedly commit misdemeanors are perhaps the most difficult to effectively divert into services from the criminal justice system. Despite extensive criminal histories, with today's overcrowded jails they face relatively little jail time. Offered a choice between a few days in jail or 12 to 24 months of court supervision, they often serve the jail sentence on recommendation of defense counsel.

In 2002, the New York City Mayor's Office partnered with the Center for Alternative Sentencing and Employment Services to develop a strategy for engaging this population in services. This partnership led to the development of EXIT, a jail diversion program for justice-involved people with mental illness who are processed through Manhattan's Criminal Court.

At arraignment, a forensic clinical coordinator screened referred individuals for serious mental illness and program eligibility standards: nonviolent misdemeanor instant offense, at least three prior misdemeanor convictions, and a possible 5 to 30 day jail sentence on the current charge.

Rather than divert people into a lengthy period of court supervision, EXIT emphasized voluntary access to services through a required three-hour Mandated Treatment Assessment Session (MTAS), which was conducted by staff at the program's office immediately following sentence. The goals of the MTAS were to: 1) assess and address the participant's immediate needs, including food, shelter, and clothing; 2) outline short- and medium-term goals the participant could pursue through nonmandated case management services; 3) explain the potential benefits of program engagement; and — if the individual accepted services — 4) establish mutually agreed-upon expectations, including means for maintaining contact, level and frequency of contact, and service goals.

After completing the MTAS, an individual could elect to participate in nonmandated case management services to address identified needs. The program coordinated services among various providers, and maintained as-needed contact with participants to ensure sufficient community supports necessary for stability and the reduction of risk for rearrest. Core program elements were drawn from identified best practices, focusing heavily on strengths-based engagement combined with intensive case management. EXIT established a strong commitment to consumer involvement at all stages of program planning, implementation, evaluation, and promotion. A peer specialist was employed to serve as an escort to appointments and to provide other supportive services to participants and staff, including case consultation, as a full member of the treatment team.

EXIT's high engagement–low coercion model provided a path from the court to community-based treatment with minimal judicial oversight and no probation or parole monitoring. Beyond reporting completion of the MTAS, the program was not obligated to provide status updates on participants to the court.

Participant Characteristics

As shown in Table 1 (below), bipolar, schizophrenia spectrum, and depressive disorders were about equally distributed among defendants who entered the program with a diagnosis. There were 31 of 173 (18 percent) individuals who could not specify a diagnosis, but were admitted to the program based on signs of mental illness apparent to clinical staff during screening.

1 EXIT Project Director, New York City Mayor's Office of the Criminal Justice Coordinator, New York, New York
2 Research Associate, Center for Alternative Sentencing and Employment Services, New York, New York

Mental Health Diagnosis	Number	Percent
Schizophrenia/Schizoaffective Disorder	38	22
Bipolar Disorder	37	21
Depressive Disorder	36	21
Anxiety	2	1
Two or More Diagnoses	29	17
Diagnosis Unavailable	31	18
Intake Arrest Charge		
Property Crime	57	33
Possession of Controlled Substances	47	27
Theft of Services	12	7
Trespassing	12	7
Disorderly Conduct	12	7
Forgery Crimes	8	5
Criminal Tampering/Criminal Mischief	6	3
Criminal Possession of a Weapon	5	3
Other/Unknown	14	8
Gender		
Male	150	87
Female	20	12
Other	3	1
Race/ Ethnicity		
Non-Hispanic African American	108	63
Hispanic	35	20
Non-Hispanic Caucasian	28	16
Other	2	1
Age Range		
18-29 years	32	18
30-39 years	51	29
40-49 years	66	39
50-59 years	23	13
60+ years	1	1

Table 1. Demographics of EXIT Participants (n=173)

EXIT participants were a needs-intensive group. In addition to serious mental illness, 87 percent reported current substance use and approximately half were homeless.

The largest number of participants (57) entered the program due to arrest for a property-related offense, followed by possession of a controlled substance (47).

Although screenings comprised only 11 percent women, women were admitted to the program at a rate comparable to their male counterparts (43 percent, compared to 41 percent of all men screened). The average age of participants at intake was 39 years.

Results

Criminal Justice Buy-In

The EXIT program experienced increased levels of criminal justice buy-in over the life of the program as evidenced by the high utilization rate among judges. All but 23 of the 196 defendants found eligible were released to the program. This is significant given the initial reticence on the part of some judges to release defendants to the program due to concerns that the three-hour MTAS did not constitute a sufficiently stringent sanction. Moreover, judges expressed concern that the program's voluntary case management model would neither allow for judicial oversight nor provide a compelling reason for participants to remained engaged with services.

EXIT's high engagement-low coercion model provided a path from the court to community-based treatment with minimal judicial oversight and no probation or parole monitoring.

Consumer Engagement

Ninety-seven percent of defendants court ordered to complete the MTAS fulfilled their obligation to the court. Of the 168 defendants who completed the MTAS, 120 (71 percent) had subsequent nonmandated in-person contact with program staff. Two-month retention was at 54 percent, with 21 percent remaining engaged with the program for a minimum of six months. For those who remained engaged for a minimum of eight months, program contacts averaged approximately three per month.

Recidivism

A snapshot of 90 EXIT participants was selected for the purpose of analyzing conviction patterns. Participants with felony convictions in the 12 months before or after the MTAS were excluded, since it was

expected that far fewer days at liberty would decrease their likelihood of reconviction on misdemeanor charges. EXIT participants with open cases were also excluded from the analysis. Nine individuals were excluded, leaving a cohort of 81.

Across the cohort, there was an 18 percent reduction in the aggregate number of convictions in the year following program engagement compared to the year before, representing a decrease from 261 convictions to 214 convictions in the 12-month pre- versus post-MTAS periods [$t(80) = 2.09$, $p=.039$].

To determine whether participation in post-MTAS case management services had any effect on recidivism, the 81 participants were divided into three subgroups:

- Group 1 - Those who did not engage in any post-diversion case management sessions
- Group 2 - Those who engaged in between one and nine case management sessions
- Group 3 - Those who engaged in 10 or more sessions

Groups were defined based on an analysis of case management engagement patterns across the entire sample pool. Of the 81-member cohort, 24 subjects (29.6 percent) had no contact, 25 (30.9 percent) had between one and nine contacts, and 32 (39.5 percent) had at least 10 post-MTAS case management contacts.

… there was an 18 percent reduction in the aggregate number of convictions in the year following program engagement compared to the year before …

While all groups experienced a reduction in the aggregate number of convictions in the post- versus pre-MTAS period, the cohort with 10 or more post-MTAS case management contacts (Group 3) experienced the largest decline (24 percent, compared to 18 percent and 11 percent for Groups 2 and 1, respectively). Further analysis revealed that in the post-MTAS year this same Group 3 cohort comprised the highest number and percentage of individuals with no convictions (11, or 34 percent of cohort, representing 52.4 percent of the 21 subjects across all groups with zero convictions in the post-MTAS year).

Discussion

Based on the EXIT program data, the chronic patterns of both re-conviction and transient service engagement long associated with people with serious mental illness who repeatedly commit misdemeanors can be interrupted through nonmandated engagement in services. It also suggests that the program services provided by EXIT were viable and responsive to individual needs, as evidenced by the number of participants who remained engaged in program services for periods up to and exceeding six months, and as confirmed through consumer feedback.

The presumption that mandated engagement would have yielded lengthier program tenure rates is tempered by several considerations. First, the aggregate and cohort conviction rate decline suggest that retention drop off is not necessarily indicative of undesirable outcome. Drop off could have reflected more positive alternatives such as reduced reliance on EXIT resulting from the fulfillment of immediate service needs or successful transition to permanent providers. Also compelling is the possibility that retention rates may have been increased with enhanced staffing as opposed to imposition of mandate. For example, during the program's second year, when it was fully staffed, the minimum six-month retention rate of 35 percent approximated the three-month rate averaged over the life of the program (36%).

EXIT demonstrates that people with mental illness who repeatedly commit misdemeanor offenses can engage voluntarily and remain engaged in services beyond any court mandate, with significantly reduced recidivism as an outcome.

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Appendix K: Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders

The National GAINS Center for People with Co-Occurring Disorders in the Justice System

Maintaining Medicaid Benefits for Jail Detainees with Co–Occurring Mental Health and Substance Use Disorders

SAMHSA Substance Abuse and Mental Health Services Administration

Summer 1999/*Revised Spring 2002*

In most communities, individuals detained in jails find themselves without access to Medicaid benefits upon release. Medicaid is a government program that provides medical assistance, including mental health and substance abuse treatment services, for eligible individuals and families with low incomes and resources. Medicaid benefits are not payable directly to clients, but instead are paid to providers of care. Termination of Medicaid benefits occurs due to state policies governing inmates of public institutions.

To regain medical assistance benefits after release from jail, the individual may have to go through a re-application process, which may delay access to benefits two or three months. During the critical days following release, the person may be unable to meet his/her basic living needs and may be denied access to all but emergency health care. Loss of Medicaid benefits can interrupt, delay, limit, or even prevent access to community treatment services and psychotropic medication for weeks or months and potentially undo any stabilization the individual gained while in jail, placing the individual at risk of re-hospitalization and/or return to the criminal justice system.

...federal law does not require that Medicaid benefits be terminated immediately upon incarceration or that termination occur at all.

In some systems, the loss of medical assistance benefits does not prevent the person from accessing public treatment services, but instead shifts the full cost of mental health, substance abuse, and medical treatment to local city, county, or state agencies that bear these costs without the federal assistance to which they are entitled.

Lane County, Oregon (Eugene) is an example of a community that experienced this problem with regard to individuals targeted for diversion through its jail diversion program. Program staff were able to successfully address the issue of medical assistance benefits at the state and local levels to foster improved continuity of care. Lane County was one of nine sites funded by Substance Abuse and Mental Health Services Administration in the Jail Diversion Knowledge Dissemination Application Initiative (Steadman, Deanne, Morrissey, Westcott, Salasin, & Shapiro, 1999).

The Federal Guidelines on Medicaid

Medicaid is a federal-state partnership. States administer their own programs within broad guidelines provided by the federal government. Federal law prohibits State Medicaid agencies from using Federal Medicaid matching funds, known as Federal Financial Participation, to pay for medical, mental health and substance abuse treatment services to eligible individuals "who are inmates of a public institution." As defined in the law, "public institutions" include jails, prisons and juvenile detention or correctional facilities. Though the prohibition of the Federal Financial Participation begins the moment the person becomes an inmate of a public institution, federal law does not require that Medicaid benefits be terminated immediately upon incarceration or that termination occur at all.

Federal policy does not specify how states are to implement this prohibition on Federal Financial Participation, nor does it prohibit states from using their own funds to serve eligible persons who are inmates of a public institution. Federal Policy does permit states to suspend temporarily payment status for incarcerated persons, however, many states' management information systems do not allow for the suspension of cases, leaving termination the only option. Despite the prohibition on Federal Financial Participation or suspension of payment status, an individual may still retain eligibility status while in jail. Moreover, as Secretary of Health and Human Services, Tommy Thompson, wrote to Hon. Charles Rangel in Oct. 1, 2001 correspondance, "States must ensure that the incarcerated individual is returned to the rolls immediately upon release, thus allowing individuals to go directly to a Medicaid provider and demonstrate his/her Medicaid eligibility." This statement reiterates the position of former secretary of Health and Human Services, Donna Shalala, in her April 6, 2000 letter to Rangel.

"States must ensure that the incarcerated individual is returned to the rolls immediately upon release, thus allowing individuals to go directly to a Medicaid provider and demonstrate ... Medicaid eligibility." — Tommy Thompson, Secretary of Health and Human Services

Lane County's Experience

In developing its jail diversion program, Lane County encountered barriers in maintaining uninterrupted access to treatment for the target population because of difficulties maintaining Medicaid benefits after booking into the local jail. In Oregon, as in most states, once the state Medical Assistance agency was notified of the individual's admission to jail, medical assistance benefits were automatically terminated. Upon release from jail, the individual had to reapply for Medicaid benefits, and await eligibility re-determination and renewed access to treatment services.

Lane County staff raised these issues with the Director of the Oregon Mental Health Division, who in turn brought them to the attention of the state agency responsible for administering Medicaid benefits. The state recognized this as a significant barrier to continuity of care for the individuals with short-term stays in jails, the majority of people incarcerated. The state Medicaid agency first adopted an Interim Incarceration Disenrollment Policy (5/20/98) and subsequently made the change permanent. This policy specifies that individuals will be approved for disenrollment from the Oregon Health Plan managed care plans effective the 15th calendar day of incarceration. In effect, individuals released within the 14-day window before disenrollment will have access to their Medicaid benefits as if the incarceration had not occurred. The disenrollment after 14 days is based on holding a third party, i.e., the local jurisdiction responsible for incarceration, responsible for paying for medical costs during incarceration.

...in addition to the 14-day delay in termination of Medicaid benefits, the application process can begin while the detainees are still in custody for those individuals who did not have benefits upon arrest...

Lane County has developed an ongoing working relationship with the local application processing agency for Medicaid—the Senior and Disabled Services office. Now, in addition to the 14-day delay in termination of Medicaid benefits, the application/re-application process can begin while detainees are still in custody for those individuals who did not have benefits upon arrest or whose Medicaid had been terminated because of incarceration longer than fourteen days. Jail diversion staff help inmates fill out Medicaid applications, which are faxed to the Senior and Disabled Services office prior to the inmates' release. This office "fast tracks" diversion program participants, both those previously determined eligible for benefits and those who have never before applied, processing their applications in a day or two. The Senior and Disabled Services office faxes temporary Medicaid cards to the jail, ensuring that the individual has immediate access to all health plan benefits upon release from jail. Permanent cards follow by mail.[1]

The Lane County diversion staff report this change in state policy has greatly benefited jail detainees with co-occurring disorders by addressing a critical barrier to uninterrupted treatment in the community after release from jail.

Lane County's experience suggests a careful examination of medical assistance benefit processing in any community designing, implementing, or operating a criminal justice linkage program for persons with co-occurring mental health and substance use disorders. Specifically, it is worthwhile to investigate the following:

- the state Medicaid agency's interpretation and application of federal law;
- the state's information management systems that identify when Medicaid-eligible people enter or leave jail;
- the state Medicaid agency's suspension of benefits and disenrollment policies;
- the state Medicaid agency's policy regarding resumption of benefits.

Linkage program staff should develop lines of communication with the local benefits application agency and state Medicaid agency to ensure medical benefits or eligibility thereof are not lost or interrupted unnecessarily. ■

For more information about the Lane County Diversion Program, contact Richard K. Sherman, M.S., at (541) 682-2121 or richard.sherman@co.lane.or.us.

This factsheet was written by Patricia A. Griffin, Ph.D., Michelle Naples, M.A., Richard K. Sherman, M.S., Mark Binkley, J.D., and Kristin Stainbrook, M.S.

[1] Lipton, Liz (2001) *Psychiatric News*. Vol. 36(16).

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The National GAINS Center for People with Co-Occurring Disorders in the Justice System is a national center for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system. The GAINS Center is a partnership of the Substance Abuse and Mental Health Services Administration's two centers—the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS)—and the National Institute of Corrections, the Office of Justice Programs and the Office of Juvenile Justice and Delinquency Prevention. The GAINS Center is operated by Policy Research Associates, Inc. of Delmar, New York in collaboration with the Florida Mental Health Institute (FMHI), the University of Maryland's Center for Behavioral Health, Justice and Public Policy and R.O.W. Sciences, Inc.

Cross-Systems Mapping & Taking Action for Change

Appendix L: Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists

Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists

Larry Davidson, Ph.D.[1], and Michael Rowe, Ph.D.[2]

The CMHS National GAINS Center May, 2008

The past decade has witnessed a virtual explosion in the provision of peer support to people with serious mental illness, including those with criminal justice system involvement. Acting on one of the key recommendations of the President's New Freedom Commission on Mental Health, 30 states have developed criteria for the training and deployment of "peer specialists," while at least 13 states have initiated a Medicaid waiver option that provides reimbursement for peer-delivered mental health services.

What Is Peer Support?

While people in recovery can provide conventional services, peer support *per se* is made possible by the provider's history of disability and recovery and his or her willingness to share this history with people in earlier stages of recovery. As shown in Figure 1, peer support differs from other types of support in that the experience of having "been there" and having made progress in one's own personal recovery comprises a major part of the support provided.

Forensic peer support involves trained peer specialists with histories of mental illness and criminal justice involvement helping those with similar histories. This type of support requires special attention to the needs of justice-involved people with mental illness, including an understanding of the impact of the culture of incarceration on behavior. Recognition of trauma and posttraumatic stress disorder, prevalent among this population, is critical.

What Do Forensic Peer Specialists Do?

Forensic Peer Specialists assist people through a variety of services and roles. Given the history of stigma and discrimination accruing to both mental illness and incarceration, perhaps the most

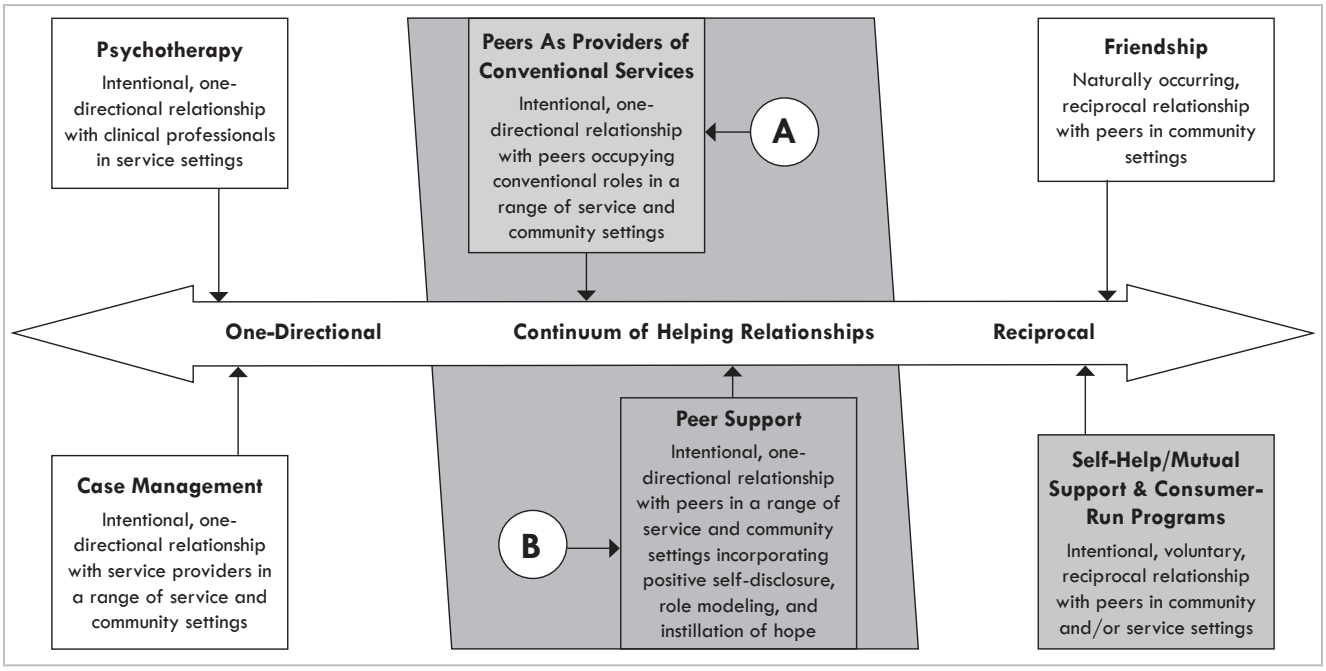

Figure 1. A Continuum of Helping Relationships

1 Associate Professor/Director, Program for Recovery and Community Health, Yale University School of Medicine and Institution for Social and Policy Studies

2 Associate Clinical Professor/Co-Director, Program for Recovery and Community Health, Yale University School of Medicine and Institution for Social and Policy Studies

important function of Forensic Peer Specialists is to instill hope and serve as valuable and credible models of the possibility of recovery. Other roles include helping individuals to engage in treatment and support services and to anticipate and address the psychological, social, and financial challenges of re-entry. They also assist with maintaining adherence to conditions of supervision.

Forensic Peer Specialists can serve as community guides, coaches, and/or advocates, working to link newly discharged people with housing, vocational and educational opportunities, and community services. Within this context, they can model useful skills and effective problem-solving strategies, and respond in a timely fashion to prevent or curtail relapses and other crises. Finally, Forensic Peer Specialists provide additional supports and services, including:

Forensic Peer Specialists embody the potential for recovery for people who confront the dual stigmas associated with serious mental illnesses and criminal justice system involvement.

- Sharing their experiences as returning offenders and modeling the ways they advanced in recovery
- Helping people to relinquish attitudes, beliefs, and behaviors learned as survival mechanisms in criminal justice settings (such as those addressed by SPECTRM [Sensitizing Providers to the Effects of Incarceration on Treatment and Risk Management] and the Howie T. Harp Peer Advocacy Center)
- Sharing their experiences and providing advice and coaching in relation to job and apartment hunting
- Supporting engagement in mental health and substance abuse treatment services in the community, including the use of psychiatric medications and attending 12-step and other abstinence-based mutual support groups
- Providing information on the rights and responsibilities of discharged offenders and on satisfying criminal justice system requirements and conditions (probation, parole, etc.)
- Providing practical support by accompanying the person to initial probation meetings or treatment appointments and referring him or her to potential employers and landlords
- Helping people to negotiate and minimize continuing criminal sanctions as they make progress in recovery and meet criminal justice obligations.
- Working alongside professional staff
- Training professional staff on engaging consumers with criminal justice history

How Forensic Peer Specialists Can Help Transform Mental Health Services and Linkages Between Systems

Forensic Peer Specialists embody the potential for recovery for people who confront the dual stigmas associated with serious mental illnesses and criminal justice system involvement. Forensic peer specialists are able to provide critical aid to persons in the early stages of re-entry, in much the same way that peer specialists who support peers with mental illness alone (i.e., without criminal justice system involvement), have been able to engage into treatment persons with serious mental illnesses (Sells et al., 2006; Solomon, 2004). Beyond the initial engagement phase, however, little is known empirically about the value Forensic Peer Specialists add to existing services. Nonetheless, in the limited number of settings in which they have been supported, case studies clearly suggest using Forensic Peer Specialists is a promising, cost effective practice.

Five Things Your Community Can Do to Integrate Forensic Peer Specialists in Services and Supports

1. Identify and educate key stakeholders, including consumers, families, victims' rights organizations, mental health care providers, criminal justice agencies, and peer-run programs regarding the value of Forensic Peer Specialists.

2. Convene focus groups with these constituencies to assess the demand for trained Forensic Peer Specialists and to identify barriers to their employment.

3. Identify and contact potential funding sources such as state vocational rehabilitation agencies,

local and state departments of health, and the judiciary.

4. Work with human resources departments of behavioral health agencies to identify and overcome bureaucratic obstacles to hiring Forensic Peer Specialists, such as prohibitions to hiring people with felony histories.

5. Address stigma within both the local community and the larger mental health and criminal justice systems so that people with histories of mental illness and criminal justice involvement will be more readily offered opportunities to contribute to their communities.

Future Directions

Little attention has been paid to the nature of training and supervision required by Forensic Peer Specialists, Study in this area would ensure that systems of care are able to reap the maximum benefit from the contributions of Forensic Peer Specialists. Future directions should involve systematic efforts to design and evaluate training curricula, and to build on and expand current knowledge about the effectiveness of forensic peer services through research and information sharing. Future work should also involve creating clear roles, job descriptions, and opportunities for advancement in this line of work. In addition, for this alternative and promising form of service delivery to mature, barriers to the implementation and success of Forensic Peer Specialist work, including non-peer staff resistance, the reluctance of behavioral health agencies to hire people with criminal justice histories, and state criminal justice system rules forbidding ex-offenders from entering prisons to counsel returning offenders, will need to be addressed.

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Cross-Systems Mapping & Taking Action for Change

Appendix M: Overcoming Legal Impediments to Hiring Forensic Peer Specialists

Overcoming Legal Impediments to Hiring Forensic Peer Specialists

LaVerne D. Miller, Esq.[1] and Jackie Massaro, LMSW[2]

The CMHS National GAINS Center May, 2008

As peer support roles have expanded in the delivery of mental health treatment and support services, it has become evident that individuals with serious mental illness who have had criminal justice system involvement can leverage that experience into a unique position to help engage and provide services to peers in earlier stages of recovery. As agencies have increasingly become committed to including these individuals as voluntary or paid Forensic Peer Specialists in treatment and support service teams, many have met daunting legal impediments to employment because of the very experience that makes their inclusion on these teams so valuable: criminal justice history.

Impediments

Among the major impediments to employment of Forensic Peer Specialists are:

- Employment laws that may prohibit hiring individuals with criminal histories
- Public information about a person's criminal justice system involvement that is often inaccurate or misleading
- Individuals lacking awareness of their current legal status or what information is available to potential employers

Employment Laws

Most states have laws that relate to hiring people with criminal histories, and agencies are often unaware of these laws as potential obstacles to employing Forensic Peer Specialists. While laws vary by state, all such statutes are intended to protect the public. Unfortunately, the same laws often block individuals in recovery from becoming self-supporting and active contributors to their communities.

Restrictive state employment laws and licensing requirements may apply to a variety of jobs or may be specific to positions in the human services fields. Typically, there is no consideration of the relevance of criminal history to the specific license or employment sought. Many states do provide avenues for flexibility or lifting of restrictions, but individuals and agencies are often unaware of these options.

Public Information

Many states ... provide avenues for flexibility or lifting of restrictions, but individuals and agencies are often unaware of these options.

Public information about a person's involvement in criminal activity and culpability is often inaccurate or misleading. When individuals in a mental health crisis are arrested, it may be because the arresting officer is unaware of alternatives that provide safety or access to treatment. Therefore, the person's rap sheet, a record that details an individual's arrests and convictions, can be deceptive. Also, for a variety of reasons, rap sheets can be inaccurate. In some states, laws permit employers and licensing agencies to inquire about and consider arrests that never led to conviction. Many states allow access to records about arrests, incarceration, and conviction online. Since this information is not accompanied by any explanation, it is often misinterpreted.

Current Legal Status

Individuals often do not know to ascertain their legal status, how to access information about their arrest history, or how to expunge arrest information. They also do not know what information is available to the public. When people with mental illness are arrested, it is often for minor offenses, and the individuals are released with the expectation of returning to court at a future date. Frequently, however, they do not understand they must return to court. When a person is homeless, the court may not have an address at which the person (the defendant) can be reached with

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a notification for a court date. If the person fails to appear in court, the judge may issue a warrant. Failure to appear in court is often a more serious charge than the original offense. These warrants are often left open and unresolved. Individuals may be unaware that these warrants exist until a potential employer does a background check.

Avoiding Impediments

Potential employers, employment programs, and Forensic Peer Specialist applicants can take proactive steps to avoid impediments to employment. These steps should include gaining an understanding of state employment laws and obtaining assistance with legal issues that might interfere with employment.

Awareness of Employment Laws

It is essential that both potential employers and those with criminal histories entering the work force become aware of state laws that are relevant to hiring individuals with criminal histories. Agencies that wish to hire individuals in recovery as Forensic Peer Specialists should be familiar with any restrictions affecting individuals with a criminal record in the expected job role. Also, it is essential to determine if the state issues "certificates of rehabilitation" or if it provides other avenues to allow flexibility or lifting of restrictions for hiring individuals with criminal histories. This responsibility is often delegated to the human resources division of an agency.

Preparing for Employment.

Providing Direction. Potential employers and employment services can help applicants by providing direction for resolving any active legal issues or to expunge arrests that have not led to conviction. For instance, in New York City, the Legal Action Center will assist individuals in obtaining copies of rap sheets and in challenging inaccurate information. The City of San Francisco's Public Defenders Office has a section dedicated to clearing inaccurate rap sheets. These services are free or fees may be waived.

Determining Legal Status. The job applicant should determine his or her legal status, (i.e., whether charges are pending, whether there has been a guilty plea and conviction, or whether there are any outstanding warrants). An individual with a criminal history should review his or her rap sheet on a regular basis, ensure its accuracy, and seek correction of any errors.

When conditions have been met or a sentence completed, individuals should obtain a written document, often called a certificate of disposition, as proof of successful completion of legal obligations. Individuals should explore whether it is possible to have arrests that did not lead to conviction expunged.

Potential employers and employment services can help applicants by providing direction for resolving any active legal issues or to expunge arrests that have not led to conviction.

Vacating a Warrant. If a job applicant has any open warrants, steps must be taken to have them vacated. The first step is to restore the case to the court calendar. A defendant, prosecutor, or defense attorney can make a formal request (written or oral) to the judge to restore to the court calendar a case that was previously removed. Once this has been accomplished, the person can properly respond to the charges. A judge can vacate (dismiss) a warrant upon a motion of the defendant or the prosecution. The judge may determine that the warrant was issued in error, or the judge may decide to accept the defendant's explanation for not appearing or for other behavior. For example, the judge may accept an explanation such as failure to appear because the person was hospitalized for a psychiatric emergency. A judge may also be interested in quickly disposing minor cases where an individual is able to demonstrate his or her rehabilitation, including employment, treatment, volunteer work, participation in a training program, or successful completion of the conditions of a jail diversion program. It may take more than one court appearance to successfully dispose of the open case.

It is important that individuals understand the legal consequences of "surrendering" to a court to vacate a warrant, and they should make an informed decision about doing so. The public defender's office (or other legal counsel) should be consulted.

Probation, Parole or Other Community Corrections. When individuals are sentenced to probation, remain under the supervision of state parole agencies, or have other court-imposed conditions of release, it can impact job responsibilities, job placement, and job retention strategies. For example, a position may be available for

Glossary

Rap Sheet – An official record that details arrests and convictions.

Certificates of Disposition – An official court document detailing the case and certifying how a criminal case was resolved. It indicates the charges, defendant's plea, case disposition (found guilty or not), sentence or fine that was imposed, whether the defendant successfully served the sentence or met other conditions that were imposed.

Open Warrant – An order to appear in court or to provide information to the court. Warrants can be issued if an individual fails to make a required appearance in court, parole, probation, or fails to pay a fine without being excused by the court.

Vacate Warrant – The judge can determine that a warrant is no longer in effect.

Restore to Court Calendar – A defendant, prosecutor or defense attorney can make a formal request that the judge put a case back on the calendar that was previously removed from the calendar. Once a case is restored to the calendar, the individual can properly respond to any charges.

Disposed – When a case has been resolved by dismissal, sentencing or completion of conditions.

a Forensic Peer Specialist to provide jail in-reach, but the applicant's active parole or probation status may prohibit entry to a correctional facility. Joint efforts between correctional agencies, the courts, human service employers, and the individuals with criminal backgrounds can remove some obstacles. Some successful joint efforts include asking the courts to modify orders and conditions of release or requesting early termination of parole or probation.

Mitigating Evidence. Job applicants with criminal histories who are subject to background checks may have an opportunity to offer mitigating evidence supporting their application for employment. Individuals should begin to collect supporting documents at the earliest opportunity. This evidence might be obtained from a variety of sources:

- Division of Parole or Probation (letter of reference or good conduct; documentation of completion of treatment or other conditions)
- Applicant's prospective and/or former employer(s) (letters of support)
- Treatment providers (letters indicating achievements in recovery and rehabilitation milestones)
- Educational and vocational records (including peer specialist training programs)
- Community members who know the applicant (letters of support)

Future Directions

Forensic Peer Specialists are not only an important source of support for others in recovery, but also they are a potential resource for interrupting the cycle of arrest and recidivism. However, to utilize this resource, states will have to re-examine laws relating to the employment of people with criminal histories and adopt policies and practices that facilitate successful reintegration in society. Individuals seeking employment as Forensic Peer Specialists should take proactive steps to avoid impediments where they can. Employers and programs committed to full employment of this population must be proactive and dedicate staff to manage these issues. Partnerships with consumer-run programs can help fulfill this need.

Resource

Legal Action Center, (2004). After prison: Roadblocks to re-entry, A report on state legal barriers facing people with criminal records. Retrieved from the internet at www.lac.org/roadblocks.html.

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Appendix N: Supported Employment

Supported Employment

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The National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness May, 2006

One factor that has facilitated Supported Employment's (SE's) popularity and its subsequent designation as an evidence-based practice (EBP) is that the definition of SE is relatively straightforward. The essential characteristics of SE have even been defined in the Rehabilitation Act Amendments of 1986 as competitive work in integrated work settings with follow along supports for people with the most severe disabilities.

As a practice, SE is designed to help the person select, find, and keep competitive work. The development of the practice of SE was most innovative in several important ways: 1) placement into jobs was achieved more quickly without the extensive job preparation common in sheltered workshops; 2) the provision of supports after the person obtained a competitive job was offered for as long as was needed, and; 3) the assumption that all people, regardless of disability severity, could do meaningful, productive work in normal work settings (Anthony & Blanch, 1987).

Supported Employment as an Evidence Based Program

Compared to rigorous research on most psychiatric rehabilitation interventions, the research on SE is voluminous. Bond's 2004 review of the SE research based its conclusions on a review of four studies of the conversion of day treatment to supported employment and nine randomized controlled trials (RCT). Bond estimated that in the RCTs 40–60 percent of people with psychiatric disabilities obtained jobs, compared to less than 20 percent in the controlled conditions. Anthony, Cohen, Farkas, and Gagne (2002) estimated that supported employment interventions could triple the employment base rate from 15–45 percent.

No doubt the most extensive research of SE reported after Bond's reviews is the seven state, multi-site study of supported employment (Cook et al., 2005a; 2005b) called the Employment Intervention Demonstration Program (EIDP). This RCT study showed that SE participants were significantly more likely (55%) than comparison participants (34%) to achieve competitive employment. Based on the research cited above, the Center for Mental Health Services has sponsored the Supported Employment implementation resource kit. (www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/).

Anthony, Cohen, Farkas, and Gagne (2002) estimated that supported employment interventions could triple the employment base rate from 15–45 percent

Supported Employment Applications to Criminal Justice System Clients

No known published studies have addressed the effectiveness of supported employment services in populations of justice-involved individuals with severe mental illness. There is some evidence, albeit highly preliminary, that supported employment may be efficacious for forensic populations, based on an exploratory analysis of data from a large multi-site study of evidence-based practice (EBP) supported employment programs called the Employment Intervention Demonstration Program (EIDP) (J.A. Cook, personal communication, September 22, 2005). In the EIDP, 1,273 newly enrolled participants who met criteria for "severe and persistent mental illness" based on diagnosis, duration, and disability were randomly assigned at seven sites to EBP supported employment programs or services as usual/comparison control programs and followed for 2 years. At baseline, participants were asked whether they had been arrested or picked up for any crimes in the past 3 months and, if so, how many times this had occurred. Only 3 percent of the sample (n=37) responded in the affirmative, and the large majority of these individuals said that they had been arrested/picked up once (78%) with the remainder reporting multiple incidents.

Regarding background characteristics, there were no significant differences between those with recent justice involvement and those without on gender, minority status, education, marital status, self-rated functioning, prior hospitalizations, self-reported substance use, diagnosis with mood disorder, diagnosis with depressive disorder, or level of negative symptoms (such as blunted affect or emotional withdrawal). However, compared to their counterparts, the justice-involved group was significantly younger, more likely to have worked in the 5 years prior to study entry, and less likely to have a diagnosis of schizophrenia. The justice-involved group also had significantly higher levels of positive symptoms (such as hallucinations and delusions) and general symptoms (such as anxiety and disorientation). There was no significant difference in study condition assignment.

Turning next to vocational outcomes, there was no difference between those who reported forensic involvement and the remainder of the cohort on the likelihood of employment over the 2 year follow-up period, the likelihood of working full-time during the follow-up, the total number of hours worked during this time, or the total number of dollars earned. Next, these 4 outcomes were tested in multivariate models that included study condition (experimental condition vs. control) and recent forensic involvement, while controlling for time and all background variables on which the forensic and non-forensic

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groups differed (i.e., age, prior work, schizophrenia, positive symptoms, and general symptoms). In all of the models, the indicator for forensic involvement was non-significant while study condition remained significant, indicating that experimental condition participants had better work outcomes. These preliminary results suggest that evidence-based practice supported employment services produced better outcomes regardless of whether participants had been arrested or picked up for a crime in the 3 months prior to study entry. Further study is required to refute or confirm these initial findings, and to address whether and how supported employment assists consumers with forensic involvement to return to work.

Suggestion for Practice

Based on this analysis of existing SE research and its application to people with psychiatric disabilities in contact with the criminal justice system, there are a number of suggestions of what to do given the absence of data specific to employment interventions for these individuals.

1 The implied logic model for people with psychiatric disabilities in contact with the criminal justice system assumes that after an arrest people should have the opportunity to receive mental health treatment. Such mental health treatment is assumed to lead to fewer arrests, less violence, and less public nuisances. However, with respect to employment outcomes we cannot expect that mental health treatment will also lead to future employment (Anthony et al., 2002); in this instance, "you get what you pay for." If a supported employment intervention is not part of the mental health treatment, then employment outcomes should not be expected to be effected. Nevertheless, employment remains a legitimate goal for this population. Without a mental health treatment intervention that incorporates an SE practice, the possibility of achieving employment outcomes for this population is insignificant.

If a supported employment intervention is not part of the mental health treatment, then employment outcomes should not be expected to be effected.

2 Assume, unless proven otherwise, that the empirically supported principles of SE apply to people with a criminal justice background. This assumption is in line with the notion that people are more alike than clinically/functionally different, and that research-based SE knowledge gained on people with psychiatric disabilities may apply across different subgroups of individuals with psychiatric disabilities, including those in contact with the criminal justice system. This is not to imply that there are not inherent differences between subgroups, but that the place to start an examination is with the assumption of similarities in the principles of how to help people achieve competitive work.

3 It is clear that increasing numbers of individuals are becoming involved with both the mental health system and the criminal justice system (Massaro, 2004), with the resulting need for providers trained across both systems. In particular, mental health providers need to know about the barriers to employment experienced by people in the criminal justice system (Legal Action Center, 2004). Furthermore, it must be noted that while there are unique knowledge components integrated into each of these fields, it presently should be assumed that both groups would need to become expert in the fundamental principles of supported employment.

4 The lack of evidence-based SE programs for justice-involved persons with mental illness attests to the lack of vocational interventions for this group. Access to such programming can occur either by increasing the programs directly focused on this population or by explicitly targeting this population for involvement in generic SE programs. Given the dearth of current programming available, it would seem both type of access initiatives are critically needed. With this group being younger and more often employed in the past five years than comparable, non-justice-involved persons with mental illness, there is every reason to place a high priority on supported employment programs to enhance recovery and to offer the prospects of reduced long range service costs to the community.

Employment is a stabilizing factor for justice-involved individuals and important to maintaining a healthy, productive lifestyle. Research has stated that there is an increasing number of individuals becoming involved with both the mental health and criminal justice systems, so it is important for providers to be trained across both mental health and criminal justice systems to be better able to understand the challenges in improving employment outcomes. Two programs, Howie the Harp and the Center for Behavioral Health Services, both located in New York City, offer comprehensive supported employment programs that integrate many services under the guidance of teams of specialists. □

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Cross-Systems Mapping & Taking Action for Change

Appendix O: Moving Toward Evidence-Based Housing Programs for Persons with Mental Illness in Contact with the Justice System

Moving Toward Evidence-Based Housing Programs for Persons with Mental Illness in Contact with the Justice System

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The CMHS National GAINS Center

May 2006, *Updated May 2009*

Research shows that a one-size-fits-all approach to housing for persons with mental illness who are justice involved will not work. What works in housing for most persons with mental illness may be different from what works for those who are justice involved — particularly those individuals released from jail and prison to the community and placed under correctional supervision.

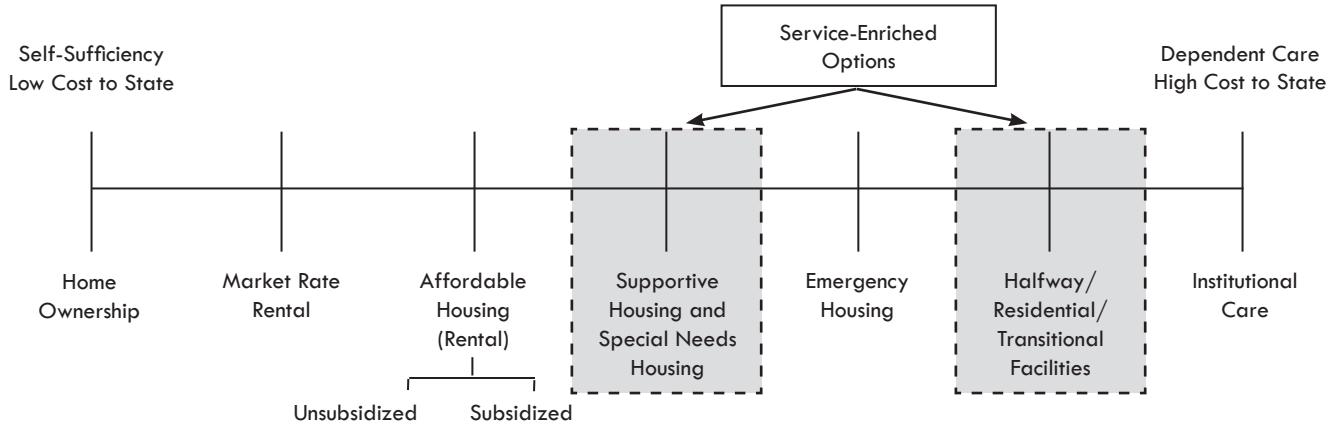
The reentry population may have differing needs than individuals with mental illness who have *not* had contact with the justice system. The *type* of criminal justice contact can play an important role in determining the best housing options for consumers as well. Persons returning from prisons and jails may have high-level needs given the requirements of supervision (e.g., remain drug free, obtain employment). Housing options should provide a balance between the often competing needs of criminal justice supervision and flexible social service provision.

Taking into consideration the reentry point of individuals can provide the basis for understanding how their mental health needs can be integrated with criminal justice system needs. When a person is under criminal justice supervision, housing and the services that come with housing must simultaneously satisfy the service needs of the individual and the demands of the criminal justice system. Furthermore, those returning to the community after being in the custody of the criminal justice system for long periods of time often lack awareness of the range of housing options, as well as the skills to make appropriate housing-related decisions.

With regard to returning prisoners, research suggests that residential instability and incarceration are compounding factors influencing both later residential instability and re-incarceration. A large study examining persons released from New York State prisons found that having both histories of shelter use and incarceration increased the risk of subsequent re-incarceration and shelter use (Metraux & Culhane, 2004). Data collected on individuals in U.S. jails suggests that individuals who experience recent homelessness have a homelessness rate 7.5 times higher than the general population (Malone, 2009). Individuals with links to the mental health system had considerably higher proportions of shelter stays and re-incarcerations post release than those without links to the mental health system. Other studies have found that persons with mental illness who experience housing instability are more likely to come in contact with the police and/or to be charged with a criminal offense (Brekke et al., 2001; Clark, Ricketts, & McHugo, 1999). These factors contribute to the overrepresentation of homelessness and mental illness among inmates in correctional facilities.

Housing for persons with mental illness who have had contact with the justice system can be viewed along a continuum of options from full self-sufficiency to full dependent care (see Figure 1). The most available or

Figure 1. The Continuum of Housing Options for Persons with Mental Illness Who Have Had Contact with the Justice System



Source: Modified from Safe Homes, Safe Communities. 2001. Minnesota Department of Corrections

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appropriate housing option for individuals may differ depending on which reentry point (i.e., diversion, jail, or prison) an individual enters the community. Supportive housing and special needs housing, and transitional facilities (highlighted in Figure 1) are the main options for consumers of housing in need of services to treat mental health conditions, outside of the provision of institutional care. Supportive housing and special needs housing are permanent housing options coupled with support services. These types of housing are most often partially or wholly supported by HUD and specifically designed to support disadvantaged populations. Permanent housing options have proven to have a one-year retention rate of 72% or higher at keeping formerly homeless individuals from returning to homelessness (Malone, 2009).Transitional housing is an umbrella term to capture any housing that is not permanent but is designed to provide at least some type of service that assists clients with establishing community reintegration or residential stability.

To navigate the intricate landscape of housing for persons with mental illness who have had contact with the justice system, it is important to understand that the service-enriched options for housing can utilize a range of approaches from *housing first* to *housing ready*. These approaches are underlying principles that guide the provision of housing and services to individuals who are homeless or have been deemed "hard to house."

The *housing first* approach offers the direct placement from the street (or an institution) to housing with support services available, but not required. Often, the only requirements are that individuals not use substances on the premises and abide by the traditional lease obligations of paying rent and refraining from violence and destruction of property. In contrast, *housing ready* starts with treatment and progresses through a series of increasingly less service-intensive options with the goal of permanent supportive housing as people are "ready." Housing is transitional in *housing ready* models and generally features services that are "high demand," as described below.

Although requirements and configurations of services vary tremendously across service-enriched housing options, service-related models cluster along a continuum from low demand to high demand. The literature describing housing options suggests that the service component is a key variable that will impact outcomes. Although some evaluation studies have found that housing with low-demand service provision may work well for persons with mental illness, low demand services might not be an option when individuals are under high levels of correctional supervision. Although correctional supervision-related coercion (e.g., mandatory drug testing) has been shown to work well in many circumstances with criminal justice-involved clients who have a mental illness, experts know little about how coercion works with those who have a mental illness.

Using Supportive Housing Programs for Persons with Mental Illness: Cook County's Frequent Users Program

In 2006, the Corporation for Supportive Housing (CSH) launched its Returning Home Initiative. Under this initiative, CSH has worked collaboratively with the Cook County Jail in Illinois to pilot a program that links people with long histories of homelessness, mental illness, and incarceration to supportive housing. The Illinois Demonstration Program for Frequent Users of Jail, Shelter, and Mental Health Services focuses on people that:

- √ Have demonstrated a history of repeated homelessness upon discharge from jail;
- √ Have been engaged by the jail's mental health services or state mental health system at least 4 times;
- √ Have a diagnosed serious mental illness of schizophrenia, bipolar, obsessive compulsive or schizo-affective disorder.

These "frequent users" are provided with permanent affordable housing, and comprehensive mental health and long-term support services. The program targets the 10,000 people with serious mental illness that cycle annually between homelessness and the county jail.

For more information, visit: http://www.csh.org

Lessons can be learned from a California initiative focused on persons with mental illness and other major challenges including homelessness, recent incarceration, and a co-occurring substance use disorder. In 1999, California passed Assembly Bill 34 to fund housing and treatment programs for homeless individuals with a diagnosed mental illness. Specifically, the programs are designed to provide comprehensive services to adults who have severe mental illness and who are homeless, at risk of becoming homeless, recently released from jail or state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided. State funds provide for outreach programs and mental health services along with related medications, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and other non-medical programs necessary to stabilize this population.

Evaluation of findings from the California initiative suggests that the provision of housing to persons who have mental illness and are justice involved through a

housing first approach can enhance residential stability and increase successful community integration (Burt & Anderson, 2005; Mayberg, 2003). Findings also indicate that programs serving the most challenging clients (those with longer histories of homelessness and incarceration) produce similar housing outcomes as programs serving less challenging clients (Burt & Anderson, 2005). Essentially, people with serious mental illness and histories of arrest or incarceration can achieve housing stability with adequate support.

Likewise, Malone (2009) examined housing outcomes for 347 homeless adults with disabilities and behavioral health disorders in a supportive housing program in Seattle WA and found that the presence of a criminal history did not predict housing success or failure. In fact, results of the study indicate that when adequate supports are utilized individuals with more extensive criminal history, more serious criminal offenses, and more recent criminal activity all succeed in supportive housing at rates equivalent to others.

Although results from the AB2034 evaluation and the Seattle study suggest that *housing first* models are appropriate and often successful strategies for housing persons with multiple challenges, our review of seven promising reentry housing programs operating nationwide (in-depth interviews were conducted with program directors) found that, with the exception of one program, the reentry programs are utilizing *housing ready* approaches.

Six of the seven programs reviewed were designed as transitional programs with a treatment focus. For the majority of the programs, all or some consumers of housing are under parole supervision. Some of the programs offer combination housing, where consumers can progress through different housing options. Related to the *housing ready* approach, the reentry populations served generally have little service or housing choice in the beginning of their continuum. Tenant rights are usually program based (but the program may transfer rights of tenancy if participants move into more permanent housing within the supported housing program). There is often 24-hour supervision and surveillance and on-site service teams present during the day for mandated sessions and activities. But, importantly, at the end of the progression through the various housing options, at least three housing programs offer permanent housing.

In summary, when criminal justice system contact is added into the mix of characteristics of clients served by current housing options targeting persons with mental illness, some issues may be more relevant/salient than others. The AB 2034 programs in California and the study in Seattle have shown that success can be achieved with *housing first* models, but it is important to note that, for the most part, the consumers in these two studies were not under correctional supervision. Although the seven programs reviewed in the discussion paper were not selected to be representative of all existing programs, it appears that, in practice, providers serving the reentry population are utilizing *housing ready* approaches, as opposed to housing first approaches. Not surprisingly, the review found that reentry programs offering permanent housing are rare. However, we see evidence that the number of permanent housing options for returning prisoners is increasing across the country.

This fact sheet is based on a larger discussion paper, developed for and reviewed by an expert panel convened by the National GAINS Center and is available for distribution. The discussion paper provides a detailed synthesis of the criminal justice and housing and homelessness literature as it pertains to reentry housing, and describes seven promising reentry housing programs that serve persons with mental illness. ■

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Appendix P: Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions

Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions

A Consensus Report of the CMHS National GAINS Center's Forum on Combat Veterans, Trauma, and the Justice System

August 2008

> *… The 33-year-old veteran's readjustment to civilian life is tormented by sudden blackouts, nightmares and severe depression caused by his time in Iraq. Since moving to Albany last June … [he] accidentally smashed the family minivan, attempted suicide, separated from and reunited with his wife and lost his civilian driving job.*
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> *In June … [he] erupted in a surprisingly loud verbal outbreak, drawing police and EMTs to his home.*
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> War's Pain Comes Home
> Albany Times Union – November 12, 2006
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> *… His internal terror got so bad that, in 2005, he shot up his El Paso, Texas, apartment and held police at bay for three hours with a 9-mm handgun, believing Iraqis were trying to get in …*
>
> *The El Paso shooting was only one of several incidents there, according to interviews. He had a number of driving accidents when, he later told his family, he swerved to avoid imagined roadside bombs; he once crashed over a curb after imagining that a stopped car contained Iraqi assassins. After a July 2007 motorcycle accident, his parents tried, unsuccessfully, to have him committed to a mental institution.*
>
> The Sad Saga of a Soldier from Long Island
> Long Island Newsday – July 5, 2008

On any given day, veterans account for nine of every hundred individuals in U.S. jails and prisons (Noonan & Mumola, 2007; Greenberg & Rosenheck, 2008). Although veterans are not overrepresented in the justice system as compared to their proportion in the United States general adult population, the unmet mental health service needs of justice-involved veterans are of growing concern as more veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) return home with combat stress exposure resulting in high rates of posttraumatic stress disorder (PTSD) and depression.

OEF/OIF veterans constitute a small proportion of all justice-involved veterans. The exact numbers are unknown—the most recent data on incarcerated veterans are from 2004 for state and Federal prisoners (Noonan & Mumola, 2007) and 2002 for local jail inmates (Greenberg & Rosenheck, 2008), before OEF/OIF veterans began returning in large numbers.

Some states have passed legislation expressing a preference for treatment over incarceration (California and Minnesota) and communities such as Buffalo (NY) and King County (WA) have implemented strategies for intercepting veterans with trauma and mental conditions as they encounter law enforcement or are processed through the courts. However, most communities do not know where to begin even if they recognize the problem.

This report is intended to bring these issues into clear focus and to provide local behavioral health and criminal justice systems with strategies for working with justice-involved combat veterans, especially those who served in OEF/OIF.

Combat Veterans, Trauma, and the Criminal Justice System Forum

The CMHS National GAINS Center convened a forum in May 2008 in Bethesda, MD, with the purpose of developing a community-based approach to meeting the mental health needs of combat veterans who come in contact with the criminal justice system. Approximately 30 people participated in the forum, representing community providers, law enforcement, corrections, the courts, community-based veterans health initiatives, peer support organizations, Federal agencies, and veteran advocacy organizations. See Appendix.

We begin with the recommendations that emerged from this meeting and then provide the data that support them.

Recommendations for Screening and Service Engagement Strategies

The following recommendations are intended to provide community-based mental health and criminal justice agencies with guidance for engaging justice-involved combat veterans in services, whether the services be community-based or through the U.S. Department of Veterans Affairs's health care system—the Veterans Health Administration (VHA).

➤ Recommendation 1: Screen for military service and traumatic experiences.

The first step in connecting people to services is identification. In addition to screening for symptoms of mental illness and substance use, it is important to ask questions about military service and traumatic experiences. This information is important for identifying and linking people to appropriate services.

The Bureau of Justice Statistics of the U.S. Department of Justice, Office of Justice Programs, has developed a set of essential questions for determining prior military service (Bureau of Justice Statistics, 2006). These questions relate to branch of service, combat experience, and length of service. See Figure 1 for the questions as they were asked in the 2002 Survey of Inmates in Local Jails. One question not asked in the BJS survey, but worth asking, is:

Did you ever serve in the National Guard or Reserves?

Yes
No

Did you ever serve in the U.S. Armed Forces?
- Yes
- No

In what branch(es) of the Armed Forces did you serve?
- Army (including Army National Guard or Reserve)
- Navy (including Reserve)
- Marine Corps (including Reserve)
- Air Force (including Air National Guard and Reserve)
- Coast Guard (including Reserve)
- Other – Specify

When did you first enter the Armed Forces?
- Month
- Year

During this time did you see combat in a combat line unit?
- Yes
- No

When were you last discharged?
- Month
- Year

Altogether, how much time did you serve in the Armed Forces?
- # of Years
- # of Months
- # of Days

What type of discharge did you receive?
- Honorable
- General (Honorable Conditions)
- General (Without Honorable Conditions)
- Other Than Honorable
- Bad Conduct
- Dishonorable
- Other – Specify
- Don't Know

Figure 1. Military Service Questions from the Bureau of Justice Statistics 2002 Survey of Inmates in Local Jails (Bureau of Justice Statistics, 2006)

A number of screens are available for mental illness and co-occurring substance use. Refer to the CMHS National GAINS Center's website (www.gainscenter.samhsa.gov) for the 2008 update of its monograph on behavioral health screening and assessment instruments. The National Center for PTSD of the U.S. Department of Veterans Affairs provides the most comprehensive information on screening instruments available for traumatic experiences, including combat exposure and PTSD. Many of the screens are available for download or by request from the Center's website (http://www.ncptsd.va.gov). Comparison charts of similar instruments are provided, rating the measures based on the number of items, time to administer, and more. Measures available from the Center include:

- PTSD Checklist (PCL): A self-report measure that contains 17 items and is available in three formats: civilian (PCL-C), specific (PCL-S), and military (PCL-M). The PCL requires up to 10 minutes to administer and follows DSM-IV criteria. The instrument may be scored in several ways.
- Deployment Risk and Resilience Inventory (DRRI): A set of 14 scales, the DRRI can be administered whole or in part. The scales assess risk and resilience factors at pre-deployment, deployment, and post-deployment.
- Clinician Administered PTSD Scale (CAPS): A 30-item interview that can assess PTSD symptoms over the past week, past month, or over a lifetime (National Center for PTSD, 2007).

➤ **Recommendation 2: Law enforcement, probation and parole, and corrections officers should receive training on identifying signs of combat-related trauma and the role of adaptive behaviors in justice system involvement.**

Knowing the signs of combat stress injury and adaptive behaviors will help inform law enforcement officers and other frontline criminal justice staff as they encounter veterans with combat-related trauma. Such information should be incorporated into Crisis Intervention Team (CIT) trainings. The Veterans Affairs Medical Center in Memphis (TN) (www.memphis.va.gov) has been involved in the development of the CIT model, training officers in veterans crisis issues, facilitating dialogue in non-crisis circumstances, and facilitating access to VA mental health services for veterans in crisis.

The Veterans Health Administration has committed to outreach, training, and boundary spanning with local law enforcement and other criminal justice agencies through the position of a Veterans' Justice Outreach Coordinator (Veterans Health Administration, 2008a). Each medical center is recommended to develop such a position. In addition to training, a coordinator's duties include facilitating mental health assessments for eligible veterans and participating in the development of plans for community care in lieu of incarceration where possible.

➤ **Recommendation 3: Help connect veterans to VHA health care services for which they are eligible, either through a community-based benefits specialist or transition planner, the VA's OEF/OIF Coordinators, or through a local Vet Center.**

Navigating the regulations around eligibility for VHA services is difficult, especially for those in need of services. To provide greater flexibility for OEF/OIF combat veterans in need of health care services, enrollment eligibility has been extended to five years past the date of discharge (U.S. Department of Veterans Affairs, 2008) by the National Defense Authorization Act (Public Law 110-181). Linking a person to VHA health care services is dependent upon service eligibility and enrollment. Community providers can help navigate these regulations through a benefits specialist or by connecting combat veterans to a VA OEF/OIF Coordinator or local Vet Center.

Vet Centers, part of the U.S. Department of Veterans Affairs, provide no-cost readjustment counseling and outreach services for combat veterans and their families. Readjustment counseling services range from individual counseling to benefits assistance to substance use assessment. Counseling for military sexual trauma is also available. There are over 200 Vet Centers around the country. The national directory of Vet Centers is available through the national Vet Center website (http://www.vetcenter.va.gov/).

OEF/OIF Coordinators, or Points of Contact, are available through many facilities and at the network level (Veterans Integrated Service Network, or VISN). The coordinator's role is to provide OEF/OIF veterans in need of services with information regarding services and to connect them to facilities of their choice—even going so far as to arrange appointments.

In terms of access to VA services among justice-involved veterans, data are available on one criterion for determining eligibility: discharge status. Among jail inmates who are veterans, 80 percent received a discharge of honorable or general with honorable conditions (Bureau of Justice Statistics, 2006). Inmates in state (78.5%) or Federal (81.2%) prisons have similar rates (Noonan & Mumola, 2007). Apart

from discharge status, access to VA health care services is dependent upon enrollment within a fixed time period after discharge, service needs that are a direct result of combat deployment, and length of active duty service So despite this 80 percent figure, a significant proportion of justice-involved veterans who are ineligible for VA health care services based on eligibility criteria or who do not wish to receive services through the VA will depend on community-based services.

➤ **Recommendation 4: Expand community-based veteran-specific peer support services.**

Peer support in mental health is expanding as a service, and many mental health–criminal justice initiatives use forensic peer specialists as part of their service array. What matters most with peer support is the mutual experience—of combat, of mental illness, or of substance abuse (Davidson & Rowe, 2008). National peer support programs such as Vets4Vets and the U.S. Department of Veteran Affairs's Vet to Vet programs have formed to meet the needs of OEF/OIF veterans. It is important that programs such as these continue to expand in communities around the country.

➤ **Recommendation 5: In addition to mental health needs, service providers should be ready to meet substance use, physical health, employment, and housing needs.**

Alcohol use among returning combat veterans is a growing issue, with between 12 and 15 percent of returning service members screening positive for alcohol misuse (Milliken et al, 2007). Based on a study of veterans in the Los Angeles County Jail in the late 1990s, nearly half were assessed with alcohol abuse or dependence and approximately 60 percent with other drug (McGuire et al., 2003). Moreover, the same study found that of incarcerated veterans assessed by counselors, approximately one-quarter had co-occurring disorders. One-third reported serious medical problems. Employment and housing were concerns for all the incarcerated veterans in the study.

Available information suggests that comprehensive services must be available to support justice-involved veterans in the community.

Background

Since the transition to an All Volunteer Force following withdrawal from Vietnam, the population serving in the U.S. Armed Forces has undergone dramatic demographic shifts. Compared with Vietnam theater veterans, a greater proportion of those who served in OEF/OIF are female, older, and constituted from the National Guard or Reserves. Fifteen percent of the individuals who have served in OEF/OIF are females, almost half are at least 30 years of age, and approximately 30 percent served in the National Guard or Reserves.

From the start of combat operations through November 2007, 1.6 million service members have been deployed to Iraq and Afghanistan, with nearly 500,000 from the National Guard and Reserves (Congressional Research Service, 2008). One-third have been deployed more than once. For OEF/OIF, the National Guard and Reserves have served an expanded role. Nearly 40 percent more reserve personnel were mobilized in the six years following September 11, 2001, than had been mobilized in the decade beginning with the Gulf War (Commission on the National Guard and Reserves, 2008). The National Guard, unlike the active branches of the U.S. Armed Forces and the Reserves, serves both state and Federal roles, and is often mobilized in response to emergencies and natural disasters.

Combat stress is a normal experience for those serving in theater. Many stress reactions are adaptive and do not persist. The development of combat-related mental health conditions is often a result of combat stress exposure that is too intense or too long (Nash, n.d.), such as multiple firefights (Hoge et al., 2004) or multiple deployments (Mental Health Advisory Team Five, 2008).

A recent series of reports and published research has raised concerns over the mental health of OEF/OIF veterans and service members currently in theater. The Army's Fifth Mental Health Advisory Team report (2008) found long deployments, multiple deployments, and little time between deployments contributed to mental health conditions among those currently deployed for OEF/OIF. The survey found mental health problems peaked during the middle months of deployment and reports of

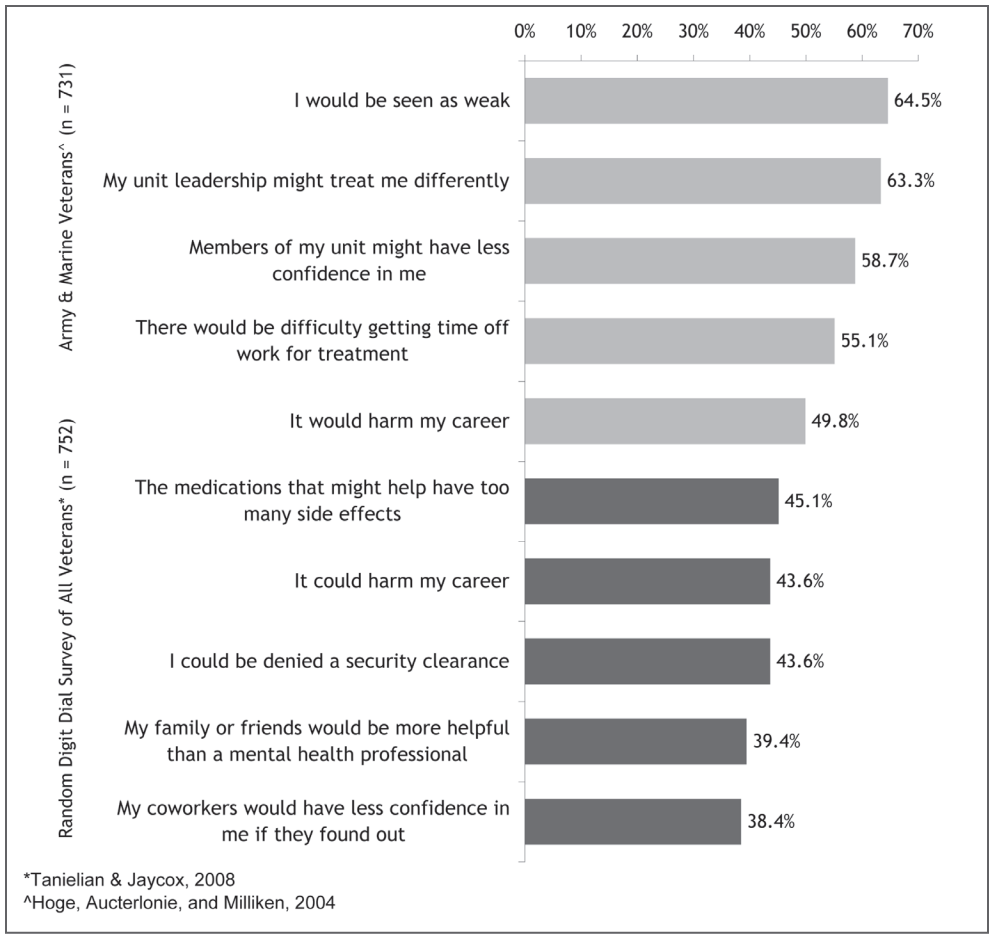

Figure 2. Most Reported Barriers to Care from Two Surveys of Individuals Who Served in OEF/OIF & Who Met Criteria for a Mental Health Condition

problems increased with successive deployments. In terms of returning service members, a random digit dial survey of 1,965 individuals who had served in OEF/OIF found approximately 18.5 percent had a current mental health condition and 19.5 percent had experienced a traumatic brain injury (TBI) during deployment. The prevalence of current PTSD was 14.0 percent, as was depression (Tanielian & Jaycox, 2008).

Reports of mental health conditions have increased as individuals have separated from service. By Department of Defense mandate, the Post-Deployment Health Assessment is administered to all service members at the end of deployment. Three to six months later, the Post-Deployment Health Reassessment is re-administered. From the time of the initial administration to the reassessment, positive screens for PTSD jumped 42 percent for those who served in the Army's active duty (from 12% to 17%) and 92 percent for Army National Guard and Army Reserve members (from 13% to 25%) (Milliken, Auchterlonie, & Hoge, 2007). Depression screens increased as well, with Army National Guard and Army Reserve members reporting higher rates than those who were active duty.

In addition to the increase in mental health conditions, the post-deployment transition is often complicated by barriers to care and the adaptive behaviors developed during combat to promote survival.

Behaviors that promote survival within the combat zone may cause difficulties during the transition back to civilian life. Hypervigilance, aggressive driving, carrying weapons at all times, and command and control interactions, all of which may be beneficial in theater, can result in negative and potentially criminal behavior back home. Battlemind, a set of training modules developed by the Walter Reed Army Institute of Research, has been designed to ease the transition for returning service members. Discussing aggressive driving, the Battlemind literature states, "In combat: Driving unpredictably, fast, using rapid lane changes and keeping other vehicles at a distance is designed to avoid improvised explosive devices and vehicle-born improvised explosive devices," but "At home: Aggressive driving and straddling the middle line leads to speeding tickets, accidents and fatalities." (Walter Reed Army Institute of Research, 2005).

Many veterans of OEF/OIF in need of health care services receive services through their local VHA facilities, whether the facilities be medical centers or outpatient clinics. Forty percent of separated active

duty service members who served in OEF/OIF use the health care services available from the VHA. For National Guard and Reserve members, the number is 38 percent (Veterans Health Administration, 2008b).

A number of barriers, however, reduce the likelihood that individuals will seek out or receive services. According to Tanielian and Jaycox (2008), of those veterans of OEF/OIF who screened positive for PTSD or depression, only half sought treatment in the past 12 months. To compound this treatment gap, the authors determined that of those who received treatment, half had received only minimally adequate services. In an earlier study of Army and Marine veterans of OEF/OIF with mental health conditions, Hoge and colleagues (2004) found only 30 percent had received professional help in the past 12 months despite approximately 80 percent acknowledging a problem. Even among OEF/OIF veterans who were receiving health care services from a U.S. Department of Veterans Affairs Medical Center (VAMC), only one-third of those who were referred to a VA mental health clinic following a post-deployment health screen actually attended an appointment (Seal et al., 2008). Based on surveys (Hoge, Auchterlonie, & Milliken, 2004; Tanielian & Jaycox, 2008) of perceived barriers to care among veterans of OEF/OIF who have mental health conditions, the most common reasons for not seeking treatment were related to beliefs about treatment and concerns about negative career outcomes.[1] See Figure 2 for a review of the findings from the two surveys.

Justice System Involvement Among Veterans

At midyear 2007, approximately 1.6 million inmates were confined in state and Federal prisons, with another 780,000 inmates in local jails (Sabol & Couture, 2008; Sabol & Minton, 2008). Based on Bureau of Justice Statistics data (Noonan & Mumola, 2007; Greenberg & Rosenheck, 2008), on any given day approximately 9.4 percent, or 223,000, of the inmates in the country's prisons and jails are veterans. Comparable data for community corrections populations are not available.

The best predictor of justice system involvement comes from the National Vietnam Veterans Readjustment Study (NVVRS). Based on interviews conducted between 1986 and 1988, **the NVVRS found that among male combat veterans of Vietnam with current PTSD (approximately 15 percent of all male combat veterans of Vietnam), nearly half had been arrested one or more times (National Center for PTSD, n.d.).** At the time of the study, this represented approximately 223,000 people.

Veterans coming into contact with the criminal justice system have a number of unmet service needs. A study by McGuire and colleagues (2003) of veterans in the Los Angeles County Jail assessed for service needs by outreach workers found 39 percent reported current psychiatric symptoms. Based on counselor assessments, approximately one-quarter had co-occurring disorders. Housing and employment were also significant issues: one-fifth had experienced long term homelessness, while only 15 percent had maintained some form of employment in the three years prior to their current jail stay. Similar levels of homelessness have been reported in studies by Greenberg and Rosenheck (2008) and Saxon and colleagues (2001).

Conclusion

This report provides a series of recommendations and background to inform community-based responses to justice-involved combat veterans with mental health conditions. Many combat veterans of OEF/OIF are returning with PTSD and depression. Both for public health and public safety reasons, mental health and criminal justice agencies must take steps to identify such veterans and connect them to comprehensive and appropriate services when they come in contact with the criminal justice system.

1 In May 2008, Department of Defense Secretary Robert Gates, citing the Army's Fifth Mental Health Advisory Team report (2008) findings on barriers to care, announced that the question regarding mental health services on the security clearance form (Standard Form 88) would be adapted (Miles, 2008). The adapted question will instruct respondents to answer in the negative to the question if the delivered services were for a combat-related mental health condition. Those whose mental health condition is not combat related will continue to be required to provide information on services received, including providers' contact information and dates of service contact.

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Appendix

Participants of the CMHS National GAINS Center Forum on Combat Veterans, Trauma, and the Criminal Justice System

May 8, 2008, Bethesda, MD

A. Kathryn Power, MEd, Director of the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration, provided the opening comments at the forum.

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